



REGIONAL OFFICE 3
Department of Health
City of San Fernando, Pampanga



Vision:

A healthy and responsive community in Central Luzon.

Mission:

-to ensure effective delivery of quality affordable, accessible, equitable, and sustainable health services

-to develop, organize and mobilize stakeholders for health; and

-to foster collaboration, partnership and linkages with GOs and NGOs for the people of Central Luzon especially the poor, disadvantaged & marginalized.

Core Values:

*Integrity
Excellence
Commitment
Compassion
Professionalism
Stewardship
Teamwork*

KP Strategic

Thrust:

- 1. Improve Financial Risk Protection*
- 2. Improve Quality In and Out-patient care*
- 3. MDG Max*

HEALTH SEEKING BEHAVIOR OF MOTHERS BELONGING TO FAMILIES IDENTIFIED AS POOREST BY NATIONAL HOUSEHOLD TARGETING SYSTEM-POVERTY REDUCTION (NHT-PR) IN REGION III

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Abstract

This study determined the health seeking behavior of mothers who belong to the poorest families identified by the National Household Targeting System. Membership to PHILHEALTH, socio-demographic profile, perceived benefits of health services, perceived needs for health services were described and were correlated to actual utilization of health services. Accessibility of health facilities and availability of health personnel were also assessed.

The respondents of the study were 399 mothers from four provinces of Region 3 that registered having the highest number of poor households. A researcher devised questionnaire was used as the primary data gathering tool. Frequency count, percentage and ranking were used for descriptive analysis of data while Pearson r was used for inferential analysis.

Results showed that the respondents believe in the importance of seeking health services. Facilities and health care personnel were available in barangay centers and rural health units. There was high demand for consultation and medication. The average number of years of membership to PHILHEALTH was 3.77 years. However these enabling factors did not translate to actual utilization of health services.

It was also found out that older respondents have higher utilization of health services while those who were better educated have lower utilization of health services.



Keywords: health seeking behavior, poor households, mothers

Introduction

In 2007, the Department of Social Welfare and Development (DSWD) embarked on a social welfare reform agenda that will serve as a springboard for improving the delivery of social services to the poor households. Given the fact of scarcity of resources, it is imperative to identify who and where the poor are. This will ensure equitable distribution of resources and the issue of the leakage (of non-poor being included) and deprivation (poor being excluded as beneficiaries) of social services will be addressed.

Accordingly, the office of the National Household Targeting System for Poverty Reduction (NHTP-PR) was created. Also known as Listahanan, this office serves as the arm of DSWD in systematically identifying and creating database of the poorest household in the country. This can serve as reference in targeting the beneficiaries of different social programs including the Conditional Cash Transfer and enrollment to Philhealth. In 2012, the Philippine Health Insurance Corporation (PhilHealth) is in the process of enrolling about 5.2 million poor households in its subsidized health insurance program for the indigent.

This initiative is also in consonance with the Aquino health agenda of achieving Universal Health Care for All Filipinos. This agenda is anchored on the Republic Act (RA) 7875 as amended by RA 9241 stated that "the National Health Insurance Program (NHIP or the Program) shall provide all citizens the mechanisms to gain access to health services, in combination with other government health programs. Clearly these government reforms aimed at accelerating the provision of health services to all Filipinos, especially the poor segment of the population. With such mandates, the Department of Health (DOH) and the Philippine Health Insurance Corporation (PhilHealth) continue to device mechanisms so that most vulnerable poor will receive quality health care services with no out-of-pocket expenditures. The Universal Health Care or Kalusugang Pangkalahatan (KP), aspires to improve implementation of the compulsory nature of premium payments to avoid adverse selection and achieve social solidarity, the indigent poor shall have their premium payments subsidized through National Government appropriations. In 2013,

PhilHealth's support to the program essentially adds another P to the 4Ps which now stands for PhilHealth para sa Pantawid Pamilyang Pilipino Program,

Hence, it is assumed that enrolment to PhilHealth will shape the health seeking behavior of the beneficiaries. This program gives them better access to healthcare. However, several studies in the past pointed out that a variety of variables influenced the decision to seek health care. The study of Grundy and Annear (2010) found that socio-economic status was associated with hospitalization with poor households having lower rate of hospitalization. MacKian (2003) in her extensive review of available literature concluded that health seeking behavior is not just a one off isolated event. It is part and parcel of a person's, a family's or a community's identity, which is the result of an evolving mix of social, personal, cultural and experiential factors.

