Before I saw my grandma, my lola, again this year, I knew she would not be in good health. When we visited in 2015, she had gone from being active around the house to only standing when she was changing chairs. She was perpetually going to the bathroom at night, ate little, and tired easily. Her mental state had declined too. Instead of the lengthy, enthralling Skype conversations to which I had grown accustomed, our last call consisted of short replies from her after considerable prompting.

When I asked her what the doctor had said about the incontinence, or the poor appetite, or the forgetfulness, I was told that her doctor had said nothing because she had not seen her doctor.

‘Why not?’ I asked incredulously. I knew she lived about an hour’s drive away from the nearest hospital. It would be difficult, but not impossible to transport her.

My dad replied, with sad resignation, ‘Well, she’s grown old. They say that’s just how it is.’

Healthy ageing

Let us consider what ageing is ‘supposed’ to be from an evidenced-based perspective.

According to the World Health Organisation, healthy aging is ‘the process of developing and maintaining the functional ability that enables wellbeing in older age’. [1] This entails the individual’s ability to meet basic needs; to learn, grow and make decisions; to be mobile; to build and maintain relationships; and to contribute to society. When I last visited lola in December 2017, this is where things stood:

• She needed a full-time carer to assist her with all tasks. She could barely sit upright, much less walk.

Marisse Sonido

Marisse is a fourth year medical student at the University of New South Wales. Besides being a doctor, her dream career was always to be a writer. Turns out, there was a way she could do both!
• She would say short phrases to indicate when she was hungry, feeling too warm, or in pain. Beyond this, she made no other decisions and could not execute any of them independently.
• She failed to recognise many members of her own family without repeated reminders. Even her children. During my week-long visit, she was only able to acknowledge me lucidly for five seconds. After my aunt reminded her who I was, she said one short but heart-warming sentence: ‘It’s good you could come home.’ Despite repeated efforts, I could not start a conversation with her again.

Regardless of how devastating it was for me to witness my lola in this state, I believe it is worrying that this condition was to be ‘expected’ for anyone. She had lost all functional ability and was seemingly receiving no active medical intervention for a variety of chronic issues, including dementia.

During my visit, I realised that my grandmother’s case was not a single incident of an elderly woman receiving poor medical care. One of my lola’s carers, Lyn told me that she had cared for two of her own elderly relatives in the same way until they passed. She provided the same full-time assistance and described similar declines in their health as we were seeing in my grandmother. However, she did not share my disbelief and outrage at the way things had turned out with her relatives. To me—with my perspective heavily based on the Australian model of geriatric care—these stories represented a missed opportunity for timely, much-needed and pre-emptive medical intervention. To Lyn and many who lived in my lola’s rural town, they represented an inevitable progression. There was a commonplace acceptance that a state of being like my lola’s was to be anticipated.

Barriers to care

A question I found myself wondering a lot during and since that visit is why this resignation has become commonplace in my lola’s town and, possibly, in other rural towns in the Philippines. Peters et al.[2] comprehensively outlined these reasons in their model on the obstacles to care in developing countries: (1) geographic accessibility, (2) availability, (3) financial accessibility and (4) acceptability. According to Jacobs et al.[3] considering supply and demand for each dimension is critical to appropriately addressing the issues at hand.

Geographic accessibility

Given where she lived, accessing healthcare was clearly not something that was in my lola’s favour. Based on my nephew’s stories, the two nearest health centres in neighbouring towns had closed since a change in political administration. This led to healthcare funds being redirected to other budget priorities. While seemingly unbelievable at the time, I later learned that public healthcare is the responsibility of local government. As such, local authorities have considerable autonomy in interpreting and executing central health policies.

The best mode of transport to the nearest city available to my lola was a borrowed van. Would she be able to survive a 2–4 hour round trip in a shaking van over dirt roads? It was easy to say that the risk was worth taking but none of her family, including myself, felt comfortable insisting on it. Many other Filipino families have undoubtedly also faced distance as an obstacle to health, given that the average travel time to a hospital is around 39 minutes. In some remote areas, this can average up to 90 minutes,[5] which is not conducive in urgent situations and transporting patients with unstable health.

Availability

If the issue of distance could be miraculously resolved, then came the question of whether treatment was available once she arrived at the city hospital. In the Philippines, supply of available health practitioners fails to meet population needs, even with numerous vacant positions in rural areas, exacerbated by emigration in recent decades.[6] Based on the latest available statistics, the Philippines has 1.11 doctors, versus the 3.496 rural areas, exacerbated by emigration in recent decades.[6] Based on the latest available statistics, the Philippines has 1.11 doctors, versus the 3.496 rural areas, exacerbated by emigration in recent decades.[6] Based on the latest available statistics, the Philippines has 1.11 doctors, versus the 3.496 doctors in Australia, for every 1000 individuals.[7] While measures are being taken to improve the number of rural doctors (e.g., increased salaries) and doctors in general (e.g., reducing the length of medical education), it will be several years before these shortages are fully addressed.[8]

Because of this, the waiting time for a doctor in the Philippines could take hours in non-urgent situations. Considering that my lola had multiple comorbidities in the context of a resource-stretched healthcare system, I am not confident that her local public hospital would be able to provide the coordinated long-term care she would require. When she had been more able, she would make a biannual 13-hour road trip to Manila’s more equipped and better-staffed hospitals, where there are approximately 17 beds per 10,000 persons versus the 4 beds per 10,000 persons for the rest of the country.[9] This was no longer a viable option given her health.

