Chapter 4

Health Status, Healthcare, and Healthcare Utilisation

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Population ageing presents both an opportunity and a challenge. The improvements in human longevity due to developments in medicine, technology, public health, nutrition, and overall living are also accompanied by a rise in age-associated disabilities. People in old age are more likely to develop chronic diseases, which can lead to physical and cognitive impairments and frailty, concomitantly reducing their quality of life. Managing chronic diseases requires extensive medical care, which places a strain on healthcare systems and economic burdens on communities and families. Increased dependency amongst older adults requires assistance with daily activities; this creates emotional and financial stress, particularly on the family.

Achieving good health is important as we age because healthy ageing is a precondition for active ageing. A healthy older population is essential not only for individual well-being but also for society in general. Longer and healthier lives translate to enhanced well-being, more productive older populations, and reduced burdens on pension and healthcare systems. At the same time, harnessing the benefits of the shift towards an ageing population requires investments in quality healthcare, adaptable workplaces, and community engagement, amongst others. Such investments will result in a virtuous cycle in which older adults who are healthier can enjoy fulfilling lives, contribute to economic and social development, and reduce the financial strains on public systems.

The first step to attaining good health and late-life autonomy is a better understanding of health status, its key determinants, and its underlying mechanisms. This is particularly relevant in the Philippine context, where older people have poor health conditions with significant disparities across sectors of the population.

This chapter, which is the core of the LSAHP Wave 2 (W2) study, will describe a wide range of health and health-related factors that are key to understanding the health status of older Filipinos. In particular, we discuss health status using various dimensions of health, including physical, mental, and functional states, health care utilisation, health-related behaviours, diet, and nutrition.

1. Health Status

The W2 survey collected data on both subjective and objective measures of health which were collected in Wave 1 (W1) to ensure future analyses of health transitions. The following analysis will focus only on the W2 survey results.

1.1. Self-assessed Health

Generally, older persons expressed a modest view of their health, with no significant difference by gender or age. A greater proportion of older Filipinos rated their health as 'average' (46%). The proportion reporting poorer-than-average health is higher than the proportion who perceive their health as either 'very healthy' or 'healthier than average' (Table 4.1).

Table 4.1. Self-assessed Health by Sex and Age

Self-assessed Health	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Current								
Very healthy	8.2	13.4		12.6	9.7	12.8		11.4
Healthier than average	8.7	7.9		8.1	9.9	2.9		8.2
Of average health	49.6	44.5	*ns*	49.9	43.7	42.8	*ns*	46.4
Somewhat unhealthy	25.7	29.8		25.1	29.8	34.8		28.2
Very unhealthy	7.9	4.4		4.3	7.0	6.7		5.7
N	*1,160*	*2,225*		*1,034*	*1,556*	*795*		*3,385*

ns = not significant.

Source: Calculated by the DRDF using original LSAHP W2 data.

1.2. Diagnosed Illnesses

This poor self-rated health aligns with other health measures, with 73% of older Filipinos reporting having been diagnosed with at least one physical illness, including fractures, with no statistically significant differences by age or sex. The reported prevalence of illnesses is expected to be lower than the true prevalence, as it does not account for individuals who may have an illness but had not yet been diagnosed by a physician at the time of the interview. This is confirmed by earlier findings of a substantial proportion of older persons with unmet health needs (Paguirigan, 2023).

High blood pressure is the most commonly reported illness, with about half (48%) of older Filipinos reporting being diagnosed with hypertension (Table 4.2). Following high blood pressure in prevalence are cataracts (19%); arthritis, neuralgia, or rheumatism (18%); diabetes (13%); renal or urinary tract infection (10%); respiratory illnesses (9%); and angina or myocardial infarction (9%). These illnesses afflict older persons with no discernible variations across age and sex, except for diabetes and arthritis, neuralgia, or rheumatism, which display significant age discrepancies. The latter conditions show a monotonic increase with advancing age, from 13% amongst those less than 70 years old to 24% amongst those in their 80s.

Table 4.2. Diagnosed Illnesses by Sex and Age

Diagnosed Illnesses	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
GROUP 1								
Arthritis, neuralgia, or rheumatism	15.0	19.5	*ns*	13.0	20.4	23.8	***	17.9
Chronic back pain	1.4	1.9	*ns*	1.4	1.7	2.9	*ns*	1.8
Cataracts	15.0	21.7	*	10.4	23.7	30.6	*ns*	19.3
Fractures of the hip, thigh, and pelvis or broken hip	1.3	2.4	*ns*	1.3	1.8	4.1	*ns*	2.0
Other fractures	2.9	2.5	*ns*	1.3	3.9	3.2	*ns*	2.7
At least one of the Group 1 illnesses	29.2	38.3	*	23.3	41.6	48.3	***	35.0
GROUP 2								
High blood pressure	43.2	51.2	*ns*	48.1	48.0	49.4	*ns*	48.3
Angina or myocardial infarction, etc.	7.6	10.3	*	8.9	9.1	10.8	*ns*	9.3
Cerebrovascular disease (e.g. haemorrhage, infarction, and stroke)	7.0	9.0	*ns*	5.5	10.0	11.2	*	8.3
Diabetes	11.5	13.5	*ns*	15.4	10.5	11.6	*	12.8
Respiratory illness (chronic, such as asthma and emphysema)	10.3	8.9	*ns*	7.8	11.0	9.5	*ns*	9.4
Digestive illness (stomach or intestinal)	6.7	3.3	**	4.2	4.7	5.1	*ns*	4.5
Renal or urinary tract ailments or kidney disease	10.2	10.7	*ns*	11.3	9.4	11.2	*ns*	10.5
Osteoporosis	0.0	1.6	***	0.4	1.0	2.5	***	1.0
Tuberculosis	5.9	1.1	***	3.7	2.0	2.8	*ns*	2.8
Ailments of the liver or gall bladder	2.0	2.7	*ns*	3.4	1.4	2.6	*ns*	2.4
Glaucoma	1.6	2.1	*ns*	1.7	2.1	2.1	*ns*	1.9
Cancer	0.6	0.7	*ns*	0.7	0.5	0.9	*ns*	0.7
Slipped disc	0.6	0.4	*ns*	0.1	0.1	1.9	***	0.4
At least one of the Group 2 illnesses	63.7	67.5	*ns*	65.0	65.7	70.0	*ns*	66.1
At least one of any illnesses (excluding dementia)	72.0	73.5	*ns*	69.8	73.4	79.9	*ns*	73.0
N	*1,343*	*2,668*		*1,076*	*1,731*	*1,204*		*4,011*
Dementia (only asked of the proxy)	2.7	6.4	*ns*	3.5	3.4	6.8	*ns*	5.4
N	*172*	*419*		*34*	*161*	*396*		*591*

Diagnosed Illnesses	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
At least one of any illnesses (including dementia)	72.2	73.7	*ns*	69.8	73.5	80.6	*ns*	73.1
N	*1,343*	*2,668*		*1,076*	*1,731*	*1,204*		*4,011*
Have blood pressure monitor at home	20.0	32.7	**	25.6	31.2	26.3	*ns*	28.0
N	*1,218*	*2,399*		*1,054*	*1,624*	*939*		*3,617*

*p < .05, **p < .01, ***p < .001, ns = not significant.

Source: Calculated by the DRDF using original LSAHP W2 data.

Despite the high prevalence of high blood pressure amongst older Filipinos, only 28% of them have a blood pressure monitor at home. This level is significantly higher amongst females than males (33% vs 20%).

We also inquired about the level of physician-diagnosed dementia, with the question limited to proxy respondents of older persons. Proxy interviews were allowed for respondents who either did not pass the cognitive test or were unable to respond due to various health and health-related conditions, such as hospitalisation, illness, incapacity, difficulty hearing, difficulty speaking, or a psychological disorder. Results indicate that 5% of this subgroup of older persons have been diagnosed with dementia, with no significant sex or age differences but a higher prevalence amongst the oldest age group relative to their young counterparts.

1.3. Experience of Heart Attack

Heart disease is the top killer disease for both men and women in the Philippines (Lusica and Jimeno, 2023; UPPI and DRDF, 2021). As such, it is important to monitor the prevalence of this illness, particularly amongst older adults who are likely to exhibit higher levels of association. Results show that at least 5% of older Filipinos have experienced a heart attack, with no significant variation observed across sex and age. Heart attacks occurred at an average age of 58 years (Table 4.3). The majority of those who have experienced heart attacks do not take any medication for their condition. Only 42% are currently taking medicines for their heart condition, with those in the youngest age group (<70) exhibiting the highest level at 61%. Further analysis is needed to understand why individuals aged 70–79 exhibited the lowest level.

Table 4.3. Experience of Heart Attack by Sex and Age

Heart Attack	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Ever had a heart attack	7.2	3.4	*ns*	4.4	5.8	3.2	*ns*	4.8
N	*1,343*	*2,668*		*1,076*	*1,731*	*1,204*		*4,011*
Mean age experienced heart attack	58.98	55.88	*ns*	57.37	56.82	61.62	*ns*	57.58
N	*59*	*101*		*48*	*74*	*38*		*160*
Currently taking medicine for heart condition	28.0	58.8	*ns*	60.9	24.0	54.5	*	41.9
N	*59*	*101*		*48*	*74*	*38*		*160*

*p < .05, ns = not significant.

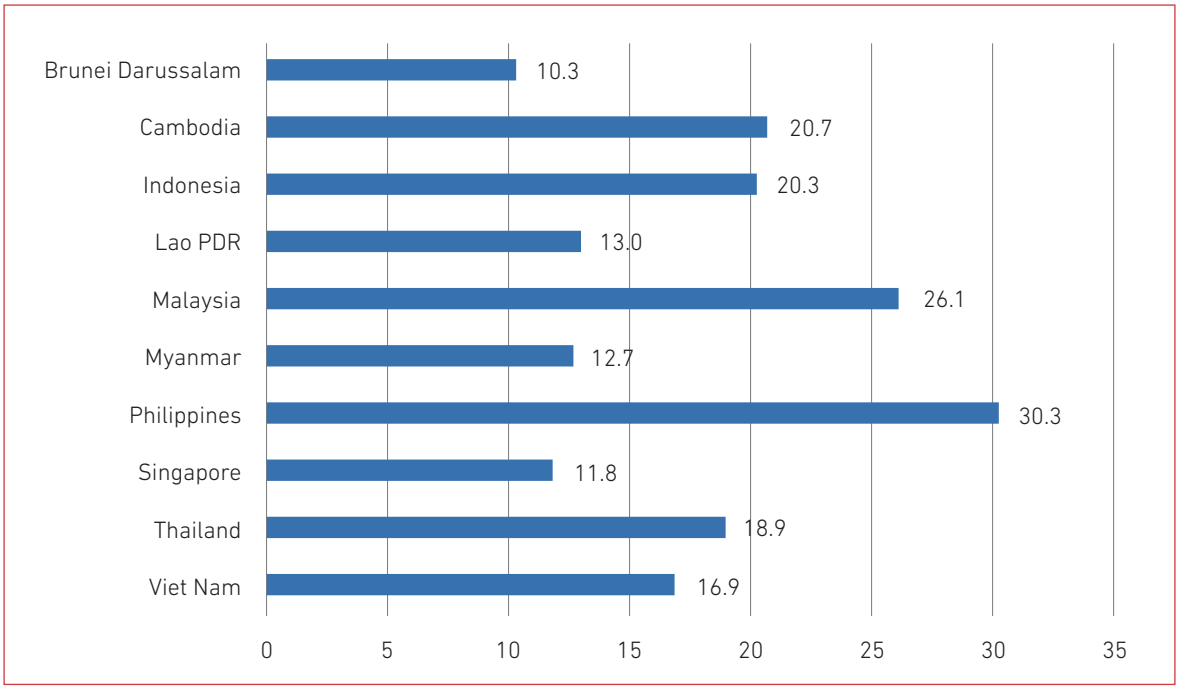
Source: Calculated by the DRDF using LSAHP W2 data.

