Largo, F. M. & Alegado, J.L.G. (2023). SDG 3. Health Care Access and Utilization among Households with Adolescents. In USC-Office of Population Studies Foundation, Inc. (OPS). (2023). The Impact of the COVID-19 Pandemic on the SDG Youth Agenda. https://www.opsusc.org/lcsfc-survey-reports.php

Access to health care facilities has been shown to affect health outcomes in both developing (Karra et al., 2017) and developed country (Kelly et al., 2016) settings. The Department of Health in the Philippines reported that access to primary health care facilities is particularly limited in the Philippines with 50% of the population not having access to primary health care facilities within 30 minutes of travel from the residence (DOH, 2020).

The United Nations Sustainable Development Goal 3 which aims "to ensure healthy lives and promote well-being for all at all ages" includes addressing health care access in a global framework of cooperation (United Nations, 2015). Target 3.8 under SDG 3 aims to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all." Indicator 3.8.1 measures the coverage of essential health care services while Indicator 3.8.2 looks at the proportion of population with large household expenditures on health as a share of total household expenditure on income. Both indicators combined measure the ability of households and individuals to use health care services without the ruinous effects of large out of pocket expenditures. Progress on this SDG target has been uneven prior to the pandemic but improving on the average at a global level in terms of universal health coverage (United Nations, 2022). Health care, however, continued to be mostly borne out of pocket which can be catastrophic for a significant number of households which are already pushed into extreme poverty due to spending on health care.

The Philippine government's targets for this area are outlined in its document of commitments (PSA, 2022a). Target 3.8 keeps true to the aim of universal health care coverage from the measured baseline of 91% in 2016 to 100% in 2030. The government aims to achieve this either through universal health insurance or coverage by the public health system. The target for out of pocket is a slight lowering of the baseline measure from 45% to 43.5% by 2030. These targets are marked as "on track" by the government's progress tracker (PSA, 2022b), although Ulep (2021) still pointed out the low uptake of essential health services. This low uptake is likely due to a confluence of factors including demand and supply side factors. Ulep (2021) also showed that health care utilization has been further negatively affected by the pandemic.

The Longitudinal Cohort Study on the Filipino Child (LCSFC) provides another source of data to track the progress among households with adolescents with regard to SDG3. This chapter reports on various aspects of health care access and utilization, including national social health insurance coverage, using LCSFC data collected from 2016 to 2021. The LCSFC survey rounds covered in this chapter include those done prior to the pandemic (Wave 1 in 2016, Wave 2 in 2018, Wave 3 in 2019 and Wave 4 in Q1 of 2020), during the early stage of the pandemic (Wave 4A in Q4 of 2020) and the later part of the pandemic (Wave 5 in 2021). With such data, this chapter also includes a discussion on the impact of the pandemic on the variables of interest.

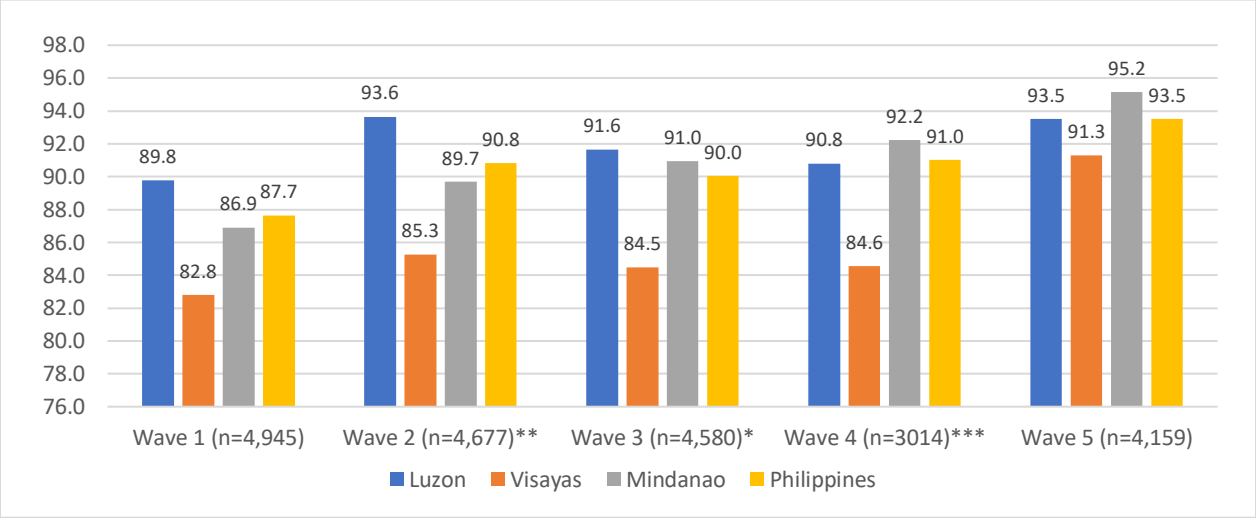
A. Health Care Facility Proximity and Utilization

Barangay Health Station (BHS)

The BHS is the first level of the public health system under the supervision of the respective City or Municipal Health Offices tasked with basic health services and health promotion. The Department of Health

reports that only one half of all Philippine barangays have at least one BHS as of 2019 (DOH, 2020). The LCSFC households appear to have near universal access to a BHS within their own barangay (Figure 5.1). Households without a BHS in their barangay reported the nearest one to be in another barangay in the same municipality or city.

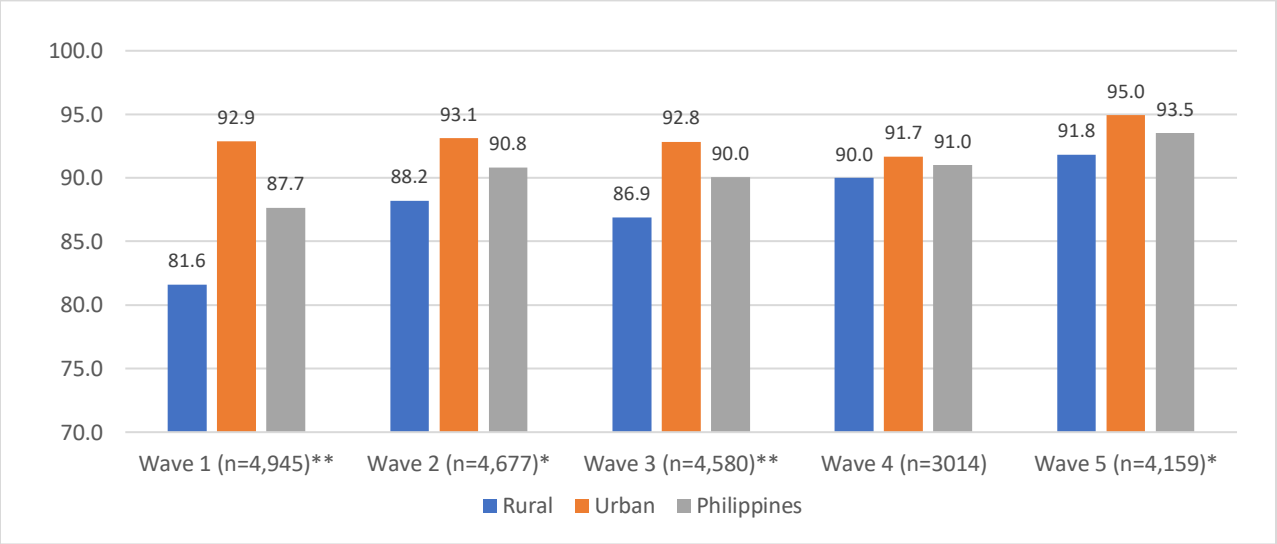
Figure 5.1. Proportion of Households with a BHS Located in Barangay by Wave and Island Group[#]



[#]Weighted proportions per wave
*Significantly different at p<0.10,**at p<0 .05, ***at p<0.01

Visayas households has the least access to a BHS located within their barangay compared to those in Luzon and Mindanao which showed proportions that were closer to the national average for the sample households. Figure 5.2 shows that rural households are less likely to report having a BHS within their own barangay than urban households, but the rural-urban gap decreased in later waves.

Figure 5.2. Proportion of Households with a BHS Located in Barangay by Wave and Urban/Rural Stratum[#]

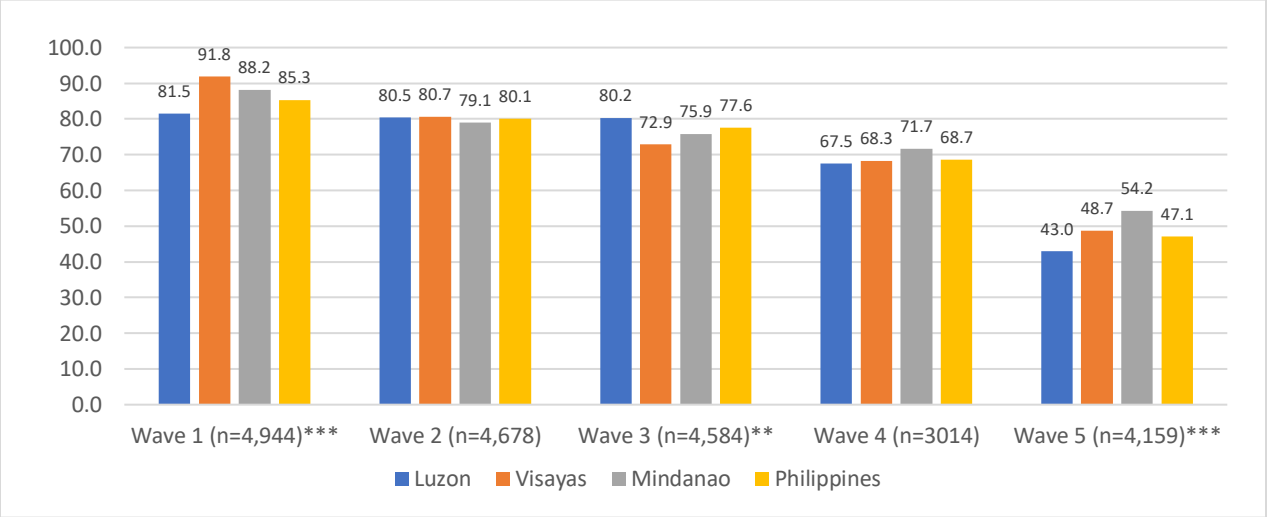


[#]Weighted proportions per wave
*Significantly different at p<0.10,**at p<0 .05, ***at p<0.01

Respondents were also asked if any household member sought care from a BHS in the 12 months prior to the survey visit. Figure 5.3 shows a declining trend in household BHS utilization across waves particularly in Wave 5 during the pandemic. The decline is largest for those in Luzon, home of major urban epicenters of pandemic cases (WHO, 2020).