This study is interested in determining the extent at which the beneficiaries specifically the mothers belonging to the poor as identified by the LISTAHANAN utilize health services.

Anchored on the Andersen's Model of Health Services Utilization, different variables relating to utilization of health services will be analyzed. The Andersen's model proposed that utilization of health services is determined by three major variables. These are the predisposing, enabling and need based characteristics. The predisposing characteristics refer to the socio-demographic profile and the beliefs of health services benefits of the beneficiaries. The enabling characteristics include the family and community resources while the need based characteristics refer to the perception of need for health services whether by individual or clinical evaluation.

Anchored on this model, the paradigm of the study is presented in Fig. 1.

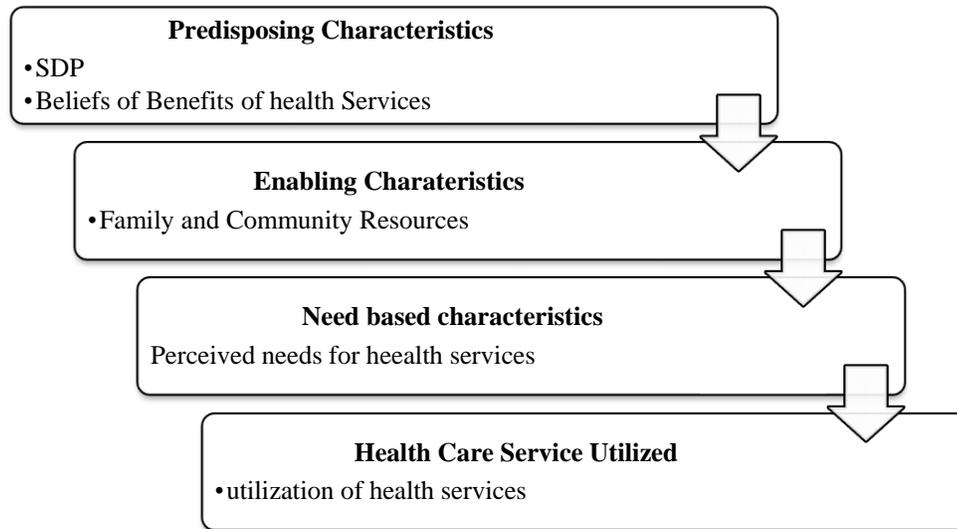


Figure 1. Research Paradigm

The main objective of this study is to investigate among other factors how enrolment to Philhealth shapes the health seeking behavior of the respondents. Specifically the following objectives are set forth:

1. To determine the socio-demographic profile of the respondents;
2. To determine the respondents' beliefs as to the benefits of health services;
3. To assess the availability and accessibility of health facilities in the community;
4. To determine the respondents' perceived needs for health services;
5. To describe the respondents' PHILHEALTH membership and utilization of health services; and
6. To determine the relationship between the respondents utilized health services and:
 - a. Socio-demographic profile
 - b. Beliefs as to the benefits of health services

Methods

This study utilized a descriptive-correlation method with the use of a researcher devised instrument as the primary data gathering tool. Descriptive method will be utilized in determining the variables related to characteristics, beliefs and needs for health services of the respondents.

These are the independent variables of the study. Correlation method will be utilized in determining the relationship of the independent variables with the respondents' utilization of health services.