1.4. Oral Health

Oral health is an important aspect of overall health and well-being amongst older people. As individuals age, they are more prone to losing some or all their natural teeth. Tooth loss can impact an individual's ability to chew food effectively, affect speech, and potentially result in nutritional deficiencies. Dentures play a vital role in maintaining proper oral health by preventing the remaining natural teeth from shifting out of position.

Filipino older adults exhibit poorer oral health compared to their Association of Southeast Asian Nations (ASEAN) counterparts. An intercountry comparison of the level of edentulism amongst the population aged 60 years and over shows that the Philippines has the highest rate, with 30% of its older adults toothless as of 2021. In contrast, Brunei Darussalam has the lowest rate amongst ASEAN countries, with just 10% of its older adult population experiencing edentulism (Figure 4.1).

Figure 4.1. Prevalence of Edentulism (%), ASEAN, 2021



Note. The prevalence rate was calculated by dividing the number of cases by the total population aged 60 and over.

Source: Graph generated by the DRDF using the Global Burden of Disease Study 2021 results (Global Burden of Disease Collaborative Network, 2021).

Evidence from the W2 survey validates the poor health status of older people. Table 4.4 shows that older persons have an average of eight remaining teeth, with the males having significantly more remaining teeth than the females (11 vs 7, respectively).

Approximately 32% of older Filipinos are edentulous, a rate nearly identical to that of the Global Burden of Disease Study presented in Figure 4.1. Tooth loss is more prevalent amongst females than males, with 38% and 20%, respectively, having no teeth. Age exacerbates tooth loss, as evidenced by a significant decline in the average number of teeth with advancing age. Those in their 80s have an average of 5 remaining teeth, compared to 10 amongst those in their 60s.

Table 4.4. Oral Health by Sex and Age

Oral Health	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Mean number of original teeth	10.46	6.51	***	9.58	7.57	4.59	***	7.94
N	*1,314*	*2,591*		*1,064*	*1,693*	*1,148*		*3,905*
% with no teeth	20.1	38.4	***	21.1	35.3	51.1	**	31.8
N	*1,314*	*2,591*		*1,064*	*1,693*	*1,148*		*3,905*
Mean number of functioning teeth	3.34	1.74	***	2.80	2.25	1.24	***	2.32
N	*1,313*	*2,588*		*1,064*	*1,690*	*1,147*		*3,901*
% who have dentures	21.2	45.1	***	37.1	34.2	39.9	*ns*	36.4
N	*1,343*	*2,668*		*1,076*	*1,731*	*1,204*		*4,011*
% who use dentures when they eat	85.8	88.5	*ns*	92.3	85.3	83.0	*ns*	87.9
N	*245*	*1,015*		*332*	*539*	*389*		*1,260*
% who are satisfied with their dentures	69.7	80.1	*ns*	78.8	77.1	77.1	*ns*	77.9
N	*245*	*1,015*		*332*	*539*	*389*		*1,260*

**p < .01, ***p < .001, ns = not significant.

Source: Calculated by the DRDF using original LSAHP W2 data.

Oral health was further assessed by examining the number of functioning teeth. Functioning teeth refers to pairs of upper and lower teeth that respondents use for biting and chewing food, regardless of their condition. When asked about the number of pairs of upper and lower teeth they possess, older persons reported an average of 2.

Dentures are a common dental solution for older persons who have lost some or all of their natural teeth. Despite the high prevalence of tooth loss, only 36% of older persons have dentures, with the prevalence amongst females more than double that of males (45% vs 21%). Amongst those with dentures, 9 out of 10 use their dentures when eating. However, there is also some level of dissatisfaction with their dentures, as only 78% of users reported being satisfied, with no apparent differences across sex and age.

1.5. Sleep

Sleep is a common concern for many older adults. Changes in sleep patterns are commonly observed in old age, and older adults develop sleep disorders such as restlessness, trouble falling asleep, trouble waking up during the night, difficulty falling asleep, interrupted sleep, and frequent awakenings. Sleep problems necessitate an assessment as they are linked to poor physical and mental health and, when untreated, can lead to a diminished quality of life.

Older persons reported an average of 6 hours of sleep per night, with no significant differences by sex and age (Table 4.5). Four in five (80%) older persons are satisfied with their sleep. Two in five (42%) take naps regularly for an average of almost an hour. Both the proportion of individuals taking naps and the average nap duration significantly increase with age. For instance, 35% of the youngest cohort take regular naps, with the proportion significantly increasing to 60% amongst those in the oldest cohort. The duration of naps likewise increases from an average of 44 minutes amongst the youngest cohort to 68 minutes for the oldest cohort.

Table 4.5. Sleeping Habits by Sex and Age

Sleeping Habits	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Mean number of hours of sleep per night	6.21	6.31	*ns*	6.19	6.36	6.30	*ns*	6.27
N	*1,162*	*2,239*		*1,038*	*1,561*	*802*		*3,401*
% who are satisfied with their sleep	81.6	79.3	*ns*	78.1	81.7	82.8	*ns*	80.2
N	*1,151*	*2,195*		*1,027*	*1,540*	*779*		*3,346*
Have trouble falling asleep								
Most of the time	19.0	23.6	*ns*	23.3	20.0	23.1	*ns*	21.9
Sometimes	28.8	27.5		27.3	28.6	28.6		28.0
Rarely	*28.2*	*28.3*		*25.9*	*30.0*	*31.4*		*28.3*
Never	24.0	20.6		23.6	21.5	16.9		21.9
N	*1,171*	*2,244*		*1,041*	*1,568*	*806*		*3,415*
Have trouble with waking up during the night								
Most of the time	14.5	19.1	*ns*	17.6	15.6	22.6	*ns*	17.4
Sometimes	26.9	30.8		33.5	25.4	27.1		29.3
Rarely	33.9	28.5		30.3	31.5	28.1		30.5
Never	24.8	21.5		18.6	27.5	22.2		22.8
N	*1,169*	*2,246*		*1,041*	*1,566*	*808*		*3,415*

Sleeping Habits	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Have trouble with waking up too early and not being able to fall asleep again								
Most of the time	28.0	31.0		29.0	29.5	34.4		29.9
Sometimes	32.4	28.8	*ns*	28.6	31.6	31.3	*ns*	30.2
Rarely	22.0	26.2		23.7	25.4	25.2		24.6
Never	17.6	14.0		18.6	13.5	9.1		15.3
N	*1,170*	*2,245*		*1,041*	*1,567*	*807*		*3,415*
Feels really rested when waking up in the morning								
Most of the time	46.0	47.0		42.7	50.7	47.5		46.6
Sometimes	29.4	34.4	*ns*	36.5	28.0	32.9	*ns*	32.5
Rarely	20.4	15.2		17.1	17.1	17.4		17.1
Never	4.2	3.4		3.7	4.2	2.2		3.7
N	*1,168*	*2,243*		*1,041*	*1,565*	*805*		*3,411*
Goes to bed and gets out of bed at about the same times (within one hour) every day								
Most of the time	28.0	37.9		30.6	37.0	37.9		34.2
Sometimes	30.7	30.8	*ns*	31.2	30.3	30.9	*ns*	30.8
Rarely	25.6	21.9		27.4	19.7	20.3		23.3
Never	15.8	9.4		10.8	13.0	10.9		11.8
N	*1,168*	*2,242*		*1,038*	*1,566*	*806*		*3,410*
Stays awake all day without dozing off (either intentionally or unintentionally)								
Most of the time	14.9	17.9		16.4	16.9	17.7		16.8
Sometimes	34.1	34.1	*ns*	34.3	34.2	33.0	*ns*	34.1
Rarely	27.6	27.4		25.6	28.9	29.7		27.5
Never	23.5	20.6		23.7	20.0	19.6		21.7
N	*1,171*	*2,247*		*1,041*	*1,569*	*808*		*3,418*
Usually asleep between 2:00 AM and 4:00 AM								
Most of the time	42.3	40.8		41.1	41.9	40.8		41.4
Sometimes	25.7	31.3	*ns*	29.0	29.6	28.6	*ns*	29.2
Rarely	20.6	20.1		19.9	20.3	21.4		20.3
Never	11.4	7.9		10.0	8.2	9.3		9.2
N	*1,171*	*2,246*		*1,041*	*1,569*	*807*		*3,417*

Sleeping Habits	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Spends less than 30 minutes awake in bed when they sleep at night (including the time it takes to sleep and wake from sleep)								
Most of the time	33.1	41.8		43.7	32.0	41.6		38.5
Sometimes	37.0	30.6	*	31.6	35.5	29.7	ns	33.0
Rarely	21.4	16.0		15.5	20.9	17.8		18.1
Never	8.5	11.7		9.2	11.7	10.9		10.5
N	*1,169*	*2,246*		*1,041*	*1,566*	*808*		*3,415*
% who have taken any medications or used other treatments to help induce sleep in the past 2 weeks	2.6	4.6	*ns*	2.8	4.8	4.5	*ns*	3.9
N	*1,343*	*2,666*		*1,075*	*1,731*	*1,203*		*4,009*
% who take naps regularly	44.2	41.0	*ns*	35.0	42.5	59.6	***	42.2
N	*1,340*	*2,665*		*1,075*	*1,728*	*1,202*		*4,005*
Mean duration of naps (in minutes)	53.89	50.09	*ns*	44.01	51.69	67.99	***	51.48
N	*1,143*	*2,228*		*867*	*1,441*	*1,063*		*3,371*

*p < .05, ***p < .001, ns = not significant.

Source: Calculated by the DRDF using original LSAHP W2 data.

One in five older persons (22%) has trouble falling asleep most of the time. Seventeen percent have trouble with waking up during the night most of the time. Almost a third (30%) consistently have trouble with waking up too early and not being able to fall asleep again. However, a significant proportion (47%) reported feeling rested when waking up in the morning most of the time.