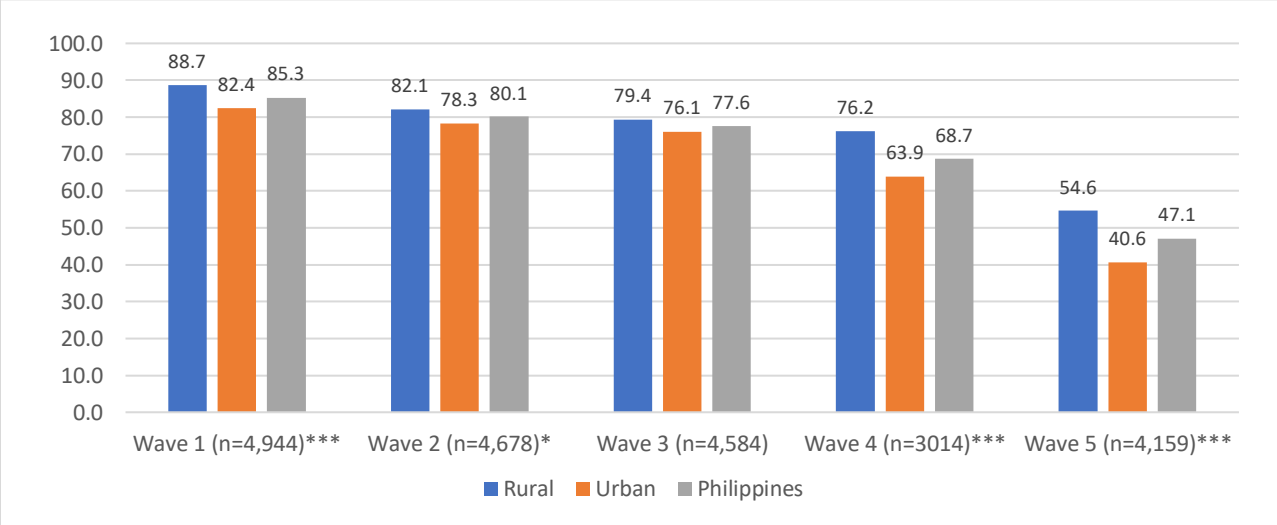
In Figure 5.4, it is seen that urban households used BHS services to a slightly lesser extent and typically below the national average. The significant differences are greatest for Waves 4 and 5. When only households with complete data in all five waves are accounted for (Figure 5.5), illustrating the true trend in BHS utilization over time, the decline in use of the BHS mirrors that of the full sample shown in Figure 5.2. As shown in Figure 5.5, utilization of barangay health stations in the preceding 12 months prior to the survey period went from 88% in Wave 1 to 72% in Wave 4 before precipitously dropping to 46% in Wave 5.

Figure 5.3. Proportions of Households Seeking Care from BHS by Wave and Island Group[#]



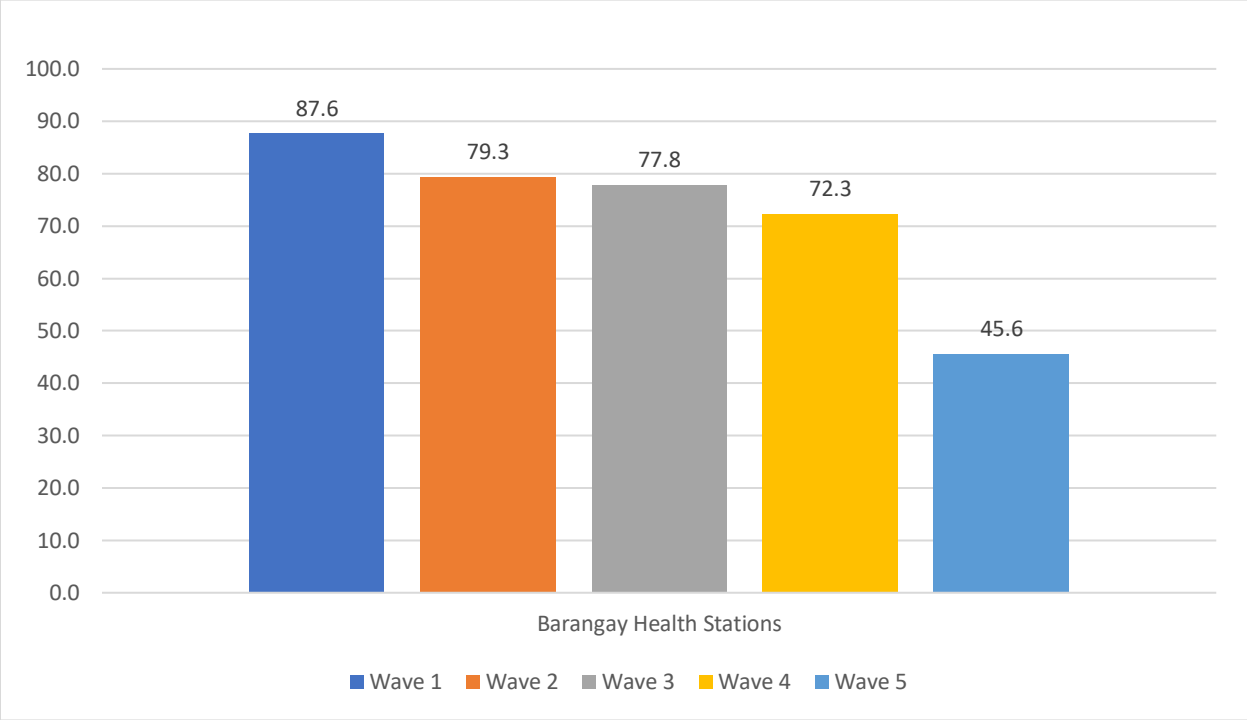
[#]Weighted proportions per wave
*Significantly different at p<0.10,**at p<0 .05, ***at p<0.01

Figure 5.4. Proportions of Households Seeking Care from BHS by Wave and Urban/Rural Stratum[#]



[#]Weighted proportions per wave
*Significantly different at p<0.10,**at p<0 .05, ***at p<0.01

Figure 5.5. Proportions of Households Seeking Care from BHS by Wave (n=,1668) [#]



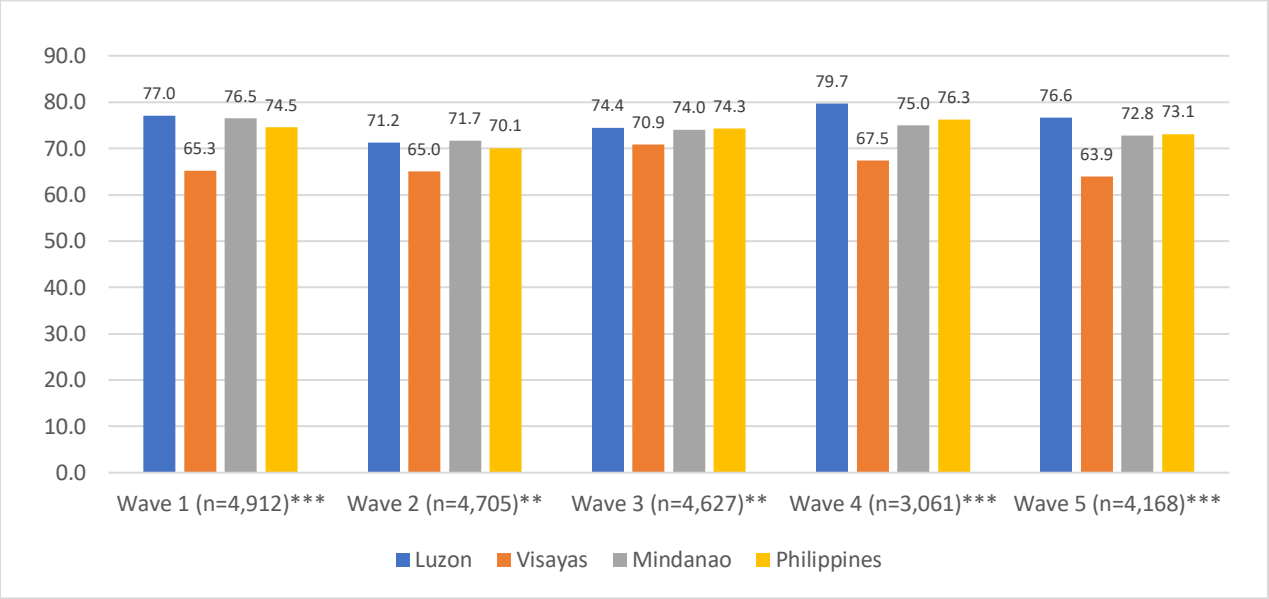
[#]Unweighted proportions per wave

Government Hospitals

The next level in the network of health care providers operated by local government units (LGU) are the government hospitals which include regional and specialty hospitals. Access to these facilities is necessary for cases beyond the purview of primary health care providers. In the LCSFC, almost all of the households reported having a government hospital either within the municipality/city (see Figure 5.6) or in another municipality/city within the same province. Overall, nearly three fourths of households surveyed have access to public hospitals within the same municipality or city, with those from the Visayas consistently having the lowest proportions across the island groups.