On the demand side, availability is limited
by the general population’s incomplete understanding of chronic diseases and awareness of where and when to seek medical assistance. Of the existing centralised health promotions run by the Department of Health, very few focus on the elderly and chronic diseases.[10] According to a statement by Dr Anthony Leachon, former president of the Philippine College of Physicians, patients often come to doctors when symptoms are already severe. He blames lack of health literacy.[11] This is could be true in the case of my lola, as the question of seeking professional care did not truly arise until her symptoms had interfered with her day-to-day life and, by then, it became too difficult to arrange.

However, one study demonstrated that late health seeking is not a hard and fast rule and that elderly Filipinos do seek care, if possible, when symptoms of concern appear.[10] Interestingly, the study also found that elderly Filipinos ranked ‘where to get care’ as the least important aspect of their health-seeking preferences. This indicated that, provided their symptoms were addressed, care was acceptable from other sources besides conventional medicine, such as self-care and family advice. According to my family who lived there, a local herbolaryo (folk healer) was sometimes called upon when people in my lola’s village were ill, to offer healing that was a mixture of religious, spiritual and herbal—a reflection of the Philippine’s current religious landscape, and roots in animistic and superstitious beliefs relating to natural health remedies.

Affordability

Affordability is considered the main reason why Filipinos, elderly or otherwise, delay health seeking behaviours or resort to alternative, cheaper sources of healthcare. According to data from the WHO in 2007,[6] 54.3% of total health expenditure in the Philippines were out-of-pocket expenses. While senior citizens in the Philippines have extra discounts via the public health insurance scheme, Philhealth, the annual health expenditure per capita was still US$68 or approximately PHP 3500.[6] According to a study by de Guzman et al. of 304 elderly Filipinos, approximately 75% of elderly Filipinos earn PHP 10,000 or less yearly—making healthcare a considerable expense.[6] My lola’s main source of income had been a military pension for my grandfather’s service and some of the earnings from the corner store she used to run that was now under my uncle’s care, certainly not enough to afford continuous private care.

Acceptability

A prevailing health-seeking attitude in the Philippines is that, if it can be avoided (i.e., the symptoms eventually subside or are manageable through self-care), then one should refrain from going to a doctor. Besides the expense and inconvenience involved in health seeking, I believe that cultural factors contribute. The dislike of relying on ‘unnatural’ methods of symptom management and cultural stoicism are some of many beliefs at play. Ignoring medical symptoms to maintain daily routines is the norm for many Filipinos, for whom a missed workday could mean financial needs for their families. However, in the elderly, this is coupled with the stigma of losing independence and previous functionality.[12] I know that, until she was no longer able, my lola made it a point to do her regular chores around the house and run her store, even if several members of my family were happy to take over. To her, and perhaps others in her situation, admitting that she needed more medical care was to admit defeat to old age.

When I saw my lola again last year, I quickly realised that the care she received at home was not sufficiently improving her condition. I also knew that the idea of a nursing home or residential care would be disagreeable and unlikely to be accepted by most Filipino families like mine, a stark contrast to the attitude in Australia. As a natural extension of the Filipino family-centric culture, wherein all members remain heavily involved in each other’s lives throughout all stages of life, it would be a source of great guilt for a family to surrender the care of another family member to strangers, and would cause a sense of abandonment in the elderly individual.[11] Perhaps this, coupled with a lack of understanding of healthy ageing, is why those who watched my lola grow weaker were not as alarmed as I had been—this was a progression they had seen in the other elderly individuals who they had known, loved and taken care of all their lives.

Final thoughts

During the time I was writing this article, my lola passed away on the morning of April 1, 2018. While it is pointless to consider how much longer she could have lived with better care, I find myself doing so anyway. My lola is one of many who was failed by the current state of healthcare and health education in the Philippines which, while continuously developing, still has great strides to make in becoming accessible to all Filipinos. By acknowledging the obstacles to health in my lola’s story, perhaps a greater understanding can
be gained of the issues faced in the Philippines and other developing countries regarding elderly care, particularly given the fast-growing ageing population in Asia.\[13\] And perhaps, it can also show how valuable it is to the elderly, and to their families, that they be given the care they need to live their final years to the fullest.

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Photo credit
Sonido family

Conflicts of interest
None declared

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References

What you need to know

- Healthy ageing entails maintaining functionality to meet one’s basic needs, maintain relationships, make decisions and contribute to society.
- Obstacles to healthcare in developing countries include: (1) geographic accessibility, (2) availability, (3) financial accessibility and (4) acceptability.