In the LSAHP W2, three additional sleep questions were added. These questions are necessary for creating a sleep health composite based on the SATED model (sleep satisfaction, daytime alertness, sleep timing, sleep effectiveness, and sleep duration) as proposed by Buysse (2014). Some of the questions related to this were already used in W1. Current research has shifted the focus from solely examining sleep-related problems to considering sleep as a health indicator. The creation of such a composite, which considers both sleep quality and sleep quantity, will provide a broader perspective on sleep. However, for the purpose of this report, individual sleep characteristics will be described, and the composite index will be reserved for future studies.

Data show that 17% of older persons consistently stay awake all day without dozing off (either intentionally or unintentionally). Two in five (41%) older persons are usually asleep between 2:00 am and 4:00 am most of the time. Furthermore, 38% spend less than 30 minutes awake in bed when they sleep at night (including the time it takes to sleep and wake from sleep) most of the time. No apparent sex or age gradients were observed for these measures.

1.6. Pain

Pain is a common experience amongst older adults, and its prevalence and severity tend to increase with age. As people age, they are more likely to develop more chronic conditions and degenerative changes that may result in worsening pain. Persistent or recurrent pain can significantly impact the daily lives of older persons, thus affecting their overall well-being.

A third (33%) of older persons said they are often troubled with pain, with no statistically significant difference observed across sex and age (Table 4.6). Amongst those experiencing pain, the majority described it as moderate (58%), whilst 9% and 33% reported severe and mild pain, respectively. Pain is mostly experienced in the following body parts: knees (56%), lower back (34%), hip joint (27%), feet (26%), shoulders (25%), and ankles (18%). The extent to which the experience of pain affects the well-being of older persons is most evident in the significant proportion of older persons (53%) who claimed that the pain makes it difficult for them to do their usual activities such as household chores or work.

Table 4.6. Experience of Pain by Sex and Age

Pain Experience	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who are often troubled with pain	33.2	33.5	*ns*	33.5	32.9	34.3	*ns*	33.4
N	*1,170*	*2,248*		*1,040*	*1,570*	*808*		*3,418*
Severity of pain experienced								
Mild	29.4	35.7		35.9	30.7	33.2		33.4
Moderate	*59.1*	*56.9*	*ns*	*54.1*	*63.6*	*51.9*	*ns*	*57.7*
Severe	11.5	7.3		10.0	5.8	14.9		8.9
N	*382*	*755*		*305*	*530*	*302*		*1,137*
% who said pain makes it difficult for them to do their usual activities	62.9	46.7	*	46.5	57.7	59.2	*ns*	52.7
N	*383*	*754*		*307*	*531*	*299*		*1,137*
Body parts that felt pain								
Head	12.5	13.1	*ns*	11.2	16.3	7.6	*ns*	12.9
Neck	9.5	5.3	*ns*	6.6	7.0	7.3	*ns*	6.8
Shoulders	24.1	25.8	*ns*	23.9	28.6	18.5	*ns*	25.2
Back	20.3	20.0	*ns*	19.4	19.6	24.1	*ns*	20.1
Lower back	32.1	34.6	*ns*	30.1	35.9	39.2	*ns*	33.6
Joints of the hands or arms	13.8	15.5	*ns*	19.9	8.1	18.5	*ns*	14.9
Hip joint	23.1	29.7	*ns*	30.7	23.5	26.8	*ns*	27.2
Knees	54.4	57.1	*ns*	51.0	59.4	64.1	*ns*	56.1
Ankles	21.9	15.3	*ns*	14.4	20.2	22.1	*ns*	17.8

Pain Experience	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Feet	32.9	21.2	*ns*	19.6	29.1	36.1	*ns*	25.5
Others (e.g. knees, ankles, and feet)	7.4	3.1	**	5.8	3.3	5.4	*ns*	4.7
N	*383*	*757*		*307*	*531*	*302*		*1,140*

*p < .05, **p < .01, ns = not significant.

Source: Calculated by the DRDF using original LSAHP W2 data.

1.7. Falls

Older persons have a higher risk of falling than younger individuals due to various factors, including age-related changes in balance, coordination, muscle strength, vision, and reaction time. Environmental hazards such as slippery floors, uneven surfaces, loose rugs, and a lack of handrails or grab bars can also contribute to falls amongst older persons.

About a quarter (24%) of older persons experienced a fall in the year before the interview (Table 4.7). Those who experienced a fall recorded almost two falls on average, and 15% of those who fell were seriously injured enough to need medical treatment. The experience of falls does not vary significantly across age and sex.

Table 4.7. History of Falls by Sex and Age

History of Falls	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who fell in the past 12 months	19.8	25.8	*ns*	24.3	21.4	27.2	*ns*	23.6
N	*1,342*	*2,665*		*1,075*	*1,729*	*1,203*		*4,007*
Mean number of times had fallen in the past 12 months	2.10	1.70	*ns*	1.80	1.70	1.90	*ns*	1.80
N	*238*	*624*		*205*	*373*	*284*		*862*
% who injured self seriously enough to need medical treatment	12.6	16.0	*ns*	10.1	15.6	24.5	*ns*	14.9
N	*240*	*626*		*206*	*375*	*285*		*866*

ns = not significant.

Source: Calculated by the DRDF using original LSAHP W2 data.

1.8. Incontinence

Most older persons (82%) do not have any problem with incontinence. For those who do, 12% have bladder control problems only, 2% have bowel movement control problems, and 4% have both bladder and bowel problems. The condition varies significantly across categories, with females exhibiting higher rates than males and those in the oldest age group expectedly showing the highest prevalence. For example, 1% of those in the youngest cohort have both bladder and bowel control problems as compared to 14% of those in the oldest cohort. Over 88% of the males have no problem, which is 10 percentage points higher than the females. Amongst those who experience incontinence, 30% experience this either often or very often, with no difference across age and sex (Table 4.8).

Table 4.8. Incontinence by Sex and Age

Incontinence	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Loss of bladder or bowel movement								
Both bladder and bowel movement control	2.3	5.2		1.4	3.2	13.5		4.1
Bladder control only	*7.5*	*13.9*	***	*9.3*	*12.8*	*14.7*	***	*11.6*
Bowel movement control only	*1.9*	*2.5*		*1.9*	*1.9*	*4.4*		*2.3*
No loss of control	88.3	78.4		87.5	82.1	67.4		82.0
N	*1,324*	*2,633*		*1,063*	*1,708*	*1,186*		*3,957*
Frequency								
Very often	12.9	12.4		8.7	12.8	16.0		12.5
Often	*14.2*	*18.4*		*13.7*	*15.6*	*23.5*		*17.4*
Sometimes	*38.3*	*35.6*	*ns*	*37.1*	*34.4*	*37.9*	*ns*	*36.2*
Seldom	*26.4*	*25.4*		*28.2*	*29.2*	*18.3*		*25.6*
Very seldom	8.3	8.2		12.4	7.9	4.4		8.2
N	*194*	*662*		*131*	*327*	*398*		*856*

***p < .001, ns = not significant.

Source: Calculated by the DRDF using original LSAHP W2 data.

1.9. Depression

The Centre for Epidemiologic Studies Depression (CES-D) scale, consisting of 20 items, is a widely recognised tool for assessing depressive symptoms (Radloff, 1977). The short-form 11-item version of the CES-D was used in the LSAHP survey because it alleviates respondent burden and reduces the likelihood of false positives (Gellis, 2010; Kohout et al., 1993). However, it has not undergone a formal

validation process in the Philippines. Findings using the LSAHP baseline data support the use of the CES-D scale as a multidimensional instrument for assessing depressive symptoms in older Filipinos. Depression chiefly manifests as somatic in older men and affective in older women (Afable, 2021).

The 11-item CES-D scale from the LSAHP W2 provides some insights into the mental health status of older Filipinos, offering a better understanding of their psychological well-being. On average, older persons in this study scored 5 on the CES-D scale, with no significant disparity in the mean scores across sex and age (Table 4.9).

Table 4.9. Mean Depressive Scores (CES-D Scale) of Older Persons by Sex and Age

CES-D	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Mean depression score	4.84	4.89	*ns*	5.00	4.65	5.18	*ns*	4.87
N	*1,171*	*2,248*		*1,041*	*1,570*	*808*		*3,419*

ns = not significant.

Source: Calculated by the DRDF using original LSAHP W2 data.

1.10. World Health Organization-Five Well-Being Index

Similar to health, there is a growing interest in measuring the well-being of older people as a measure of quality of life. The WHO-Five Well-Being Index, commonly known as the WHO-5, is a comprehensive and flexible measure of the general well-being of a population. It consists of five straightforward questions designed to assess the respondents' subjective well-being. Previous studies have demonstrated its validity as a screening instrument for depression, and it has been utilised across various fields of research (Topp et al., 2015). Since its conception in 1998, WHO-5 has become one of the most widely used scales of well-being. It is an assessment tool validated as a useful instrument for identifying older persons with depression (Heun et al., 2001; Sibai et al., 2009).

The collection of WHO-5 data in the LSAHP W2 survey provides important additional data that will be useful in coming up with additional indicators to better evaluate the mental health status of older Filipinos.

Results show a positive picture across all indicators, with over 7 in 10 older Filipinos agreeing that the following statements applied to them at least more than half of the time in the 2 weeks preceding the survey: 'I felt cheerful and in good spirits', 'I felt calm and relaxed', 'I felt active and vigorous', 'I woke up feeling fresh and rested', and 'My daily life has been filled with things that interest me'. A tiny percentage (<2%) reported not experiencing these feelings at all. The patterns do not show any significant difference by age and sex (Table 4.10).