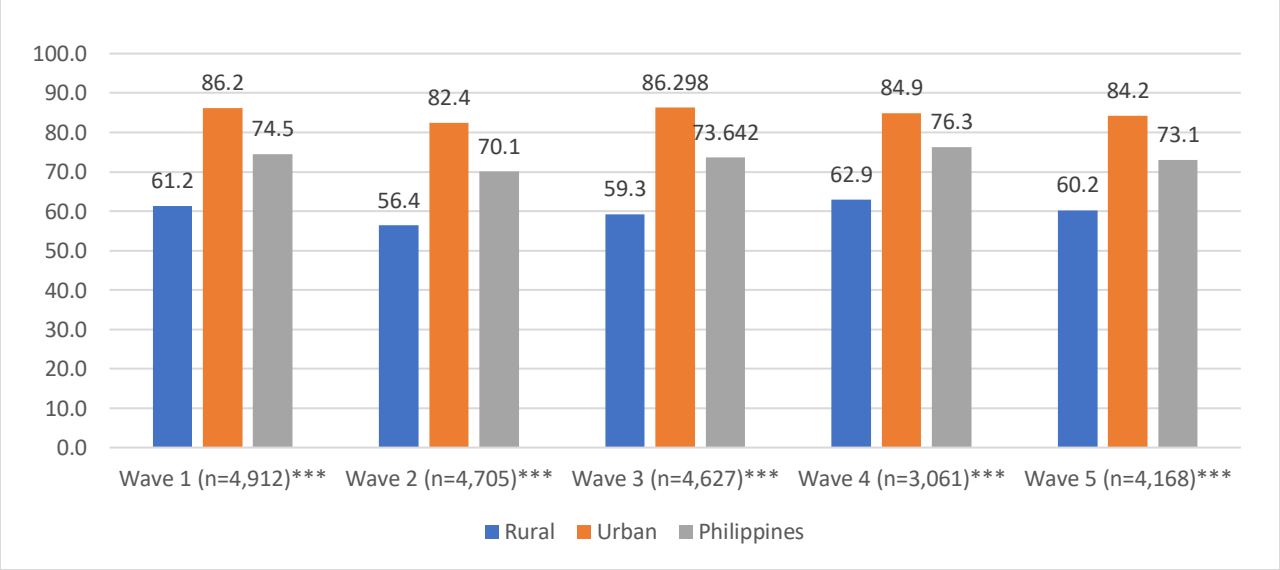
Proximity to a public hospital is also differentiated by stratum with urban households clearly having greater access on the average to a public hospital within the city or municipality (Figure 5.7). This is persistent across waves.

Figure 5.6. Proportions of Households Reporting Presence of Government Hospital in the Same Municipality/City by Island Group and Wave[#]



[#]Weighted proportions per wave
*Significantly different at p<0.10,**at p<0 .05, ***at p<0.01

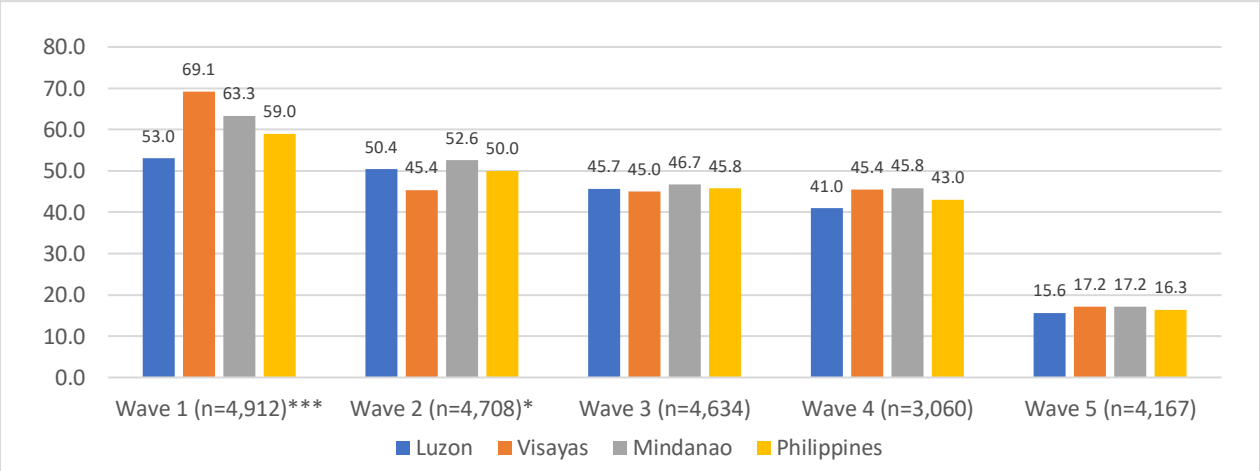
Figure 5.7. Proportions of Households Reporting Presence of Government Hospital in the Same Municipality/City by Wave and Urban/Rural Stratum[#]



[#]Weighted proportions per wave
*Significantly different at p<0.10,**at p<0 .05, ***at p<0.01

Seeking health care from government hospitals (in the past 12 months prior to the survey period) across the five waves showed a declining trend in all households even before the pandemic (Figure 5. 8). From nearly 60% in Wave 1 (2016) to about 46% in Wave 4 (Q1 2020). Similar to what was observed with BHS, a sharp drop in utilization was also seen during the pandemic (Wave 5 in 2021). No strong differentiation across island groups is observed except in Wave 1 where Visayas and Mindanao households had higher proportions.

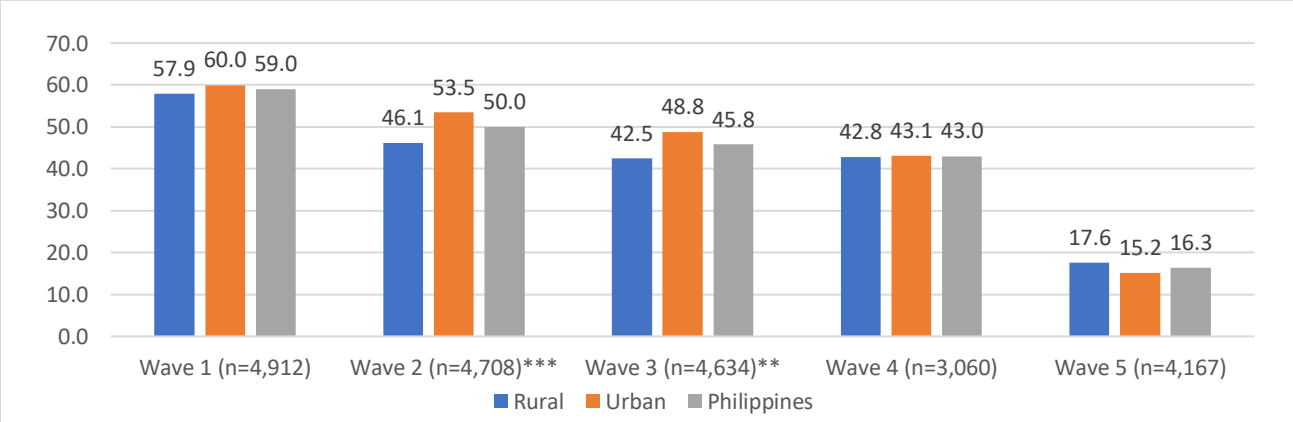
Figure 5.8. Proportions of Households Seeking Care from Government Hospital within the Same Municipality/City by Wave and Island Group[#]



[#]Weighted proportions per wave
*Significantly different at p<0.10,**at p<0 .05, ***at p<0.01

While there was a noted differentiation between public hospital proximity across urban and rural households, the differences are slightly less pronounced when it comes to take up of public hospital services (Figure 5.9).

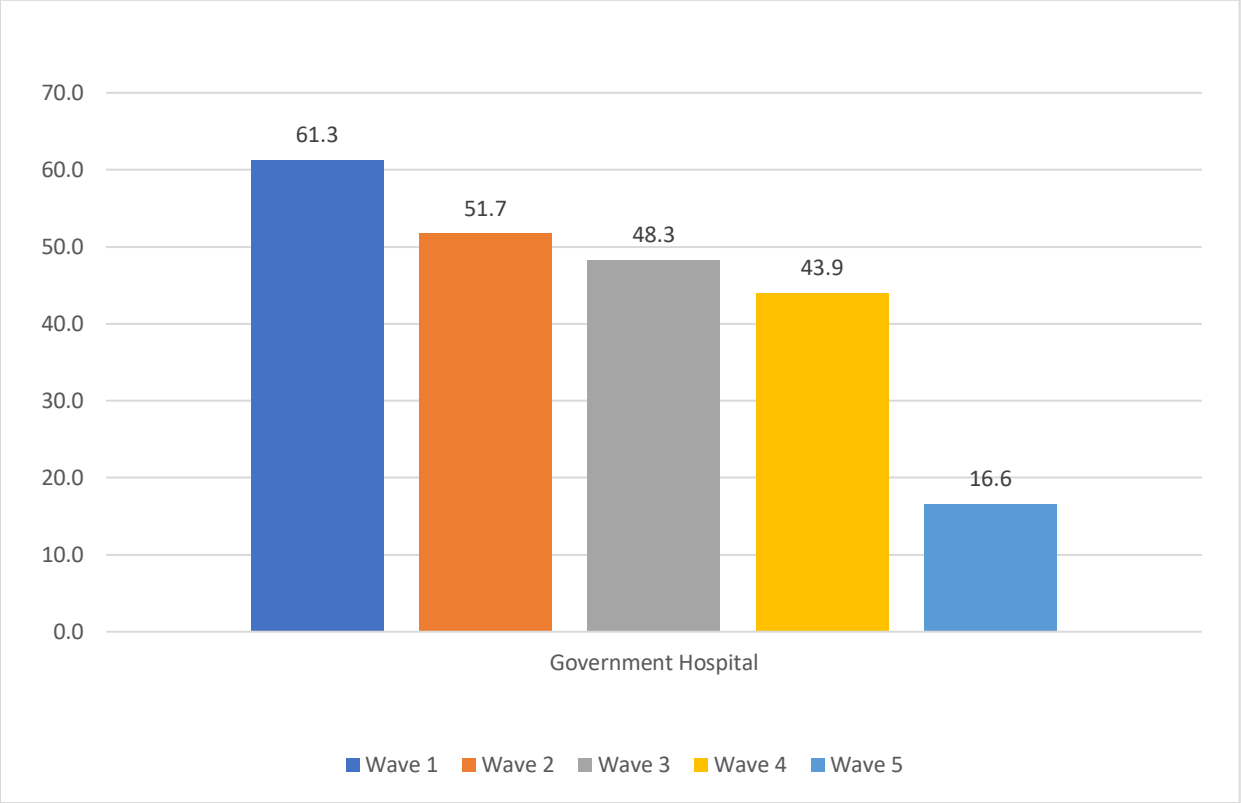
Figure 5.9. Proportions of Households Seeking Care from Government Hospital within the Same Municipality/City by Wave and Urban/Rural Stratum[#]



[#]Weighted proportions per wave
*Significantly different at p<0.10,**at p<0 .05, ***at p<0.01

This downtrend in utilization of public hospital services is persistent with the use of household data from households present across all waves. Figure 5.10 shows this downward trend for this sample.