The instrument of the study was devised after thorough research of variables related to the utilization of health services. Items were content validated by experts in the field of public health. For reliability testing, the instrument was subjected to test and re-test procedure. A coefficient of correlation of .92 was obtained which is an indication of high reliability.

Respondents of the study were 399 members of poor households as identified by the NHTS-PR. The respondents came from the four provinces in Region 3 with highest percentage of identified poor. These were the provinces of Aurora, Bulacan, Nueva Ecija, and Zambales. There were a total of 203,686 identified poor households in these provinces. Using the Slovin's formula, the computed sample size at .05 degree of error is 399. Table 1 presents the distribution of the respondents by province.

Table 1. Respondents' distribution by provinces

Province	No. of Household Assessed	Identified Poor	%	Sample Size
Aurora	18902	9333	49.37573	18
Bulacan	161637	73686	45.58733	144
NE	193657	96863	50.01782	190
Zambales	48859	23804	48.71979	47
Total		203686		399

Treatment of Data

Data were treated using descriptive and inferential statistics. Frequency count, percentage and ranking will be utilized in analyzing the respondents' socio-demographic profile, beliefs as to the benefits of health services; availability and accessibility of health facilities in the community; perceived needs for health services; and health care services utilized before and after enrolment

to Philhealth. To analyze relationship among the variables of the study, Pearson-r and chi-square were utilized.

Results and Discussion

Socio-demographic Profile of the Respondents. Table 1 presents the socio-demographic profile of the respondents. In terms of age, it can be noted that the mean age was 31.32. The biggest percentage of 34.88 were 28-38 years old, the youngest was 17 while the oldest was 61. This shows that most respondents were still in their reproductive age.

In terms of civil status, 367 or 85.35 percent were married. The rest were single ($f=15$), separated ($f=17$) and widowed ($f=17$). It can also be noted from Table 1 the predominance of Roman Catholics (86.51%). The rest belong to other religious groups like Born Again (4.65%), and Iglesia ni Cristo (3.26%) and minority belongs to other religious sect.

Table 1. Socio-Demographic Profile of the Respondents

Age	<i>f</i>	%			
17 - 27 years old	49	11.40			
28 - 38 years old	150	34.88			
39 - 49 years old	105	24.42			
50 - 60 years old	34	7.91			
61 and above	17	3.95			
No data given	75	17.44			
Total	430	100.00			
Mean Age: 31.32					
Civil Status	<i>f</i>	%			
Separated	17	3.95			
Married	367	85.35			
Widow/Widower	17	3.95			
No data given	14	3.26			
Total	430	100.00			
Religion	<i>f</i>	%			
Roman Catholic	372	86.51			
Born Again	20	4.65			
Iglesia Ni Cristo	14	3.26			
Crusada	1	0.23			
Miracle Working God	2	0.47			
United Methodist Church	3	0.70			
No data given	18	4.19			
Total	430	100.00			
			Occupation	<i>f</i>	%
			Selling	100	23.25
			Buy and Sell	1	0.23
			Direct Selling	1	0.23
			E-load retailer	2	0.47
			Fish Vendor	9	2.09
			Fishball Vendor	4	0.93
			Street Vendor	5	1.16
			Vegetable Vendor	68	2.09
			Sari-sari store owner	8	1.86
			Vegetable dealer	2	0.47
			Barangay worker	7	1.40
			Health Worker	1	0.23
			Beautician	7	0.23
			Manicurist	6	1.40
			Agriculture	40	
			Farmer	30	6.98
			Fisherwoman	1	0.23
			Vegetable farmer	8	1.86
			Planting rice	1	0.23
			House Helper	31	
			Laundress	19	4042
			Maid	12	2079