Table 4.10. World Health Organization-Five Well-Being Index by Sex and Age

% Who Said the Following Statements Applied to Them over the Last 2 Weeks	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Felt cheerful and in good spirits								
At no time	1.3	0.8		1.2	0.8	0.6		1.0
Some of the time	19.1	15.0		15.6	17.0	18.6		16.5
Less than half the time	9.7	8.4		8.3	9.6	8.4		8.9
More than half the time	20.8	20.2	*ns*	20.7	20.1	20.7	*ns*	20.4
Most of the time	36.1	38.3		37.4	39.0	32.7		*37.5*
All of the time	13.0	17.3		16.8	13.5	19.1		15.7
N	*1,170*	*2,248*		*1,041*	*1,569*	*808*		*3,418*
Felt calm and relaxed								
At no time	1.9	0.6		1.5	0.7	0.8		1.1
Some of the time	19.8	17.6		19.3	17.1	19.9		18.4
Less than half the time	9.6	10.0		10.3	9.7	8.7		9.9
More than half the time	18.1	20.3	*ns*	17.3	21.8	19.7	*ns*	19.5
Most of the time	36.0	36.5		38.3	34.7	34.1		36.3
All of the time	14.6	15.1		13.3	16.1	16.8		14.9
N	*1,170*	*2,248*		*1,041*	*1,569*	*808*		*3,418*
Felt active and vigorous								
At no time	2.3	0.8		1.2	1.7	1.0		1.4
Some of the time	15.4	15.1		16.4	13.1	18.3		15.2
Less than half the time	11.1	11.8		8.0	14.7	13.9		11.5
More than half the time	17.8	17.4	*ns*	17.7	16.7	19.9	*ns*	17.6
Most of the time	39.3	40.3		43.1	38.7	32.4		39.9
All of the time	14.1	14.6		13.6	15.1	14.6		14.4
N	*1,170*	*2,248*		*1,041*	*1,569*	*808*		*3,418*
Woke up feeling fresh and rested								
At no time	0.2	0.5		0.3	0.5	0.7		0.4
Some of the time	17.5	15.9		15.5	17.4	17.3		16.5
Less than half the time	8.4	11.3		12.1	8.5	9.1		10.2
More than half the time	17.7	19.3	*ns*	17.4	20.3	18.2	*ns*	18.7
Most of the time	38.9	37.5		40.3	35.5	38.1		38.0
All of the time	17.3	15.6		14.5	18.0	16.6		16.2
N	*1,170*	*2,248*		*1,041*	*1,569*	*808*		*3,418*

% Who Said the Following Statements Applied to Them over the Last 2 Weeks	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Felt that their daily life has been filled with things that interest them								
At no time	1.9	1.6		2.4	1.2	0.7		1.7
Some of the time	20.7	12.1		14.7	15.6	16.5		15.3
Less than half the time	8.3	10.4		8.7	10.3	10.7		9.6
More than half the time	17.5	18.2	*ns*	16.2	19.5	19.3	*ns*	18.0
Most of the time	39.0	41.7		43.3	39.7	34.1		40.7
All of the time	12.6	16.1		14.8	13.7	18.6		14.8
N	*1,170*	*2,248*		*1,041*	*1,569*	*808*		*3,418*

ns = not significant.

Source: Calculated by the DRDF using original LSAHP W2 data.

1.11. Smoking

The W2 survey inquired about the risky health behaviours of older persons, specifically smoking and drinking. Results indicate that 15% of surviving older persons are current smokers, with clear sex and age differentiations (Table 4.11). A higher proportion of males than females are current smokers (29% vs 8%). The proportion of current smokers decreases as age increases. Nearly one in five older persons aged 70 or below (18%) are current smokers compared to 7% of those in their 80s or higher. On average, current smokers consume seven cigarettes per day; cigarette consumption is significantly higher amongst males than females (9 vs 4, respectively). Those in the youngest age group are the heaviest smokers, consuming eight sticks per day compared to nearly four sticks amongst the oldest age group.

Table 4.11. Smoking by Sex and Age

Smoking	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who currently smoke	28.6	7.8	***	18.3	15.8	7.0	*	15.4
N	*1,343*	*2,667*		*1,075*	*1,731*	*1,204*		*4,010*
Mean number of cigarettes or cigars smoked per day	8.99	3.82	***	7.90	7.29	3.52	*	7.31
N	*287*	*137*		*155*	*195*	*74*		*424*

*p < .05, ***p < .001.

Note: Results of the same questions are shown in Table 4.10 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

1.12. Drinking

More than one in five older persons (22%) are currently alcohol drinkers, with a higher prevalence amongst males than females (44% vs 9%). The age pattern in smoking behaviour follows a similar gradient, with younger cohorts more likely to be current alcohol drinkers than their older counterparts. Amongst those who drink, most do so occasionally or a few times a month. About one in five drinks regularly, i.e. daily or a few times a week, with this being reported more frequently by males than females (Table 4.12).

Table 4.12. Drinking by Sex and Age

Drinking	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who are currently alcohol drinkers	43.6	9.1	***	27.5	20.1	10.8	**	21.7
N	*1,343*	*2,667*		*1,075*	*1,731*	*1,204*		*4,010*
On average, frequency of drinking alcohol amongst current alcohol drinkers								
Once a day	4.5	1.6		6.0	1.1	0.9		3.7
A few times a week	19.5	4.1		19.1	9.7	17.1		15.4
Once a week	14.0	11.5	**	12.3	15.0	12.6	ns	13.3
A few times a month	17.2	13.9		14.4	17.7	22.8		16.3
Occasional	44.8	69.0		48.3	56.5	46.6		51.2
N	*555*	*298*		*332*	*383*	*138*		*853*

**p < .01, ***p < .001, ns = not significant.

Note: Results of the same questions are shown in Table 4.11 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

1.13. Diet and Nutrition

An important addition to the W2 survey is the diet and nutrition of older persons. Two instruments were used to collect data on the eating behaviour of older people: the Rapid Diet Screener and the Mini Nutritional Assessment (MNA). Screening tools like the Diet Screener and MNA are essential to the early identification of and intervention for malnutrition amongst older adults. The Diet Screener captures dietary patterns, whilst the MNA includes dietary intake, weight loss, and basic self-care activities. The Diet Screener distinguishes between a healthful pattern, represented by the consumption of fruits, vegetables, and lean proteins, and a less optimal pattern, characterised by the intake of sweets, processed meats, and salty snacks (Bailey et al., 2009). The Center for Health Promotion and

Disease Prevention of the University of North Carolina at Chapel Hill created the tool, whilst North Carolina Prevention Partners developed the widely cited Starting the Conversation questionnaire (Paxton et al., 2011).

Overall, the results indicate that older adults consume protein sources such as chicken, fish, and beans more frequently. Their intake of less nutritious foods, including soft drinks, fried food, instant noodles, fast food, and sweets, is relatively controlled. However, the frequency of fruit and vegetable consumption is notably lower. Specifically, 42% of older adults consume protein sources such as chicken, fish, or beans three or more times per week, whilst 33% consume them one to two times per week, with no significant difference by age and sex. Fruit consumption is generally less frequent, with 78% consuming fruits less than three times each day. Similarly, vegetable intake is low, with 69% consuming them less than three times each day.

Regarding soft drinks, 72% of older adults drink them less than once a day, whilst 23% consume soft drinks one to two times each day. Fried food is consumed less frequently, with 59% of older adults eating fried food less than once a day. Instant noodles and fast food are infrequently consumed amongst older adults, with 85% and 90%, respectively, eating these foods less than once a week. Desserts and sweets follow a similar pattern, with 84% of older adults indulging in them once or less than once a week (Table 4.13).

The MNA data reveal that the majority (73%) of older people reported no decrease in food intake in the 3 months preceding the interview. However, approximately a quarter still face moderate (25%) to severe (2%) declines in food intake, with no age or sex differences. Whilst 49% of the older adults reported no weight loss, about 19% lost 1–3 kg and another 5% lost more than 3 kg within the 3 months preceding the survey. A notable percentage (26%) of older people are uncertain if they have lost weight, indicating a need for monitoring.

Table 4.13. Diet and Nutrition by Sex and Age

Diet and Nutrition	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
A. Rapid diet screener								
Frequency of eating from a fast-food restaurant, including breakfast, lunch, dinner, or snacks, whether dine in, order out, or delivery (e.g. Jollibee, McDonald's, Angel's Burger, Angel's Pizza, Chowking, and KFC)								
Less than once a week	91.5	88.4		88.1	90.8	90.6		89.5
1 to 3 times a week	8.3	10.6	*ns*	11.2	8.4	8.9	*ns*	9.8
4 or more times a week	0.2	1.0		0.7	0.7	0.5		0.7
N	*1,171*	*2,249*		*1,042*	*1,570*	*808*		*3,420*

Diet and Nutrition	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Frequency of eating fruit each day								
5 or more times each day	2.3	2.5		1.8	3.0	3.1		2.5
3 to 4 times each day	14.0	23.4	*	19.9	18.8	23.7	ns	19.9
Less than 3 times each day	83.7	74.0		78.3	78.1	73.2		77.6
N	*1,171*	*2,248*		*1,041*	*1,570*	*808*		*3,419*
Frequency of eating vegetables each day								
5 or more times each day	4.6	1.7		3.3	2.2	2.7		2.8
3 to 4 times each day	25.3	29.6	*	29.2	26.4	28.7	ns	28.0
Less than 3 times each day	70.2	68.7		67.5	71.4	68.6		69.3
N	*1,171*	*2,248*		*1,041*	*1,570*	*808*		*3,419*
Frequency of drinking soft drinks (excluding diet or zero sugar), juices (canned or powdered, 3-in-1 coffee, sweet or milk tea, or other sweetened beverages) each day								
Less than once a day	70.3	72.7		69.4	72.9	77.7		71.8
1 to 2 times each day	23.3	22.4	ns	25.6	21.0	17.6	ns	22.7
3 or more times each day	6.4	4.9		5.0	6.2	4.8		5.5
N	*1,171*	*2,248*		*1,041*	*1,570*	*808*		*3,419*
Frequency of eating chicken, fish, or beans (e.g. monggo, garbanzos (chickpeas), and pork and beans)								
3 or more times a week	38.1	44.5		41.4	43.2	40.8		42.1
1 to 2 times a week	33.6	32.3	ns	32.1	33.7	32.2	ns	32.8
Less than once a week	28.3	23.2		26.5	23.1	27.0		25.1
N	*1,171*	*2,248*		*1,041*	*1,570*	*808*		*3,419*
Frequency of eating instant noodles each week								
Less than once a week	79.7	88.1		84.9	85.0	85.3		85.0
1 to 3 times a week	19.4	10.9	*	14.6	13.6	13.6	ns	14.1
4 or more times a week	0.9	1.0		0.5	1.4	1.1		0.9
N	*1,171*	*2,248*		*1,041*	*1,570*	*808*		*3,419*

Diet and Nutrition	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Frequency of eating desserts and other sweets								
Once or less than once a week	90.2	80.7		84.5	83.6	85.5		84.3
2 to 3 times a week	7.6	15.3	*	13.8	11.0	11.8	ns	12.4
4 or more times a week	2.2	4.0		1.7	5.4	2.7		3.3
N	*1,171*	*2,248*		*1,041*	*1,570*	*808*		*3,419*
Frequency of eating fried foods each day								
Less than once a day	57.7	60.1		58.9	58.3	63.2		59.2
1 to 2 times each day	36.2	36.1	ns	36.0	37.6	31.8	ns	36.2
3 or more times each day	6.1	3.8		5.0	4.1	5.0		4.6
N	*1,171*	*2,248*		*1,041*	*1,570*	*808*		*3,419*
B. Mini Nutritional Assessment								
% who experienced a moderate or severe decrease in food intake over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties								
Severe decrease in food intake	2.5	1.7		1.9	2.0	2.0		2.0
Moderate decrease in food intake	27.9	22.9	ns	27.4	21.4	26.0	ns	24.7
No decrease in food intake	69.7	75.5		70.6	76.7	72.0		73.3
N	*1,171*	*2,248*		*1,041*	*1,570*	*808*		*3,419*
Weight loss during the last 3 months								
Weight loss greater than 3 kg (6.6 lbs.)	5.1	5.1		4.5	6.5	2.1		5.1
Weight loss between 1 to 3 kg (2.2 and 6.6 lbs.)	23.8	16.6	ns	20.2	19.4	15.3	ns	19.3
No weight loss	48.3	49.9		47.9	48.6	57.3		49.3
Does not know	22.8	28.5		27.5	25.5	25.3		26.4
N	*1,171*	*2,248*		*1,041*	*1,570*	*808*		*3,419*

*p < .05, ns = not significant.