Figure 5.10. Proportions of Households Seeking Care from Government Hospitals by Wave (n=1,668) #

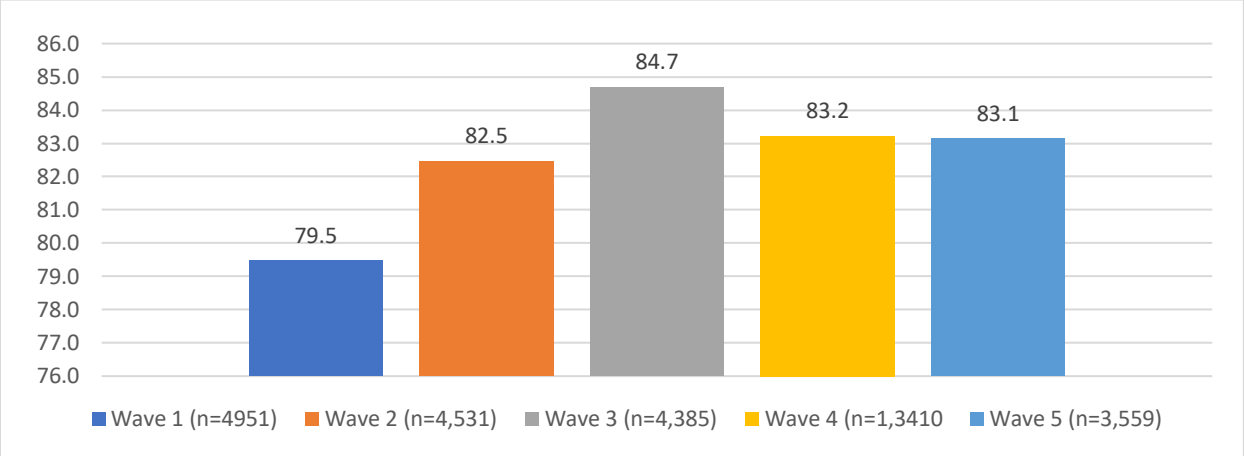


#Unweighted proportions per wave

B. Philippine Health Insurance Corporation (PhilHealth) Membership

Membership in social health insurance is the second indicator for this SDG target. The Philippine government end target for this indicator is 100% coverage. PhilHealth is the national level social health insurance program. Other government agencies and local government units may offer other forms of health insurance benefits. Figure 5.11 shows the coverage of PhilHealth membership for LCSFC households across waves. This is measured as a positive response to the question if whether the father or mother is a member. As can be seen, PhilHealth membership has hovered slightly above or below the 80% mark across the five waves. This, however, is lower than the baseline measure of 91% reported in 2016 for all households in the entire country (PSA, 2022b). This could indicate that LCSFC households, representing those with adolescent members, lag behind the national average in this regard. No differentiation across island groups, and between urban and rural households were found for PhilHealth coverage.

Figure 5.11. Proportions of Households Reporting PhilHealth Membership Across Waves[#]



[#]Weighted proportions across waves

C. Impact of the Pandemic on Health Care Seeking Behavior

The COVID-19 Pandemic has caused substantial impacts on the well-being of populations around the world. Aside from disruptions to the economies due to policy responses centered on limiting personal interactions, there is the fear that additional effects will be felt through the reduction of health care utilization due to various aspects related to the pandemic. Health care seeking behavior during the pandemic is conceptually hampered not only by mobility restrictions and higher costs of care due to precautionary measures but also by the fear of contracting COVID-19 in a health care setting. The resulting decrease in health care utilization would worsen health care outcomes in the absence of any offsetting change.

The reduction in health care utilization globally is borne out by the systematic review of Moynihan et.al (2021) of studies on health care trends around the globe in the early period of the pandemic (up to May 2020). They found a 37% reduction in over-all utilization with significant declines in health facility visits (42% reduction), admissions (28%), diagnostics (31%) and therapeutics (30%). They also point to important differences in health care sub-categories with the possible implication that reduced utilization may be more pronounced for less severe diseases. This points to the possibility of identifying excess care as well as missed essential care with long term implications. It would also be reasonable to point out that the predicament for hard pressed health care systems in low to middle income countries may be worse. While Xu et.al (2021) has pointed to an offsetting increase in teleconsultations for a large health service provider in the United States, these adjustments may be less possible for countries with substantially lower quality telecommunications and power infrastructures and populations with limited access to them as is likely the case for developing countries. What is more, developing countries may already suffer from low levels of health care utilization. Further reductions only aggravate already low levels of utilization and associated poor outcomes. Xiao et.al (2021) found significant reductions across China in the early stages of the pandemic. Rezapour et.al (2022) also saw similar declines in utilization in primary health care for Iran. Ahmed et.al (2022) showed reductions from 18 low and low middle income countries and indicated the possible negative effects on maternal and child health outcomes.

In the case of the Philippines, Ulep (2021) used national social health insurance claims and data from government facility reports to estimate the reductions in health care utilization and the losses in well being from such reductions. Substantial lowering in admissions claims was reported for high burden diseases

(47%), with high incidence noted for indigent members, and pediatric cases (70%). Consultations with rural health units show a decline in patient visits for under 5 pediatric cases, patients over 65, hypertensive cases, and visits under the tuberculosis treatment program TB DOTS. This paper notes that the Philippines already suffered from low utilization of basic health services even prior to the pandemic. These subsequent reductions due to the pandemic will lead to even further losses and these are estimated in this paper as well.

Health care seeking behavior may be seen as a result of household decision making for its members involving the demand for health care under various constraints and the supply of health care from various providers. Reduced utilization can then be rooted to changes in the demand and supply side factors. As also pointed by Ulep (2021), the likely factors affecting these drops in utilization include both reduced demand due to fear of contagion, higher costs of access, reduced purchasing power, and disruptions in supply. Data on these factors at the household level will contribute to understanding of the reductions in health care utilization.

The LCSFC presents an opportunity to look at household decision making especially as it pertains to households with adolescents. These households have the added burden of forming capabilities to determine life trajectories of these adolescents. Obtaining information on their behavior could present handles for policy action.

C.1 Health Care Utilization in the Pre-Pandemic Period

The LCSFC waves conducted prior to the pandemic collected data on household morbidity and health seeking behavior. This chapter examines these behaviors using data from survey rounds most proximate to the start of the pandemic (Wave 3 in 2019 and Wave 4 in Q1 2020), to more adequately represent pre-pandemic circumstances. As the nature of illness drives health seeking behavior, this is examined first. Table 5.1 presents the top 10 illnesses and symptom presentations experienced by households in Waves 3 and 4.

We see that virtually the same diseases and symptom presentations are cited by largest proportions of households for both waves except for Dengue which replaced communicable diseases in Wave 4. The top three morbidities (fever, cough/colds and diarrhea) also correspond to the most common diseases afflicting the cohort adolescents (see Chapter 4 of this report). For populations accustomed to such presentations, clear public health messages regarding disease gravity would need to be emphasized. Parsing or triage at the earliest point of contact for health consultations would also be advisable especially the earliest points of primary health care contact.

Table 5.1. Top Ten Reported Diseases/Symptoms by Households (HH), Waves 3 and 4[#]

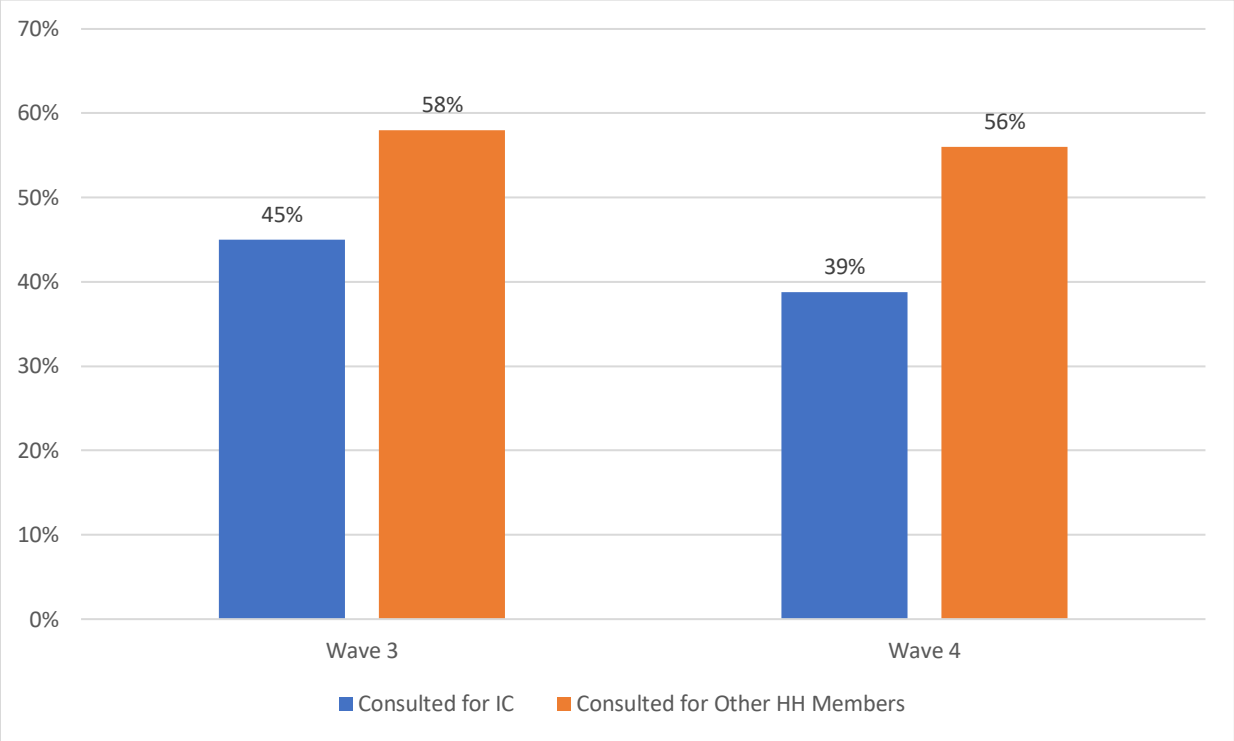
Conditions/Symptoms	Percentage of HH Reporting at least 1 incident in the Past 6 Months[#]	Mean Number of Household Members Afflicted in the Past 6 Months
WAVE 3 n=4,616		
Fever	56%	1.9
Cough/Cold	35%	1.8
Diarrhea	21%	1.5
Non-communicable Disease	18%	1.2
Asthma	13%	1.2
Female Reproductive Tract Diseases	9%	1.1
Injury	9%	1.1
Digestive System Diseases	7%	1.1
Measles	4%	1.3
Communicable Diseases	5%	1.3
WAVE 4 n=3,066		
Fever	52%	1.9
Cough/Cold	40%	2.2
Diarrhea	19%	1.6
Non-communicable Disease	16%	1.2
Asthma	12%	1.3
Female Reproductive Tract Diseases	8%	1.2
Injury	9%	1.2
Digestive System Diseases	6%	1.1
Measles	5%	1.3
Dengue	3%	1.1