Ethnicity	<i>f</i>	%	Others		12
<i>Tagalog</i>	372	86.51	Boatwoman	1	0.23
<i>Bisaya</i>	15	3.49	Carpenter	1	0.23
<i>Bicolana</i>	1	0.23	Scavenger	2	0.47
<i>Panggalatok</i>	2	0.47	Sewer	4	0.93
<i>Ilocano</i>	19	4.42	Umbrella maker	2	0.47
<i>Zambaleño</i>	5	1.16	Weaver	1	0.23
<i>Aeta</i>	1	0.23	Street sweeper	1	0.23
<i>Ilongga</i>	2	0.47	Housewife	78	18.14
No data given	13	3.02	No data given	155	36.05
Total	430	100.00	Total	430	100.00
Highest Educational	<i>f</i>	%			
Elementary level	44	10.23			
Elementary graduate	54	12.56			
High School level	91	21.16			
High School graduate	125	29.07			
College Undergraduate	37	8.60			
College graduate	20	4.65			
Vocational course	1	0.23			
No data given	58	13.49			

As to highest educational attainment, 125 or 29.07 percent were high school graduates. This was followed by 91 or 21.16 who reached but did not finish high school. There were 54 or 12.96 percent who completed elementary education. The rest were distributed into elementary level (10.23%), college level (8.60%), and college graduate (4.65%) while only 1 finished vocational course.

In terms of occupation, 100 or 23.25 percent of the respondents were engaged in selling. They were fish vendors, street vendors, direct sellers and sari-sari store owners. On the other hand, 40 or 9.3 percent were engaged in agriculture while 31 or 7.21 percent were house helpers. It is notable that most respondents were engaged in informal economy. This may be attributed to their low educational attainment which limits their opportunities for gainful employment. Relative to their occupation is a mean monthly salary of P2367.21. This figure is much lower than the 2015 monthly poverty threshold of P9140 for a family of five members.

In terms of number of children, the mean was 3.90. This figure is slightly higher than the 2008 National Demographic Health Survey which registered a fertility rate of 3.3 children per woman. The same survey also noted higher number of children among poor than well-off families. Consistently, data from the current study showed that 192 or 44.65 percent have 1-3 children. This is closely followed by 188 or 43.72 percent who have 4-7 children. As to age of children, it can be noted that there is predominance of those within the 9-17 age groups. This is closely followed by

children within the 1-8 years old. These data show that most respondents have children who were still dependent on them.

As to number of household members, the mean was 4.63 and 88.14 percent of the respondents have family size bigger than this mean. There is predominance of respondents with family size ranging from 6 to 11 members. This accounts to 59.77 percent. Also it can be noted that there were 1 to 3 members of households who were working. This comprised 162 or 37.67 percent of the respondents while 93 or 21.63 percent have 4 to 7 household members who were working. In terms of their combined monthly income, the mean was P5010.28. One hundred sixty or 37.21 percent have monthly income below this mean. This is followed by 103 or 23.95 percent whose combined household income ranges from P4001-7000. In view of the figure from the Philippine Institute of Developmental Studies, a family earning a monthly income below P7000 is considered as poor.

Table 1 continued...

Monthly Income	f	%	No. household members	f	%
less than 1000	6	1.40	1 - 5 members	51	11.86
1001 - 4000	78	18.14	6 - 11 members	257	59.77
4001 - 7000	76	17.67	12 - 17 members	46	10.70
7001 - 10000	21	4.88	18 - 24 members	12	2.79
10001 - 13000	4	0.93	No data given	64	14.88
13001 - 16000	5	1.16	Total	430	100.00
16001 - above	4	0.93	Mean number of household members: 4.63		
No data given	236	54.88			
Total	430	100.00			
Mean Monthly Income: 2367.21			No. of household members	f	%
No. of Children	f	%	1 - 3 children	162	37.67
1 - 3 children	192	44.65	4 - 7 children	93	21.63
4 - 7 children	188	43.72	8 - 11 children	45	10.47
8 - 11 children	24	5.58	12 and above	5	1.16
12 and above	6	1.40	No data given	125	29.07
No data given	20	4.65	Total	430	100.00
Total	430	100.00	Mean number of household members with occupation: 1.17		
Mean number of children: 3.90					
Ages of Children	f	%	less than 1000	2	0.47
1 - 8 years old	390	90.70	1001 - 4000	160	37.21