Source: Calculated by the DRDF using original LSAHP W2 data.

2. Functional Health

This section focuses on functional health, a new paradigm in the definition of health that emphasises an older adult's ability to self-manage and adapt to their environment rather than merely considering the absence or presence of diseases or infirmity. The functional health framework represents a departure from the earlier static and medical definitions of health to a more multidimensional formulation (Huber et al., 2011). This approach integrates biopsychosocial factors, reflecting a more comprehensive understanding of health.

Functional health is assessed in terms of disability, defined as difficulty or limitation in carrying out activities usually expected for the person's status or role in a specific sociocultural context and physical environment (Nagi's Disability Model, 2019). The term 'disability' refers to societal rather than individual functioning. The categories of required roles include self-care, home management, work, and community service. Accordingly, common measures of functional health include self-reported activities of daily living (ADLs) to measure self-care and instrumental activities of daily living (IADL) to measure independent living.

In this section, we describe the functional health status of older persons using five measures of disability: ADLs, IADLs, the Washington Group Short Set on Functioning (WGSS), the Global Activity Limitation Indicator (GALI), and the experience of being bedridden. We also discuss the Nagi measures of physical functioning as a measure of functional loss.

2.1. Activities of Daily Living

Results indicate that one in five older persons (20%) encounter at least one difficulty in performing at least one of the seven ADLs (Table 4.14). On average, older persons with ADL difficulties experience a total of three difficulties, with going outside or leaving the house (15%) and standing up from a bed or chair or sitting down on a chair (11%) identified as the most difficult to perform, especially amongst those in their 80s. There are no significant sex differences in functional ability, but it varies significantly across age categories. The proportion experiencing ADL difficulties increases from 11% amongst the youngest age group to 44% amongst the oldest cohort.

Table 4.14. Activities of Daily Living (ADL) by Sex and Age

% Who Experience Difficulty with the Following Activities	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Take a bath or shower by oneself	6.0	8.5	*ns*	3.0	5.0	25.6	***	7.6
Dress	6.1	7.7	*ns*	3.5	5.0	21.3	***	7.1
Eat	2.2	3.0	*ns*	1.2	1.1	10.3	***	2.7
Stand up from a bed or chair, sit down on a chair	8.7	11.6	*ns*	4.8	9.9	26.6	***	10.6
Walk around the house	7.7	9.5	*ns*	3.6	7.5	25.2	***	8.8
Go outside (leave the house)	11.6	16.9	*ns*	7.4	14.7	35.0	***	15.0
Using the toilet	6.5	7.8	*ns*	3.4	5.2	22.3	***	7.3
N	*1,343*	*2,667*		*1,075*	*1,731*	*1,204*		*4,010*
% who experienced at least one ADL difficulty	16.3	21.4	*ns*	10.7	18.6	44.2	***	19.5
N	*1,343*	*2,668*		*1,076*	*1,731*	*1,204*		*4,011*
Mean number of ADLs with difficulty	2.99	3.04	*ns*	2.52	2.61	3.76	**	3.03
N	*267*	*731*		*117*	*359*	*522*		*998*

**p < .01, ***p < .001, ns = not significant.

Note: Results of the same questions are shown in Table 5.1 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

2.2. Instrumental Activities of Daily Living

Compared to difficulty in performing self-care (ADLs), older Filipinos reported greater difficulty in performing home care for independent living (i.e. IADLs). About a third (32%) experience at least one difficulty in the seven IADLs, with significant gender and age disparities. The most prevalent IADL difficulty is taking the bus, jeepney, or any public transport to leave home (22%), followed by leaving home to purchase necessary items or medication (16%) and performing light housework such as dusting and cleaning (11%). Older Filipinos reported difficulties in an average of about three IADLs, with no significant differences by sex.

Females are more likely than males to encounter IADL difficulties (36% vs 24%), particularly in taking care of financial matters and taking public transportation to leave home (Table 4.15). There is a significant age gradient across all seven IADLs, with the proportion with at least one IADL difficulty amongst the oldest cohort almost three times that of the youngest cohort (60% vs 18%).

Table 4.15. Instrumental Activities of Daily Living (IADL) by Sex and Age

% Who Experience Difficulty with the Following Activities	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Prepare own meals	10.4	11.5	*ns*	4.5	10.7	28.6	***	11.1
Leave home to purchase necessary items or medication	12.5	17.4	*ns*	7.7	15.2	36.2	***	15.6
Take care of financial matters such as paying utilities	6.8	11.0	**	4.6	8.0	25.2	***	9.5
Use the telephone	4.8	8.6	*ns*	3.5	7.0	17.0	***	7.2
Dust, clean up, other light housework	9.2	12.7	*ns*	4.7	12.7	25.0	***	11.4
Take bus, jeepney, or public transport to leave home	15.2	26.0	***	12.5	22.3	45.2	***	22.0
Take medication as prescribed	5.4	5.8	*ns*	2.1	4.1	18.3	***	5.7
N	*1,343*	*2,667*		*1,075*	*1,731*	*1,204*		*4,010*
% who experienced at least one IADL difficulty	23.8	36.5	***	18.3	34.4	60.1	***	31.9
N	*1,343*	*2,668*		*1,076*	*1,731*	*1,204*		*4,011*
Mean number of IADLs with difficulty	2.70	2.54	*ns*	2.18	2.33	3.25	***	2.58
N	*368*	*1,086*		*178*	*592*	*684*		*1,454*

**p < .01, ***p < .001, ns = not significant.

Note: Results of the same questions are shown in Table 5.2 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

2.3. Washington Group Short Set on Functioning

Another measure employed in the LSAHP to estimate functional health difficulties is the Washington Group Short Set on Functioning (WG-SS). The WG-SS consists of six questions on functioning aligned with WHO's International Classification of Functioning, Disability, and Health biopsychosocial model. It locates disability as an interaction between a person's capabilities (limitation in functioning) and environmental barriers (physical, social, cultural, or legislative) that may limit participation in society. This approach marks a departure from the prior medicalisation of disability, which placed disability within the person and characterised it by impairments or deficits in bodily functions (Madans, Loeb, and Altman, 2011).

Results show a clear age gradient in all six WG-SS activities and no significant sex differences. With advancing age, older Filipinos manifest greater difficulty in the various dimensions of functioning, which affects their social participation with their families and communities. Amongst the six activities, remembering or concentrating is the most common difficulty reported, affecting 47% of older people (Table 4.16). An almost similar proportion reported at least some difficulty in walking or climbing steps (45%), with about 3% claiming they could not do this activity at all. Communicating is the least common difficulty reported, affecting less than a tenth of the older population.

Table 4.16. Washington Group Short Set on Functioning (WG-SS) by Sex and Age

WG-SS Difficulty	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Seeing, even if wearing glasses								
No difficulty	64.4	65.7		72.2	64.2	50.2		65.2
Some difficulty	25.8	27.3	*ns*	24.0	27.7	31.4	***	26.7
A lot of difficulty	7.9	5.5		2.4	7.1	14.6		6.4
Cannot do it at all	1.9	1.5		1.4	1.0	3.9		1.7
Hearing, even if using a hearing aid								
No difficulty	75.0	78.3		86.4	76.2	55.8		77.1
Some difficulty	18.6	14.2	*ns*	11.0	17.7	23.4	***	15.8
A lot of difficulty	3.6	5.5		0.4	4.2	17.3		4.8
Cannot do it at all	2.8	2.0		2.2	1.9	3.5		2.3
Walking or climbing steps								
No difficulty	60.8	51.6		65.5	54.4	29.8		54.9
Some difficulty	27.9	34.6	*ns*	29.1	33.2	37.1	***	32.1
A lot of difficulty	8.8	9.9		4.0	10.3	21.5		9.5
Cannot do it at all	2.6	3.9		1.4	2.1	11.6		3.4

WG-SS Difficulty	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Remembering or concentrating								
No difficulty	57.2	51.0		64.0	51.1	31.4		53.2
Some difficulty	37.9	41.7	*ns*	34.5	43.9	46.3	***	40.3
A lot of difficulty	4.2	6.2		1.3	4.4	18.6		5.5
Cannot do it at all	0.7	1.2		0.3	0.6	3.7		1.0
Self-care (washing all over or dressing)								
No difficulty	89.9	87.0		95.5	88.7	67.7		88.0
Some difficulty	5.7	7.4	*ns*	2.9	8.2	13.1	***	6.8
A lot of difficulty	1.7	3.3		0.6	1.7	10.6		2.7
Cannot do it at all	2.7	2.3		1.1	1.4	8.6		2.5
Communicating								
No difficulty	92.5	89.5		96.5	93.0	69.8		90.6
Some difficulty	5.6	6.9	*ns*	3.2	5.3	17.3	***	6.4
A lot of difficulty	1.5	2.8		0.2	1.0	11.0		2.3
Cannot do it at all	0.5	0.8		0.1	0.7	1.9		0.7
N	*1,343*	*2,667*		*1,075*	*1,731*	*1,204*		*4,010*

***p < .001, ns = not significant.

Note: Results of the same questions are shown in Table 5.3 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

2.4. Global Activity Limitation Indicator

The Global Activity Limitation Indicator (GALI) is a global measure of disability, assessing persistent limitations in various activities within the 6 months preceding the survey. The data are collected from the question 'For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do? Would you say you have been: severely limited? limited but not severely? not limited at all?' GALI was developed within the framework of computing healthy life years to be included in the Eurostat database (Bogaert et al., 2018).

Results show that over half of older Filipinos have experienced limitations in activities they typically engage in because of health problems. Specifically, 15% say they are severely limited, and 39% claim they are limited but not severely (Table 4.17). No significant differences are found between the sexes, but there is an observable age gradient, with those in their 80s being the most limited due to health issues compared to their younger counterparts.

Table 4.17. Global Activity Limitation Indicator (GALI) by Sex and Age

GALI	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Yes, severely limited	12.4	15.9		8.5	14.8	29.7		14.6
Yes, limited but not severely	37.5	39.3	*ns*	35.1	42.1	39.4	***	38.7
Not limited at all	50.1	44.8		56.4	43.2	30.9		46.7
N	*1,343*	*2,668*		*1,076*	*1,731*	*1,204*		*4,011*

***p < .001, ns = not significant.

Note. Results of the same questions are shown in Table 5.4 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

2.5. Bedridden

Being bedridden is a marker of extreme disability that may be due to medical conditions such as chronic illnesses, severe injuries (particularly fractures), major surgeries, and age-related decline and frailty. Extended periods of immobility can lead to the weakening and shrinking of muscles and can impact mental health, leading to feelings of isolation and depression.