[#]Weighted proportions per Wave

Consultations with Health Care Practitioners

Households were queried if they consulted a health care practitioner for illnesses experienced by the cohort adolescents (referred to as index children or IC in all the Figures) as well as by any other household member. Figure 5.12 shows that, for both waves, health care was sought less for illnesses experienced by the cohort adolescents compared to illnesses afflicting other family members. A possible reason for this is that the illnesses experienced by the adolescents may be less severe (as reported in Chapter 4) than those affecting other household members. We can also see that the proportion of households seeking health care for household members declined in Wave 4. Given the relatively unchanged set of morbidities between Waves 3 and 4, other factors such as the fact that Wave 4 was conducted in the period where initial cases of COVID-19 were seen (Jan-March 2020) would have to be considered to explain this decline.

Figure 5.12. Proportions of Households That Consulted a Health Care Practitioner for Illnesses[#]

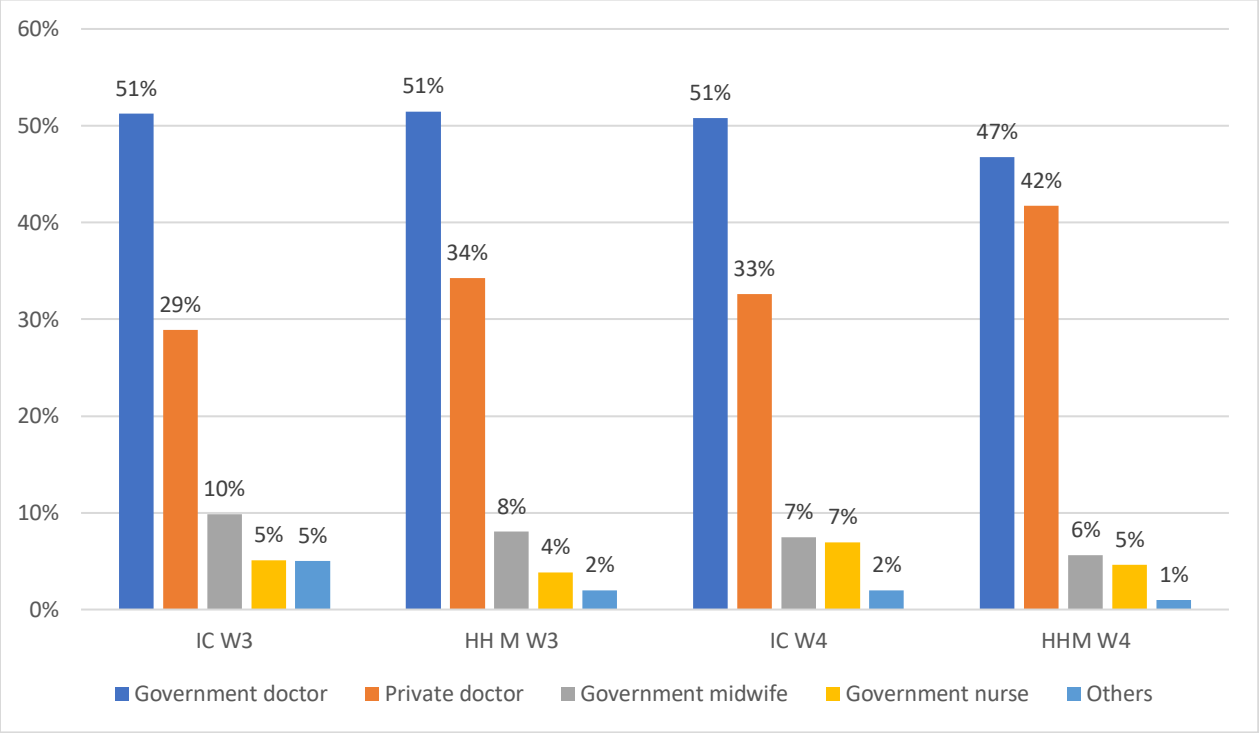


[#] IC refers to the LCSFC index children or the cohort adolescents; Weighted proportions per Wave

In Wave 3, the consultation rate for the cohort adolescents was higher for Luzon (50%) vs Visayas (40%) and Mindanao (37%); no such difference was observed for other household members. There was no significant urban/rural difference as well. This same pattern was seen in Wave 4, for instance, consultation rates for adolescents continued to be significantly higher for Luzon (45%) compared to Visayas (32%) and Mindanao (30%).

Figure 5.13 shows the types of health care practitioners mainly consulted. Government doctors are consistently consulted more across waves and type of household member involved, followed by private doctors. Among these households, reliance on government practitioners is still the norm for those who consult health care professionals.

Figure 5.13. Health Care Practitioners Consulted for Illness, Waves 3 and 4[#]

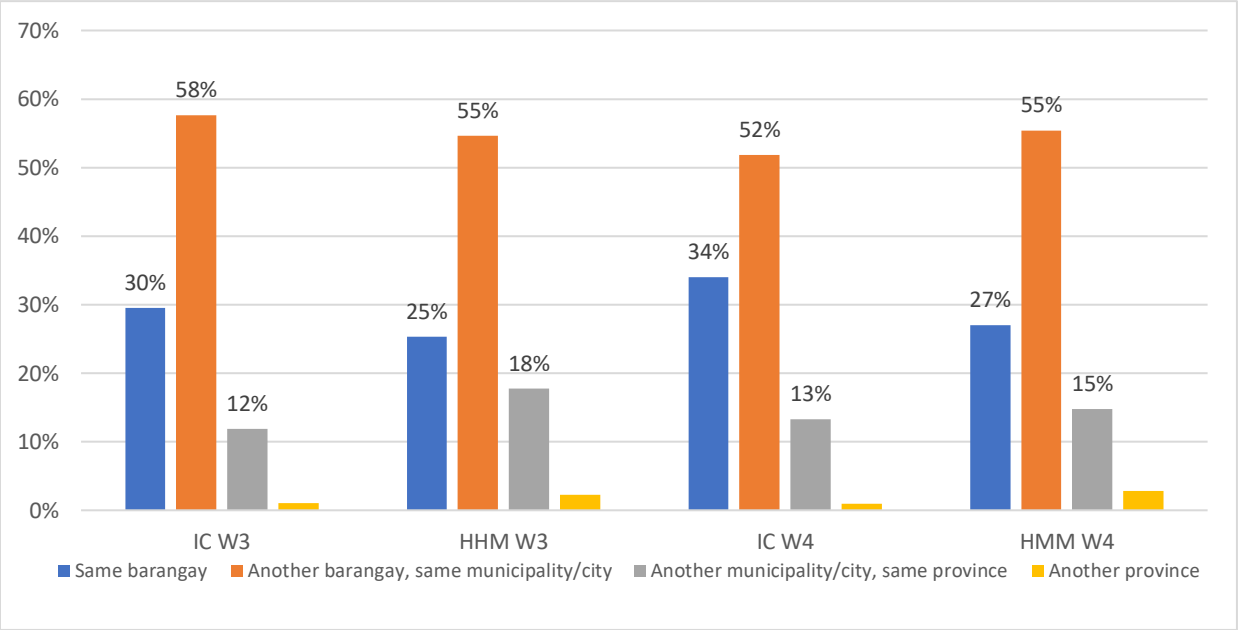


[#] IC refers to the LCSFC index children or the cohort adolescents; HHM=household members other than the cohort adolescents

For Wave 3, private doctors are approached more for urban (36%) than rural (22%) adolescents, a substantial difference in relative magnitudes. For these consultattions, government midwives were also more preferred in rural (16%) vs urban (3%) areas. For other household members, private doctors were more likely to be consulted by urban households compared to those in rural areas (41% vs 21%, respectively). Just as with adolescent consultations, government midwives were sought more in rural areas (12%) vs urban (4%) areas. Similar patterns were observed in Wave 4. Private doctors are consulted more for adolescent illnesses in urban than rural areas (40% vs 23%, respectively). Government nurses and midwives are consulted more in rural areas (11% and 15%, respectively) than in urban areas (4% and 2%, respectively). For other household member consultations. private doctors are consulted more for urban areas than urban areas (47% and 33%, respectively). Government nurses and midwives were similarly preferred in rural areas (7% and 11%, respectively) compared to those in urban areas (both at 3%).

Figure 5.14 shows the locations of the health care practitioners consulted. These patterns may indicate the proximity of health care practitioners and the preference of the consulting patient for proximate practitioners. Slightly more than half of healthcare practitioners consulted were in the same city or municipality but in another barangay. This is the case for both adolescent and other household member consultations. For Waves 3 and 4 there also appears to be a slightly higher tendency for adolescent consultations to be done within the same barangay compared to consultations of other household members.