In the LSAHP, older persons were asked if they had been bedridden for any reason within the 2 weeks prior to the survey. Results reveal that 4% of older persons had been bedridden during this period (Table 4.18). A significantly higher proportion of males than females experienced bedridden episodes (7% vs 2%). Amongst those who experienced being bedridden, the average duration of bed rest was almost 7 days.

Table 4.18. Experience of Being Bedridden by Sex and Age

Experience Being Bedridden	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who have been bedridden during the past 2 weeks	7.1	2.4	*	3.0	4.4	6.4	*ns*	4.1
N	*1,343*	*2,667*		*1,075*	*1,731*	*1,204*		*4,010*
Mean number of days in bed	5.98	7.63	*ns*	8.19	4.31	8.39	*ns*	6.53
N	*46*	*73*		*26*	*40*	*53*		*119*

*p < .05, ns = not significant.

Note: Results of the same questions are shown in Table 5.5 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

2.6. Nagi Measures of Physical Functioning

Functional loss was measured using the Nagi measures of physical functioning. Data reveal that 65% of older persons have encountered difficulties in performing at least 1 of the 10 activities, with notable disparities based on sex and age (Table 4.19). Significantly more females than males, as well as those in the older cohorts compared to the younger cohorts, reported having experienced difficulties in performing any of the activities. The most common activity that older persons have difficulty performing is lifting an object weighing approximately 10 kg (44%), followed by standing or going without sitting for 2 hours (42%). On average, amongst those with at least one difficulty, older persons face challenges in four activities.

Table 4.19. Nagi Functioning Measures by Sex and Age

Nagi Functioning Measures	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who experience difficulty with the following activities:								
Walk 200 to 300 metres	29.4	39.9	**	25.0	35.6	65.0	***	36.1
Climb 10 steps without resting	34.4	42.5	*	28.8	39.8	66.1	***	39.6
Stand (go without sitting) for 2 hours	36.1	45.3	**	33.5	39.1	70.1	***	41.9
Continue to sit for 2 hours	10.7	15.8	*	9.2	13.1	27.7	***	13.9
Stoop or bend your knees	21.5	31.3	**	19.8	26.9	49.8	***	27.8
Raise your hands above your head	7.8	6.8	*ns*	5.9	5.5	14.5	***	7.2
Extend arms out in front of you as if to shake hands	4.2	4.8	*ns*	4.2	2.6	10.5	***	4.6
Grasp your fingers or move your fingers easily	8.6	8.0	*ns*	5.9	7.9	14.8	**	8.2
Lift an object weighing approximately 10 kg	30.2	52.2	***	29.5	47.9	72.1	***	44.2
N	*1,343*	*2,667*		*1,075*	*1,731*	*1,204*		*4,010*
Lift an object weighing approximately 5 kg (amongst those who have difficulty lifting an object weighing approximately 10 kg)	40.3	41.9	*ns*	29.9	34.4	64.7	***	41.5
N	*406*	*1,533*		*289*	*795*	*855*		*1,939*
% who experienced difficulty in performing any of the 10 activities	55.2	70.3	***	51.6	69.0	88.0	***	64.8
N	*1,343*	*2,668*		*1,076*	*1,731*	*1,204*		*4,011*

Nagi Functioning Measures	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Mean number of Nagi activities with difficulty	3.53	3.82	*ns*	3.31	3.40	4.97	***	3.73
N	*775*	*1,964*		*524*	*1,172*	*1,043*		*2,739*

*p < .05, **p < .01, ***p < .001, ns = not significant.

Note: Results of the same questions are shown in Table 5.6 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

3. Healthcare Utilisation

This section presents key survey results that shed light on various aspects of healthcare utilisation. We explore patterns in inpatient and outpatient utilisation, examine the prevalence of unmet healthcare needs, assess health insurance coverage, and delve into insights regarding long-term care. These results provide a comprehensive overview of how individuals access and use healthcare services, offering valuable insights into the dynamics of healthcare utilisation.

3.1. Inpatient Care Utilisation

In this analysis, we define inpatient utilisation as staying overnight in a hospital or other medical facility in the past year because of an illness or accident. Results show an 8% prevalence of inpatient utilisation, with no disparity across sex and age (Table 4.20). Amongst those who were in inpatient care, the average number of times they sought this service in the past 12 months was 1.4, with 45% of them availing of services from a private hospital. Public health facilities, particularly provincial or city hospitals (23%) and district hospitals (13%), are the other source of inpatient care. Most hospitalisation costs (61%) were covered by the older person's children, with older people and their spouses covering 15% and 7%, respectively. About 82% of older persons availed of PhilHealth benefits as a member, and 8% availed of PhilHealth benefits as a dependent. A mere 1% availed of other medical/health insurance aside from PhilHealth. Almost all older persons (89%) availed of discounts for senior citizens for medical expenses. All indicators of inpatient care utilisation showed no significant disparity by age or sex.

Table 4.20. Inpatient Utilisation by Sex and Age

Inpatient Utilisation	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who stayed overnight in a hospital or other medical facility in the past year because of an illness/accident in the past 12 months	9.0	7.1	*ns*	7.7	7.0	10.0	*ns*	7.8
N	*1,342*	*2,667*		*1,075*	*1,730*	*1,204*		*4,009*
Mean number of times stayed at least overnight in a hospital	1.40	1.49	*ns*	1.45	1.45	1.46	*ns*	1.45
N	*153*	*243*		*94*	*168*	*134*		*396*
Type of facility used the last time hospitalised								
Municipal hospital	12.7	3.3		7.0	5.4	11.1		7.3
District hospital	17.2	10.1		7.7	17.6	15.8		13.1
Provincial or city hospital	18.8	25.6		22.7	26.8	16.0		22.8
Regional hospital	1.5	2.0		0.8	1.1	4.9		1.8
Public or national hospital (e.g. PGH)	5.3	4.5	*ns*	7.6	2.9	2.6	*ns*	4.8
Public specialty hospital	0.0	0.0		0.0	0.0	0.0		0.0
Private clinic	6.8	3.7		6.7	4.2	2.9		5.0
Private hospital	37.7	50.4		47.3	42.1	45.6		45.0
Others	0.0	0.5		0.1	0.0	1.1		0.3
N	*153*	*243*		*94*	*168*	*134*		*396*
Who paid the most for the hospitalisation								
Respondent	16.5	14.5		18.5	17.8	5.0		15.3
Spouse	14.0	2.2		8.2	10.1	0.2		7.2
Children	49.8	68.8		60.1	53.1	75.4		60.8
Grandchildren	0.6	0.9	*ns*	0.0	0.6	2.7	*ns*	0.8
Other relatives	4.3	2.0		2.9	2.8	3.5		3.0
Friends	0.2	0.0		0.2	0.0	0.0		0.1
Others (e.g. pension)	14.6	11.4		10.1	15.5	13.2		12.8
N	*153*	*243*		*94*	*168*	*134*		*396*

Inpatient Utilisation	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who availed of PhilHealth benefits								
As a member	84.0	80.2	*ns*	82.1	83.7	77.8	*ns*	81.8
As a dependent	7.0	8.0		6.3	7.2	10.7		7.6
N	*153*	*243*		*94*	*168*	*134*		*396*
% who availed of other medical or health insurance aside from PhilHealth	0.0	2.1	*ns*	0.0	0.0	5.5	***	*1.2*
N	*153*	*243*		*94*	*168*	*134*		*396*
Kind of medical or health insurance								
Veterans	0.0	9.8	*ns*	0.0	0.0	15.6	*ns*	4.3
Others (e.g. senior card)	0.2	5.2	*ns*	0.0	0.2	8.3	*ns*	2.4
N	*43*	*61*		*25*	*44*	*35*		*104*
% who availed of discounts for senior citizens for medical expenses	90.6	87.2	*ns*	85.9	93.1	86.3	*ns*	88.6
N	*153*	*243*		*94*	*168*	*134*		*396*

***p < .001, ns = not significant.

PGH = Philippine General Hospital.

Note: Results of the same questions are shown in Table 6.1 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

3.2. Outpatient Care Utilisation

Older Filipinos reported a higher level of outpatient than inpatient care utilisation. About 36% received medical care for an illness or accident from any medical facility or practitioner without the need for an overnight stay in the past 12 months, with no notable age or gender differences (Table 4.21). Those who availed of outpatient medical care reported an average of 2.1 consultations. Similar to inpatient utilisation, a considerable proportion of older persons (65%) availed of outpatient care at private facilities. The rest went to public health facilities, more commonly barangay health stations (12%), rural health units (7%), or provincial or city hospitals (7%). A nearly universal proportion (95%) sought the service of a doctor for their health problems.

Table 4.21. Outpatient Utilisation by Sex and Age

Outpatient Utilisation	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who received medical care for an illness or accident from any medical facility or practitioner without staying overnight in the past 12 months	31.8	38.1	*ns*	35.3	38.9	29.8	*ns*	35.8
N	*1,342*	*2,667*		*1,075*	*1,730*	*1,204*		*4,009*
Mean number of times received medical care without staying overnight	2.35	2.00	*ns*	2.09	2.16	2.05	*ns*	2.11
N	*403*	*949*		*371*	*622*	*359*		*1,352*
Type of facility visited most as an outpatient								
Barangay health station	6.8	13.7		10.5	12.3	11.9		11.5
Rural health unit	5.5	7.1		8.8	5.1	4.9		6.6
Municipal hospital	4.8	4.3		4.6	3.4	7.2		4.4
District hospital	3.7	2.5		2.7	3.1	2.7		2.9
Provincial or city hospital	6.9	7.7		8.1	6.3	9.0		7.4
Regional hospital	0.7	0.2	*ns*	0.4	0.3	0.4	*ns*	0.4
Public or national hospital	2.4	1.0		0.7	2.1	1.7		1.4
Public specialty hospital	0.1	0.4		0.1	0.6	0.1		0.3
Private clinic	44.6	40.7		43.9	42.3	35.0		41.9
Private hospital	24.6	21.9		20.2	24.1	26.4		22.8
Others (e.g. medical missions)	0.0	0.5		0.0	0.5	0.7		0.3
N	*403*	*949*		*371*	*622*	*359*		*1,352*
Health practitioner seen most often for health problems								
Traditional practitioner	0.0	0.1		0.0	0.1	0.1		0.1
Doctor	96.1	94.9		95.6	95.4	94.1		95.3
Nurse	2.0	2.1	*ns*	1.9	2.6	1.0	*ns*	2.1
Midwife	0.8	1.5		1.7	0.5	2.2		1.2
Barangay health worker	1.0	1.5		0.8	1.4	2.6		1.3
Others	0.0	0.0		0.0	0.0	0.0		0.0
N	*403*	*949*		*371*	*622*	*359*		*1,352*

ns = not significant.

Note: Results of the same questions are shown in Table 6.2 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

3.3. Unmet Need for Healthcare

One of the most critical measures of access to healthcare services is the subjective measure of unmet healthcare needs. In the LSAHP, this was operationalised as the perception of older individuals who felt unwell and considered consulting a doctor but did not do so in the past 12 months. In the W2 survey, 22% of the respondents reported having unmet healthcare needs (Table 4.22). Similar to the W1 findings, financial constraints were the primary reason for not seeing a doctor (62%) amongst those with unmet healthcare needs.