Figure 5.14. Locations of Health Care Practitioners Consulted, Waves 3 and 4[#]



[#] IC refers to the LCSFC index children or the cohort adolescents; HHM=household members other than the cohort adolescents

Travel costs, explicit and implicit (costs as indicated by travel time to destination) have been shown to significantly affect health care utilization especially when other costs are nominally low or zero (El Omari and Karasneh, 2021). Figure 5.15 shows the mean travel times (in minutes) and costs in pesos for those seeking health care in Waves 3 and 4. In Wave 4, while travel time decreased compared to time spent in Wave 3, a substantial increase in mean travel cost was observed. These could help explain the lower rate of health care consultations in Wave 4. For all types of consultations, mean travel time and travel costs are lower for those living in urban areas. Mean travel cost for all types of consultations was substantially higher in the Visayas than in Luzon and Mindanao.

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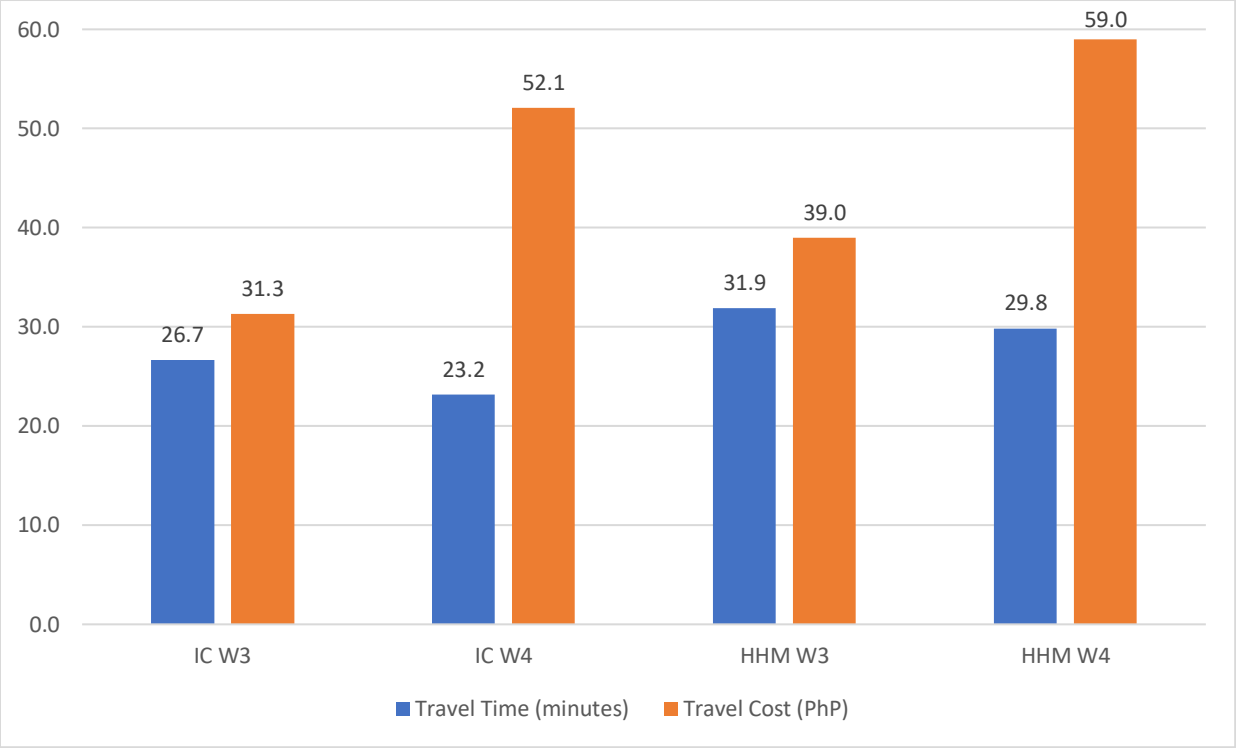
Figure 5.15. Travel Time and Cost of Travel to Health Care Practitioner Consulted, Waves 3 and 4[#]

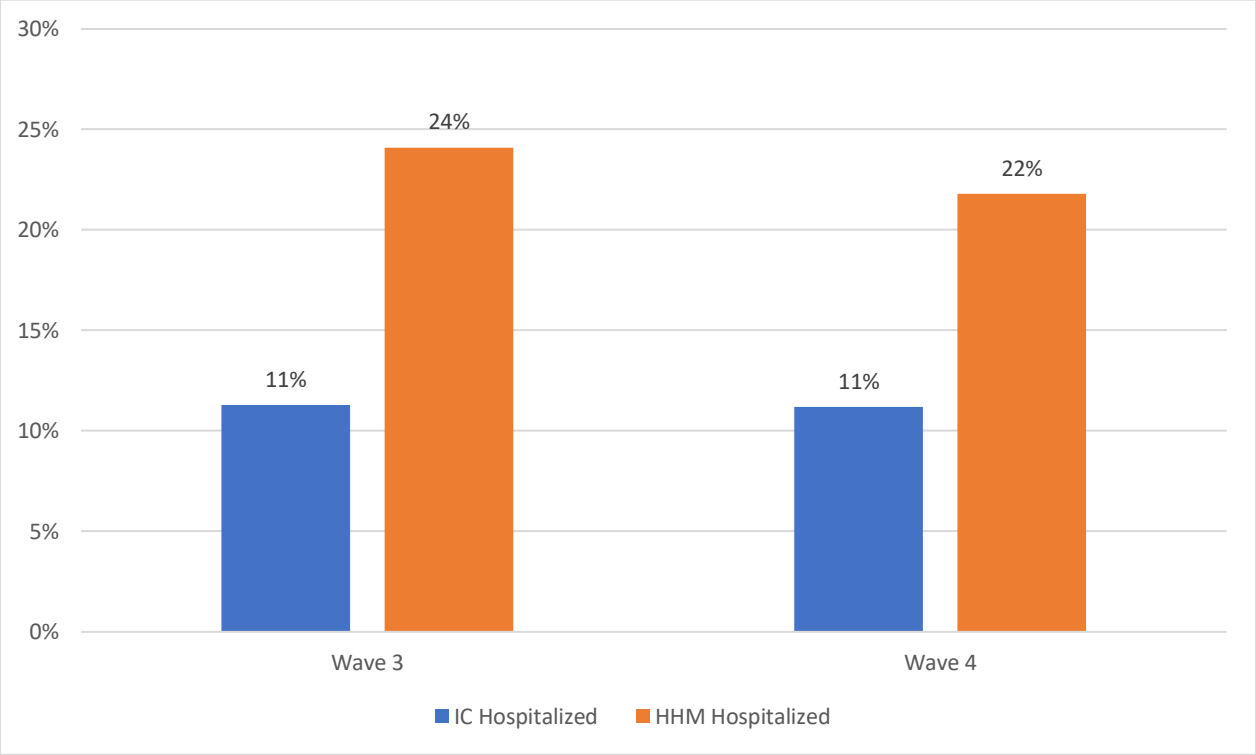


[#] IC refers to the LCSFC index children or the cohort adolescents; HHM=household members other than the cohort adolescents

Hospitalizations

Hospitalization data show little variation between Waves 3 and 4. Figure 5.16 shows the rates of hospitalization for illnesses in the 6 month period prior to survey visit.

Figure 5.16. Proportions of Households Reporting Hospitalization of Sick Members, Waves 3 and 4[#]



[#] IC refers to the LCSFC index children or the cohort adolescents; HHM=household members other than the cohort adolescents

For Wave 3, there is a significant difference in hospitalization rates for cohort adolescents across island groups. The rate for Mindanao (17%) is much higher compared to Visayas (10%) and Luzon (10%). There is no significant difference across rural and urban areas for index children. For other household members, a similar differentiation by island group is observed with Mindanao households reporting a higher hospitalization rate on the average (30%) compared to those in Visayas (23%) and Luzon (22%). No variation is observed as well between urban and rural areas for other household members. For Wave 4, the only significant difference observed is that of hospitalization rates for other household members across urban and rural areas. For this group of household members, urban area rates of hospitalization (19%) are lower than that for rural areas (26%).

In Table 5.2, we see the forms of financing used for hospitalization episodes prior to the pandemic, and type of household member affected. Paying out of pocket remains a major form of financing both on its own and in conjunction with PhilHealth coverage. Where national health insurance is intended to have universal coverage, we see in the table that coverage is still uneven across household members and waves of data collection.

For Wave 3 household member hospitalizations, the proportion who rely solely on PhilHealth is much less in Luzon (20%) than in the Visayas (45%) and Mindanao (48%). LGU financing is higher for the Visayas (7%) compared to Luzon (3%) and Mindanao (5%). Personal funding is much higher for Luzon (35%) compared to Visayas (15%) and Mindanao (11%). Personal funding with PhilHealth is lower for Visayas households (29%) compared to Luzon (34%) and Mindanao (30%).

For Wave 3 adolescent hospitalizations, PhilHealth only financing was much higher (57%) in rural areas compared to urban areas (21%). LGU financing is higher in urban areas (5%) compared to rural areas (1%). Personal financing is also significantly higher in urban areas (23%) versus rural areas (6%). Joint financing with PhilHealth and personal finances is higher for urban areas (46%) compared to rural areas (31%).

For Wave 4, there were no significant differences across island groups and urban/rural areas for hospitalization financing for adolescents and other household members. PhilHealth only financing is much lower in Luzon with higher proportions financing hospitalizations with private insurance (6%), personal funds (21%) and other government agencies (5%). Visayas households rely more on PhilHealth only financing (48%) with markedly lower incidence of personal fund use only (5%). Mindanao households have the highest proportion of LGU financing (12%) and the lowest level of joint personal and PhilHealth financing (25%).