Table 4.22. Unmet Need for Healthcare by Sex and Age

Unmet Need for Healthcare	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who felt ill and thought about seeing a doctor but did not in the past 12 months	21.5	22.4	*ns*	19.6	25.4	20.1	*ns*	22.1
N	*1,342*	*2,667*		*1,075*	*1,730*	*1,204*		*4,009*
% whose most important reason for not seeing a doctor is not having enough money	63.4	61.6	*ns*	65.6	57.9	67.4	*ns*	62.2
N	*242*	*549*		*230*	*357*	*204*		*791*

ns = not significant.

Note: Results of the same questions are shown in Table 6.3 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

3.4. Health Insurance Coverage

Results show that the majority (63%) of older people are covered by health insurance, almost universally by PhilHealth (Table 4.23). Despite the pervasive PhilHealth coverage, the findings highlight a significant gap in the older population's access to health. The Expanded Senior Citizens Act (RA 10645) provides that all senior citizens aged 60 and above are automatically considered PhilHealth members, even if they did not pay monthly contributions. These non-paying senior citizens also receive free lifetime coverage, just like any lifetime member.

Table 4.23. Health Insurance Coverage by Sex and Age

Health Insurance Coverage	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who have health insurance	60.2	64.7	*ns*	62.4	65.1	59.7	*ns*	63.1
N	*1,342*	*2,667*		*1,075*	*1,730*	*1,204*		*4,009*
Type of health insurance								
PhilHealth	99.0	99.3	*ns*	98.9	99.6	98.7	*ns*	99.2
Private health insurance	2.6	3.4	*ns*	2.7	4.0	1.7	*ns*	3.1
Others (e.g. employees' compensation)	1.7	1.5	*ns*	1.9	1.4	1.2	*ns*	1.6
N	*878*	*1,698*		*677*	*1,158*	*741*		*2,576*

ns = not significant.

Note: Results of the same questions are shown in Table 6.4 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

3.5. Vaccination

To protect older people from infectious or malignant diseases, particularly pneumonia, which is amongst their leading causes of death, the Department of Health (DOH), under its national immunisation programme, provides free pneumococcal and flu vaccines for older persons. Vaccination not only lowers the severity of infection but also reduces hospitalisations and intensive care admissions, thereby lowering overall healthcare costs.

Despite the government vaccination programme, results indicate low awareness and uptake of vaccination amongst older adults. Only half (52%) of older adults are aware of pneumococcal vaccines for their age group, with significantly more females than males being aware (56% vs 45%; Table 4.24). Amongst those who are aware of the pneumococcal vaccine, 55% have been immunised since turning 60 years old.

A similar trend is observed for influenza, with 53% of older Filipinos reporting awareness of the influenza vaccine, and more females than males being aware (57% vs 45%). Amongst those who are aware of the influenza vaccine, almost three in five (57%) have received the vaccine, with more females than males amongst the recipients.

For both vaccines, most older persons received their vaccinations at barangay health stations (82%), which is also where they received their last vaccines.

Table 4.24. Vaccinations by Sex and Age

Vaccinations	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who are aware of pneumococcal vaccine for older persons	44.6	55.7	***	52.6	53.9	44.2	*ns*	51.7
N	*1,342*	*2,667*		*1,075*	*1,730*	*1,204*		*4,009*
% who ever had a pneumococcal vaccination since they turned 60 years old	45.3	59.5	*ns*	54.9	53.2	61.1	*ns*	55.1
N	*538*	*1,342*		*567*	*856*	*457*		*1,880*
Place where last pneumococcal vaccine was received								
Barangay health station	87.2	79.9		82.9	81.1	80.8		81.8
Rural health unit	0.8	8.6		6.4	7.3	5.6		6.6
Municipal hospital	2.1	3.5		3.4	3.1	2.4		3.1
District hospital	0.1	0.2		0.0	0.2	0.5		0.2
Provincial or city hospital	4.0	0.3		2.6	0.3	0.1		1.3
Regional hospital	0.0	0.0	***	0.0	0.0	0.0	*ns*	0.0
Public or national hospital	0.0	0.0		0.0	0.0	0.0		0.0
Public specialty hospital	0.0	0.0		0.0	0.0	0.0		0.0
Private clinic	3.2	3.4		3.2	3.2	4.3		3.4
Private hospital	1.8	1.8		0.1	2.9	3.5		1.8
Others (e.g. medical mission and covered court)	0.6	2.2		1.3	1.9	2.9		1.8
N	*249*	*748*		*272*	*460*	*265*		*997*
% who are aware of flu vaccine for older persons	45.2	56.8	***	54.8	53.7	44.3	*ns*	52.6
N	*1,342*	*2,667*		*1,075*	*1,730*	*1,204*		*4,009*
% who ever had a flu vaccination since they turned 60 years old	42.8	62.9	**	55.1	56.2	62.6	*ns*	56.6
N	*526*	*1,280*		*564*	*818*	*424*		*1,806*
Place where last flu vaccine was received								
Barangay health station	89.0	79.5		86.8	75.7	84.1		81.8
Rural health unit	6.7	12.3		6.8	17.5	5.3		11.0
Municipal hospital	0.0	2.1	*ns*	1.7	1.8	1.0	*ns*	1.6
District hospital	0.0	0.8		0.0	1.5	0.0		0.6
Provincial or city hospital	1.5	0.2		0.8	0.3	0.2		0.5

Vaccinations	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Regional hospital	0.0	0.0		0.0	0.0	0.0		0.0
Public or national hospital	0.7	0.0		0.4	0.0	0.0		0.2
Private clinic	0.8	1.3	*ns*	0.6	0.9	3.7	*ns*	1.2
Private hospital	0.4	1.4		0.2	1.9	1.6		1.2
Others	0.7	2.3		2.7	0.3	4.1		1.9
N	*223*	*703*		*278*	*417*	*231*		*926*

**p < .01, ***p < .001, ns = not significant.

Note. Results of the same questions are shown in Table 6.5 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

3.6. Free Medicines for Hypertension and Diabetes

Another government health programme for older persons is the provision of free medicines for prevalent noncommunicable diseases such as hypertension and diabetes. Older adults who reported a diagnosis of either condition were asked if they take medications to manage their condition. Those who do were further asked about consistently obtaining their medicines from a public health facility.

Findings show a significant level of unmet need for treatment of hypertension and diabetes, with 16% and 24% of those diagnosed with these illnesses, respectively, not taking any medication. Whilst the majority of those diagnosed with these diseases are on maintenance medication (84% for hypertension and 76% for diabetes), with no significant age or sex differences, a significant treatment gap is apparent (Table 4.25).

Amongst those taking medication for high blood pressure, 19% reported obtaining their medicine from health centres all the time. The corresponding figure for diabetes is 11%.

Table 4.25. Level of Use and Source of Medicines by Sex and Age

Level of Use and Source of Medicines	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% who take any medicine for								
High blood pressure	77.1	87.5	*ns*	84.0	86.5	79.1	*ns*	84.2
N	*578*	*1,451*		*509*	*916*	*604*		*2,029*
Diabetes	73.5	77.6	*ns*	79.7	78.6	59.7	*ns*	76.3
N	*153*	*350*		*165*	*233*	*105*		*503*
% who get medicine from health centre(s) all the time								
High blood pressure	15.3	20.2	*ns*	21.5	15.7	19.6	*ns*	18.8
N	*452*	*1,240*		*429*	*768*	*495*		*1,692*
Diabetes	9.8	11.1	*ns*	10.4	12.5	6.3	*ns*	10.7
N	*104*	*272*		*131*	*174*	*71*		*376*

ns = not significant.

Note: Results of the same questions are shown in Table 6.6 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

3.7. Informal Care

Results from LSAHP W1 indicate that care for older Filipinos when they get sick (since the age of 60) is generally informal, with care mostly provided by female family members. Like W1, which shows the spouse as the one most commonly in charge of elder care, W2 findings indicate the dominance of the daughters and spouse as the main caregivers of older persons.

The type of caregiver varies significantly by sex and age. The spouse is most commonly cited as the carer for older males when they get sick (61%), whereas daughters assume this role for older females (42%). The proportion of sick older people cared for by their spouse is highest amongst the youngest cohort (42%), with the level significantly decreasing in older cohorts (12%). Conversely, the proportion cared for by daughters and daughters-in-law increases with advancing age.

One important finding is that 13% of older persons reported having no one to care for them when they get sick. Further analysis may be required to determine the situation of this sector as a basis for better policy and programme interventions to alleviate their condition.

Table 4.26. Person Who Usually Takes Care of Older Person When They Are Sick Since Age 60 by Sex and Age

Persons	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
None or self	12.4	12.7		13.1	13.1	10.1		12.6
Spouse	61.0	15.0		41.5	29.7	12.1		31.7
Son	7.4	12.5		9.8	10.3	13.5		10.6
Daughter	14.3	42.3		26.8	31.6	46.8		32.1
Daughter-in-law	0.5	5.6	***	1.5	4.9	6.5	***	3.8
Son-in-law	0.0	0.1		0.1	0.0	0.1		0.1
Grandchild	1.5	6.3		2.6	6.1	6.0		4.6
Other relatives	2.0	3.6		3.2	2.8	3.1		3.1
Others	0.8	1.8		1.3	1.5	1.7		1.4
N	*1,343*	*2,668*		*1,076*	*1,731*	*1,204*		*4,011*

***p < .001.

Note. Results of the same questions are shown in Table 6.7 of the baseline report.

Source: Calculated by the DRDF using original LSAHP W2 data.

3.8. Long-term Care

Long-term care involves the provision of personal care, assistance, and nursing care services to support older people in the activities that constitute their everyday lives (Llena-Nozal, Rocard, and Sillitti, 2022). It aims to provide a sufficient level of care, specifically to minimise pain and suffering and the deterioration of their health status (Kotschy and Bloom, 2022; Llena-Nozal, Rocard, and Sillitti, 2022).

In the LSAHP, long-term care is defined as nonmedical care provided to individuals who need ongoing assistance with the basic ADL. W2 data reveal that 12% of older persons are now receiving long-term care due to persistent conditions of ill health or disability (Table 4.27). This is higher than the 8% level reported at W1, which is expected given the older age structure of the W2 older respondents. There is no significant difference between males and females, but the proportion of older persons receiving long-term care amongst the oldest age cohort (80+) is five times that of those aged 70 and below (30% vs 6%).

Consistent with the findings for informal care, the results show that daughters and spouses mainly take care of older persons who are long-term care recipients. Significantly more males are cared for by their spouses (63%), whilst older females are primarily cared for by their daughters (61%).