Table 5.2. Financing for Hospitalization Episodes, Wave 3 and 4[#]

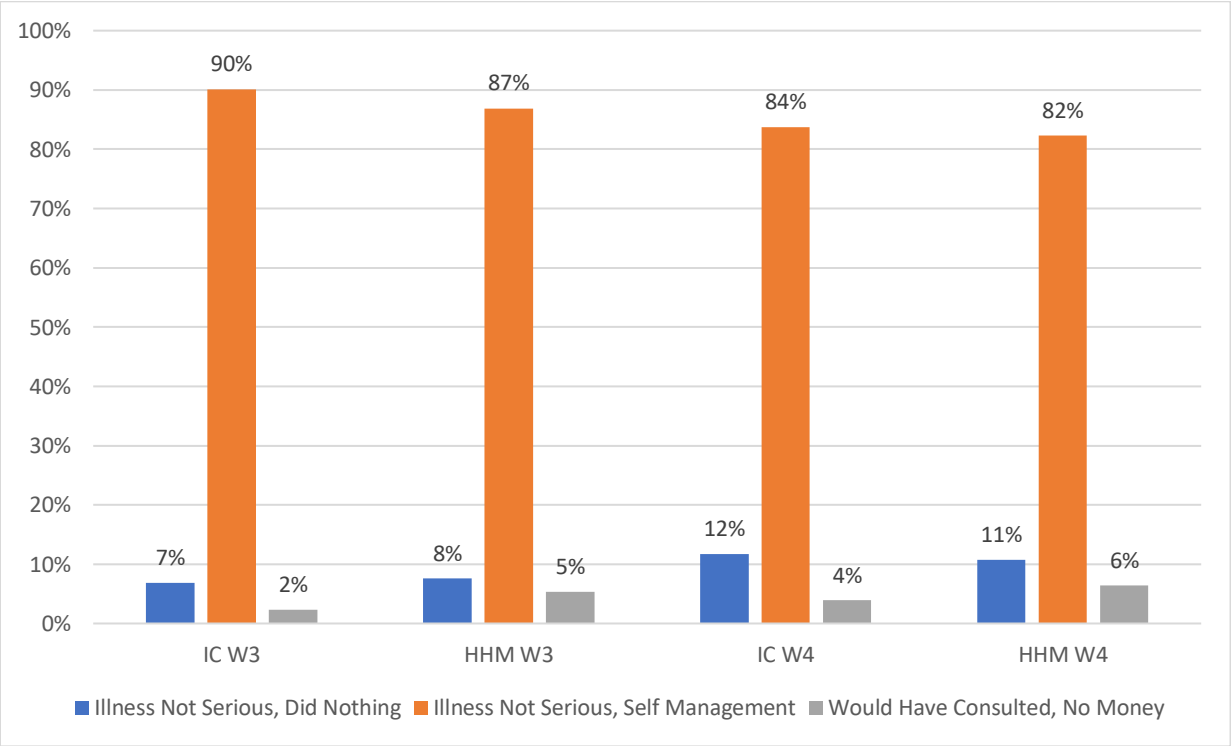
Financing for Hospitalization	Wave 3		Wave 4	
	Index Children (%)	Other Household Members (%)	Index Children (%)	Other Household Members (%)
Don't Know	-	0.3	-	0.5
Donations/sponsorship (private persons)	0.8	1.2	-	-
HMO	0.9	1.6	4.7	3.5
LGU health program	3.0	4.2	6.1	6.2
Other government agencies (DSWD, PCSO)	1.1	1.2	3.1	3.2
Personal cash only	13.6	23.6	11.5	16.9
PhilHealth and personal cash	37.7	31.8	14.9	30.8
PhilHealth and HMO	0.7	0.6	0.8	0.9
PhilHealth and LGU health program	1.8	2.1	1.1	0.1
PhilHealth only	40.5	33.2	57.8	37.8
Total	100.0	100.0	100.0	100.0
PhilHeath Coverage (alone or with other forms of finance)	80.7	67.8	74.6	69.7
Personal Financing (payment involved personal money)	51.3	55.5	26.5	47.7

[#] IC refers to the LCSFC index children or the cohort adolescents

Non-Consultations

For those that did not consult health care practitioners for their illnesses, Figure 5.17 shows the answers provided for both cohort adolescents and other household members across Waves 3 and 4. There is an extremely high tendency for self-management among these households based on an underlying judgement that the illness is not serious enough to warrant consultation with a health care practitioner. For consultations involving other household members, 25% of households in the Visayas chose to do nothing, compared to less than 10% for Luzon and Mindanao. This also lowered the proportion that did self-management for Visayas households to 70%. Households in Mindanao had a markedly higher proportion (10%) saying that having no money for consultations was the problem. This is double the proportion for the Visayas and Luzon for this wave.

Figure 5.17. Reasons for Not Consulting a Health Care Practitioner, Waves 3 and 4[#]



[#] IC refers to the LCSFC index children or the cohort adolescents; HHM=household members other than the cohort adolescents

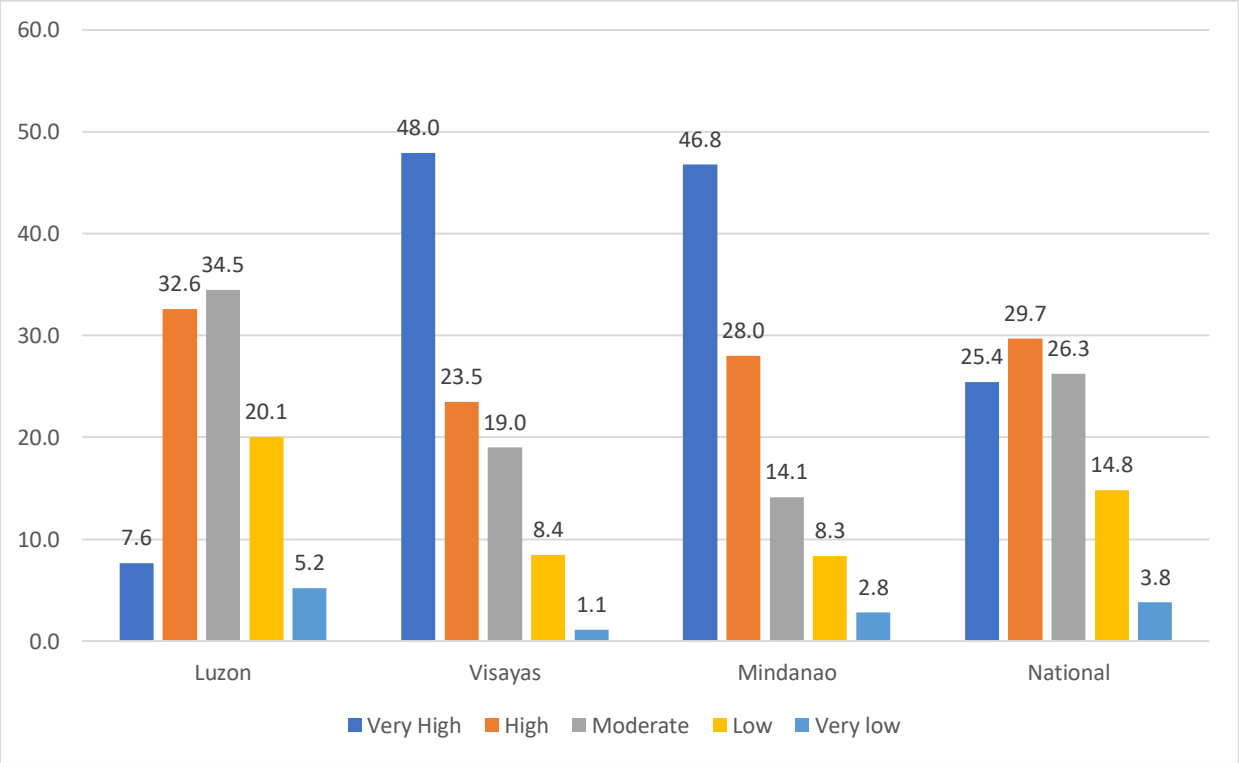
C.2 Health Care Utilization during the Pandemic Period

The LCSFC conducted a brief phone survey in November 2020 (Wave 4A) to touch base on the cohort on how they were faring during the pandemic. Towards the end of November 2020, confirmed COVID-19 cases had increased to 422, 915, the bulk of which was coming from the National Capital Region (NCR) and Calabarzon (WHO, 2020). For the whole of November 2020, quarantine classifications ranged from Modified General Community Quarantine to General Community Quarantine, the two lowest and least restrictive categories at that time (IATF, 2020).

Health care utilization during the pandemic was examined considering both demand and supply side factors. Demand side factors include the preference for health care contingent primarily on the perception of the gravity of the illness and the fear of contagion, constraints on utilization indicated by household purchasing power and the costs of accessing health care in terms of travel and time, and perceptions of supply side disruptions in health care services.

The perception of COVID-19 as a threat to health at that time would affect health care utilization in several ways. For one, the graver the perception of the health threat, especially among those experiencing symptoms, the higher the likelihood of utilization. However, fear of contagion could also dampen the desire to seek care. Figure 5.18 shows the levels of threat perception by island group. These observed differences are statistically significant ($p<0.01$). It is worth noting that the Luzon households would appear to perceive COVID-19 as less of a health threat compared to households from Mindanao and Visayas when at this time 65% of confirmed cases came from the NCR and Calabarzon (WHO, 2020). There is no significant difference in terms of health threat perception of COVID-19 between urban and rural areas for this survey.

Figure 5.18. Perception of COVID-19 as a Health Threat by Island Group[#], Wave 4A Phone Survey[##]



[#]Significantly different across domains $p<0.01$ [##]Weighted proportions per Wave

The household's source of information regarding COVID-19 could play an important part in forming perceptions of the disease as a threat, and consequently influence health care seeking decisions. Table 5.3 shows the various sources of information for the households and the source on which they relied most.

Table 5.3. Sources of Information on COVID-19, Wave 4A Phone Survey[#]

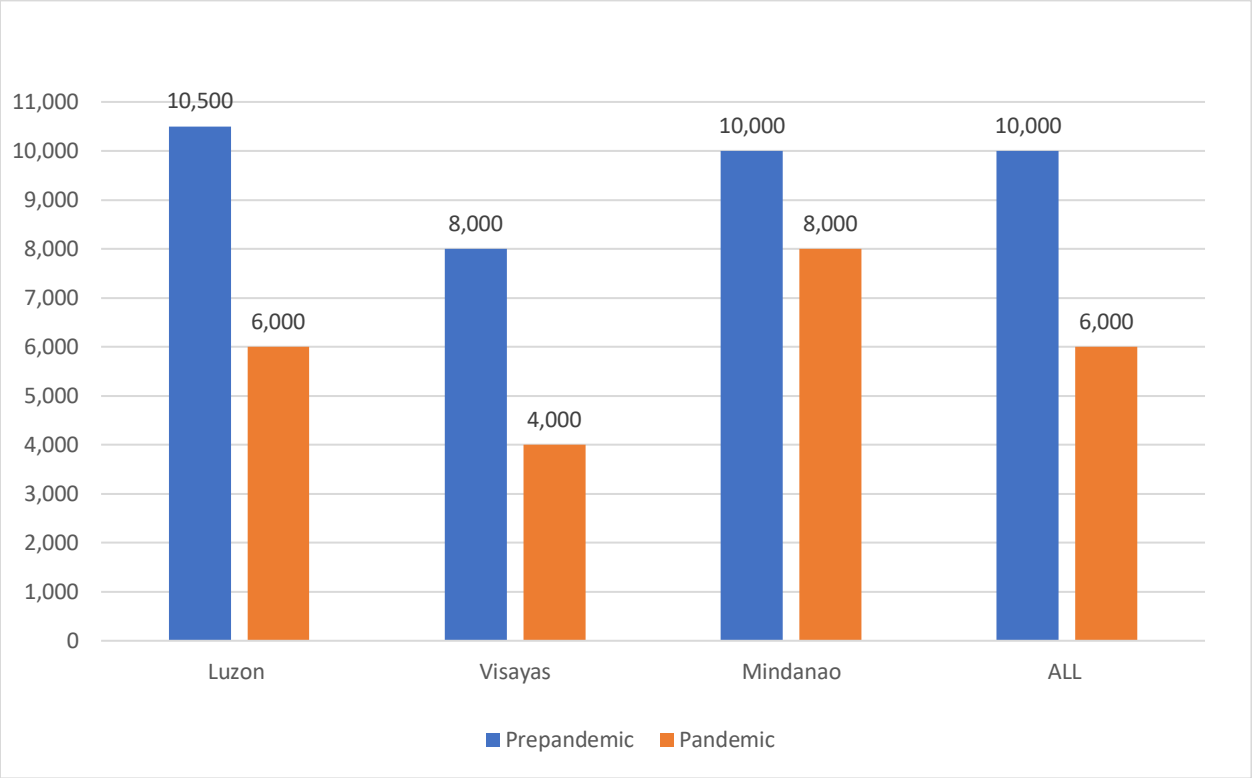
Source	Cited as Source of Information[##]	Source of Information Most Relied On
TV	86	64
Radio	38	10
Newspapers/magazines	2	0
Health personnel	5	2
Family/relatives/friends	15	2
Online, Facebook	44	11
Online, YouTube	5	1
Online, Other social media sites	4	1
Government officials (local/national)	22	9

[#]Weighted proportions (% of households) [##] Question allowed for multiple responses

Information from television shows was the most cited source and also considered the most reliable. The online social media platform Facebook was cited next but had a lower reliability rating. Radio was rated similarly. Government officials also ranked low in terms of reliability.

As the pandemic response centered around lockdowns to minimize personal interaction, the consequent reduction in economic activity affected household incomes. Estimates of income elasticity for healthcare tend to show that health care is a normal good but a necessity, with utilization increasing little in relation to changes in income (Acemoglu et.al 2013). Large reductions in household income are likely to significantly reduce health care utilization. The survey also asked the respondents to estimate their average household monthly incomes before the pandemic (before March 2020) and during the pandemic (since March 2020). Figure 5.19 shows the median peso difference between both income amounts, stratified by island group. An overall income reduction of 40% was calculated, with households in the Visayas (50%) and Luzon (43%) experiencing the most reduction, compared to those in Mindanao (20%). Another indicator of reduced purchasing power is the household's ease or difficulty in meeting expenses. Data shown in Figures 2.8 and 2.9 of Chapter 2 reveal that the proportion of households expressing difficulty in meeting expenses doubled between the pre-pandemic survey (Wave 4, Q1 2020) and the early pandemic round (Wave 4A, Q2 2020).

Figure 5.19. Changes in Median Household Monthly Income between Pre-Pandemic and Pandemic Periods, Wave 4A Phone Survey



Household Experiences with COVID-19 Symptoms and Consequent Health Care Utilization

Fifteen percent of households experienced COVID-19-like symptoms of which cough, colds, and fever were the most common and were cited by 61%, 49%, and 33 % of these households, respectively. It is worth noting that these symptoms were also cited in pre-pandemic survey rounds as the most common symptom presentations of illnesses. About 22% of the cohort adolescents were among those reported experiencing COVID-19-like symptoms (only 2% were tested for the virus). A higher proportion of households in Mindanao (20%) reported experiencing symptoms compared to Luzon and Visayas (both 13%). The corresponding rate in urban areas (20%) is double that of rural areas (10%). On the average, two household members were afflicted with COVID-19-like symptoms in the reference period. There is a low incidence of testing for COVID-19 reported for this survey.

For households that experienced COVID-19-like symptoms, 30% consulted a health care practitioner. This rate is lower compared to pre-pandemic rates reported for Waves 3 and 4 (see Figure 5.12). More households in Luzon (40%) sought health care for these COVID-19-like symptoms compared to the Visayas (23%) and Mindanao (19%). The health care practitioners consulted were predominantly employed in government institutions (63%) with the remainder from the private sector. This is consistent with pre-pandemic division among private and public sector practitioners. Common means of reaching the health care facility were walking (27%), tricycles (20%), private motorcycles (18%), private vehicles, and government vehicles (both 8%). About 9% of the households conducted the consultation by phone or online, a rather small proportion given that 80% of the households in Wave 4A had access to the internet,

and in Wave 4 more than 90% owned a cellphone. Only four households reported having household members hospitalized for COVID-19.

Among the reasons cited for not seeking health care for COVID-19-like symptoms were self-medication/management (66%), fear of contracting the virus (21%), fear of COVID-19 diagnosis being confirmed (4%), and lack of finances (1%). About 12% of the households did nothing to address these symptoms. The penchant for self-medication/management due to perceived lightness of symptoms was also observed in the pre-pandemic survey rounds.

Household Experiences with Non-COVID-19 Illnesses and Health Care Utilization

Given that worldwide and Philippine trends had pointed to lower health care utilization for non-COVID-19 cases, as previously discussed, verifying this trend with the Wave 4A data would be helpful. About 26% of the households surveyed in Wave 4A reported having household members with non-COVID-19 illnesses. Of these households, 44% consulted a health care practitioner. This rate is lower than the rate generally reported for consultations in pre-pandemic times (Figure 5.12). Households in the Visayas had a higher rate of consultations for non-COVID-19 illnesses (55%) compared to those in Luzon (44%) and Mindanao (38%). Government practitioners were the most consulted (54%) followed by private practitioners (40%). A small portion consulted traditional healers (4%). No significant difference was found for these rates across island groups and urban/rural stratum. The dominant modes of travelling to these health care practitioners were tricycles (26%), walking (16%), private motorcycles (16%), private vehicles (14%), and government vehicles (7%). Three percent of households with non-COVID-19 illnesses consulted through the telephone or the internet.

Policy Implications

These LCSFC findings point to important implications for policy action. Firstly, the need for coherent messaging is seen to be crucial given certain findings. Communication channels are important in this regard. TV had the highest citation as a source of information. This media channel had the highest trust rating among respondents and must be utilized efficiently and intensively going forward if present trends continue. However, there are indications of the increasing importance of internet channels which at the time of the survey still had low trust levels. Proper attention must be given to the internet as a source of public health information that is coherent, reliable, and understandable. The finding that low threat perception was prevalent in Luzon during the time that it accounted for the bulk of cases points to a communications gap that could have been better handled. The added fear of contagion in health care facilities could also be properly addressed by communications interventions emphasizing the observance of health care protocols in such facilities.

Health care utilization rates in the form of visits to a health care practitioner for illnesses had a decreasing trend for the cohort adolescents and a relatively stable rate for other household members in the pre-pandemic waves. As the policy literature for the Philippines bemoans the low levels of utilization even prior to the pandemic, this does not bode well even without the pandemic. The uneven utilization in favor of Luzon households also points to a prerogative for offsetting action that prioritizes the Visayas and Mindanao. The reduction in health care utilization rates for both COVID19 and non- COVID 19 cases during the early pandemic only provides more evidence of impending welfare losses from postponed or under-utilized health care systems as estimated in Ulep (2021). Setting public health system features that will offset or mitigate these reductions can be pro-actively set up. As public health practitioners remain the primary health care providers consulted at the instance of disease, ensuring availability of health human

resources in the public sector remains essential. Where feasible, public health practitioners can be complemented by investments in complementary capital such as an online or phone-based consultation system. This will address both the normal period difficulties in health access due to the lack of facilities in the proximate area of the potential patient. The fact that in the pre-pandemic waves, consultations within the barangay only accounted for a third or less of consultations points to travel over distances that might be prohibitive and discourage access even when health care is nominally free at government facilities as argued by El Omari and Karasneh (2021). Access to laboratories and other diagnostic procedures should also be ideally offered in strategic locations to balance scale and access considerations.

To have such large proportions of households engaging in self-management of illness requires a further look into the determinants of this behavior. Health care is notoriously insensitive to price and income for indigent patients in developing countries such that preferences and non-monetary constraints, such as time costs of waiting and travel, could be ultimately behind the reason why sick people self-medicate. However, when there is room to encourage health care utilization as would be appropriate where adverse preferences and non-monetary constraints are minimal or not binding, the uneven coverage of national social health insurance is a gap that needs to be addressed. This would happen as universal health care financing ramps up and becomes fully implemented. Both purchasing power and time costs have been adversely affected by the pandemic, particularly by safety measures implemented in response to the pandemic. LCSFC results showing that walking or riding a tricycle were the common forms of travelling to consultations indicate the heightening of travel restrictions during the pandemic. The use of tricycles is notable as it provides a mix of low passenger density transport for hire with sufficient flexibility in routes. However, during the pandemic, there was some confusion as to whether this form of transportation would be allowed to operate. The same confusion was seen in whether taxi cabs would be allowed. Taxi cabs also offer the higher convenience and low density use with sufficient safeguards possible (like opening windows). There was also a debate on whether private motorcycles would be allowed to carry multiple passengers.

Mitigating the impending losses due to heightened morbidity and mortality and building resilience and flexibility would be the order of subsequent policy response. Understanding the drivers of health care utilization in greater detail will help inform these initiatives especially for households with children and adolescents.

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