Long-term care requires significant effort, as indicated by the nearly universal proportion of recipients (93%) stating that long-term care is part of their daily routine. The most common type of care provided is food preparation (97%), followed by administering medicine (65%) and assistance with self-care activities such as bathing and washing (51%).

Older persons were asked about hypothetical situations, such as if they were to become demented, invalid, or bedridden. When asked about the person they would prefer to receive care from and the person who would most likely take care of them in such situations, older persons were consistent with their answers, preferring and expecting care from their daughters and spouses.

Table 4.27. Long-term Care by Sex and Age

Long-term Care	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
% currently receiving care because of continuing condition of ill health or disability	10.5	12.1	*ns*	6.0	9.5	30.1	***	11.5
N	*1,342*	*2,667*		*1,075*	*1,730*	*1,204*		*4,009*
Person mainly taking care of older person								
Spouse	63.3	4.6		62.4	26.4	3.0		24.0
Son	7.1	11.1		6.0	8.6	12.6		9.8
Daughter	13.5	61.3		20.7	48.3	55.8		45.5
Son-in-law	0.1	0.0		0.0	0.1	0.0		0.0
Daughter-in-law	2.4	7.4	***	0.9	5.8	8.1	***	5.7
Grandson	0.8	1.7		0.0	0.2	3.0		1.4
Granddaughter	2.2	7.2		0.1	4.6	9.0		5.6
Househelp	2.1	2.3		2.8	1.6	2.5		2.3
Sibling	5.1	1.7		7.2	2.9	0.7		2.9
Others (e.g. friends and caregiver)	3.3	2.7		0.0	1.5	5.4		2.9
N	*145*	*408*		*55*	*176*	*322*		*553*
Frequency of care given								
Every day	93.1	92.5		95.9	89.7	93.4		92.7
Every few days	5.8	4.9		2.6	7.5	4.8		5.2
Every week	1.0	0.2	*ns*	1.5	0.3	0.0	*ns*	0.4
Every month	0.0	0.1		0.0	0.1	0.1		0.0
Every few months	0.0	2.4		0.0	2.5	1.8		1.6
N	*145*	*408*		*55*	*176*	*322*		*553*

Long-term Care	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Kind of care provided								
Preparation of food	99.7	95.2	***	99.5	92.5	98.5	***	96.7
Give medicine	60.5	67.4	*ns*	58.5	58.6	73.4	*ns*	65.1
Self-care (e.g. bathing and washing)	43.6	55.2	*ns*	31.5	41.0	69.3	*	51.4
Getting up from bed or chair	36.9	37.2	*ns*	44.9	19.1	46.9	*	37.1
Assist in moving around	39.1	46.0	*ns*	44.9	29.4	54.0	*ns*	43.7
N	*145*	*408*		*55*	*176*	*322*		*553*
Person the older person would like to receive care from in case the older person will have dementia								
Spouse	51.6	6.4		27.7	22.6	8.6		23.3
Son	15.5	14.3		16.6	13.4	12.7		14.8
Daughter	20.9	59.1		41.4	46.4	52.7		44.9
Son-in-law	0.0	0.0		0.0	0.0	0.0		0.0
Daughter-in-law	0.3	2.5		0.9	1.4	5.7		1.7
Grandson	0.4	2.4	***	0.9	2.2	2.4	***	1.6
Granddaughter	1.6	5.0		2.9	4.0	6.1		3.7
Personal aide	0.3	0.3		0.2	0.3	1.1		0.3
Hospital	0.3	0.0		0.0	0.0	0.8		0.1
Convalescence home	0.2	0.2		0.0	0.5	0.1		0.2
Others (e.g. siblings and nieces)	6.4	6.0		7.4	5.0	5.8		6.2
Not sure	2.5	3.6		1.9	4.4	3.9		3.2
N	*1,170*	*2,248*		*1,041*	*1,569*	*808*		*3,418*
Person who will most likely take care of older person in case the older person will have dementia								
Spouse	46.9	6.0		25.5	20.6	7.3		21.2
Son	16.4	14.3		16.5	14.1	13.0		15.1
Daughter	24.4	57.9		43.5	45.4	52.4		45.4
Son-in-law	0.0	0.0		0.0	0.0	0.0		0.0
Daughter-in-law	0.2	3.1		1.5	1.5	5.9		2.1
Grandson	0.3	1.9	***	0.6	1.3	4.0	***	1.3
Granddaughter	2.0	5.5		2.7	5.2	6.1		4.2
Personal aide	0.4	0.4		0.2	0.6	0.9		0.4
Hospital	0.0	0.0		0.0	0.0	0.0		0.0
Convalescence home	0.2	0.0		0.0	0.2	0.1		0.1
Others (e.g. siblings and nieces)	5.9	5.5		7.5	3.7	5.5		5.6

Long-term Care	SEX			AGE GROUP				TOTAL
	Male	Female	Sig	<70	70–79	80+	Sig	
Not sure	3.3	5.5		2.1	7.4	4.8		4.7
N	*1,170*	*2,248*		*1,041*	*1,569*	*808*		*3,418*
Person the older person would like to receive care from in case the older person becomes invalid or bedridden								
Spouse	41.3	6.0		23.7	17.5	7.6		19.2
Son	20.2	15.9		20.6	15.1	14.2		17.5
Daughter	26.3	60.3		42.8	51.3	53.3		47.6
Son-in-law	0.1	0.1		0.0	0.1	0.1		0.1
Daughter-in-law	0.1	2.6		0.5	2.2	4.2		1.7
Grandson	0.7	2.1	***	0.9	1.7	3.6	**	1.5
Granddaughter	1.6	5.1		2.9	4.0	6.5		3.8
Personal aide	0.6	0.7		0.6	0.5	1.7		0.7
Hospital	0.0	0.1		0.0	0.0	0.3		0.0
Convalescence home	0.2	0.2		0.0	0.4	0.1		0.2
Others (e.g. siblings and nieces)	5.8	4.8		6.0	4.2	5.9		5.2
Not sure	3.1	2.1		2.0	3.0	2.6		2.5
N	*1,170*	*2,248*		*1,041*	*1,569*	*808*		*3,418*
Person who will most likely take care of older person in case older person becomes invalid or bedridden								
Spouse	41.7	6.5		23.8	18.7	7.2		19.7
Son	19.3	16.7		21.4	14.8	13.4		17.7
Daughter	26.2	54.4		41.8	43.3	54.0		43.9
Son-in-law	0.0	0.0		0.0	0.0	0.0		0.0
Daughter-in-law	0.7	3.2		1.4	2.4	5.3		2.3
Grandson	0.5	2.2	***	0.6	2.1	3.6	***	1.6
Granddaughter	2.0	7.5		3.0	8.1	5.6		5.4
Personal aide	0.4	0.7		0.6	0.5	0.9		0.6
Hospital	0.0	0.1		0.0	0.0	0.3		0.0
Convalescence home	0.2	0.1		0.0	0.2	0.1		0.1
Others (e.g. siblings and nieces)	5.9	4.3		5.9	3.7	5.2		4.9
Not sure	3.0	4.3		1.6	6.1	4.4		3.8
N	*1,170*	*2,248*		*1,041*	*1,569*	*808*		*3,418*

*p < .05, **p < .01, ***p < .001, ns = not significant.

Note: Results of the same questions are shown in Table 6.8 of the baseline report.

Source: Calculated by the DRDF using original LSAHP Wave 2 data.

4. Summary, Conclusions, and Recommendations

The foregoing discussion provides a comprehensive assessment of the health status of older Filipinos, covering the various dimensions of their health status, health-related behaviours, and healthcare utilisation. Various dimensions of health, including diagnosed illnesses, functional health, self-rated health, depressive symptoms, oral health, and health-related behaviours, including smoking, drinking, diet, nutrition, sleep, falls, pain, and incontinence, were explored by sex and age to help identify sectors with relatively higher health risks. Healthcare utilisation, including long-term care, health insurance coverage, vaccination, and access to government health services for older people, was likewise discussed.

The results indicate the poor health state of older Filipinos, marked by a high prevalence of physician-diagnosed illnesses, primarily noncommunicable diseases. Approximately three in four (73%) reported having at least one physician-diagnosed illness. Data also reveal that a substantial proportion of individuals are unable to perform at least one self-care activity or activity for independent living. This is confirmed by the GALI results, which indicate that at least 15% are severely limited. Extreme functional health difficulty is experienced by 4% of respondents who reported being bedridden within the last 2 weeks. As expected, older people experienced increasing functional difficulty with advancing age, although gender differences are not consistent across the six measures of functional difficulty considered. For items showing significant gender differences, females reported greater difficulty with specific activities due to health reasons, except for being bedridden, which is more prevalent amongst males than females. It is significant to note that Filipino older people are generally functional with almost 80% without any ADL difficulty despite that three-quarters of them have been diagnosed with at least one illness.

Older Filipinos also have poor oral health, with females exhibiting worse conditions compared to males. A third of older people are troubled with pain, with most reporting moderate to severe pain. Additionally, about one in four individuals experienced a fall in the past year.

Health gaps are notable. This is best illustrated in the case of hypertension, the most prevalent diagnosed illness, which has relatively low treatment rates. Those with high blood pressure reported limited access to the government's free medicine for hypertension. The low level of ownership of blood pressure monitors at home, particularly amongst older males also implies a risk of undiagnosed hypertension. Poor awareness is confirmed by the LSAHP W1, which shows that 38% of respondents with hypertension are unaware of their condition (Abalos et al., 2023). These and other related findings indicate a lack of basic knowledge amongst older people that would help them monitor their health condition. This is also demonstrated by the finding that almost a quarter of older people are uncertain if they have lost weight in the past quarter. These results point to the need for more educational interventions to guide older people on basic health monitoring to ensure better health management. A health gap in treatments is also observed amongst those who have experienced a heart attack, with more than half not currently taking medication for their heart condition. Ischaemic heart disease is

the leading cause of death in the Philippines (Philippine Statistics Authority, 2024). Additionally, 24% of diabetics are not taking maintenance medication.

Unmet need for health services is evident, with about a fifth of older people facing difficulties accessing healthcare services when needed, mostly due to financial reasons. Significant proportions are not aware of government programmes aimed at promoting the health of older people, such as the free vaccination programme for pneumococcal disease and influenza, as well as free medicines for hypertension and diabetes. Only 63% are covered by health insurance, mostly PhilHealth, suggesting a significant gap between the stipulations of universal healthcare law and the actual picture on the ground.

The prevalence of poor health and disability amongst older people highlights the magnitude of care requirements for older people. There is a need to reexamine care for older people traditionally provided by the family, primarily women, in the context of rapidly changing realities. These changes include increasing diversity in family and social relationships and the rising education, employment, and mobility of women. The erosion of traditional pathways and changing values, as evidenced by findings from the Young Adult Fertility and Sexuality Study, will have an impact on future social support and intergenerational financial exchanges (Laguna, Kabamalan, and Marquez, 2024). Addressing the current health gaps, which are expected to expand with the country's ageing demographics, will require adjustments in policies and programmes to better address the health demands of an ageing population.

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