9 - 17 years old	485	112.79	4001 - 7000	103	23.95
18 - 26 years old	246	57.21	7001 - 10000	17	3.95
27 - 35 years old	80	18.60	10001 - 13000	9	2.09
36 - 44 years old	30	6.98	13001 - 16000	1	0.23
45 - above	11	2.56	16001 - above	2	0.47
*multiple response			No data given	136	31.63
			Total	430	100.00
			Mean Monthly family income: 5,010.28		

Perceived benefits of health services. Table 2 presents the respondents' perceived benefits of health services. The over-all weighted mean was 2.92 with verbal interpretation of "agree". This means that the respondents generally believe that health services have beneficial effects. Examining individual means show that the respondents strongly agreed on five items and agreed on the rest of the items. The items which obtained the top three highest means were "consulting a physician whenever there is an untoward signs or symptoms felt" (WM=3.51), "preferring to undergo diagnostic tests whenever such discomforts are felt" and "obeying physician's advice for hospitalization, if any." It can be noted that these services are considered as preventive care. This implies that the respondents believe that preventive care is important.

Consistently, the item that ranked lowest was "believing or consulting quack doctors and superstition" (WM=2.40). Although belonging to the poor sector, the respondents were residing mostly in urban areas where quack doctors were seldom available.

Table 2. Perceived Benefits of Health Services

	Perceived Benefits of Health Services	WM	VI
1	Mas mainam ang kumunsulta sa doctor kung may nararamdamang hindi maganda. Mas mainam pa rin ang dumaan sa mga pagsusuri para malaman kung ano ang	3.51	SA
2	dahilan ng nararamdaman (CBC, X-ray at iba pang procedure)	3.39	SA
3	Dapat sinusunod ang payo ng doctor na ipaospital na ang pasyente.	3.36	SA
4	Bumibili lang ako ng gamot kung ito ay ipinayo ng doctor. Sinusunod ko ang payo ng doctor kung gaano kadami at katagal dapat inumin ang	3.31	SA
5	gamut. Nagtatanong ako sa botika kung ano ang gamot na puede inumin para malunasan ang	3.32	SA
6	karamdaman. Nagtatanong at sinusunod ko ang payo ng mga kaibigan o kakilala kung ano ang	2.66	A
7	gamot na mabisa para sa karamdaman.	2.31	A

8	Naniniwala ako sa payo ng mga albularyo at mga pamahiin ng mga matatanda.	2.40	A
9	Mas gumagamit ako ng halamang gamot para malunasan ang karamdaman. Ako ay naggagamot sa aking sarilung pamamaraan (self-medication) base sa	2.51	A
10	sintomas na aking nararanasan.	2.44	A
OWM		2.92	A

Legend: 3.25 – 4.00 Strongly Agree (SA)
2.50 – 3.24 Agree (A)
1.75 – 2.49 Disagree (D)
1.00 – 1.74 Strongly Disagree (SD)

Accessibility of health care facilities. In terms of travel time, there was predominance of respondents who claimed that it takes 30 minutes to one hour of walking to the nearest private clinic (38.60%), private laboratory (38.14%) hospital (38.14%), and drug store (38.60%). On the other hand, 38.37 percent claimed that the nearest RHU can be reached in 30 minutes by walking (Table 3).

Table 3. Accessibility of Health Care Facilities in terms of travel time

3. 1 Travel Time Facility	How many minutes from residence			
	Walking		With Vehicle	
	f	%	f	%
Nearest private clinic				
less than 30 minutes	13	3.02	413	96.05
30 - 60 minutes	166	38.60	1	0.23
61 - 90 minutes	0	0.00	4	0.93
91 - 120 minutes	1	0.23	1	0.23
121 - 150 minutes	30	6.98	0	0.00
151 - above	30	6.98	0	0.00
No data given	190	44.19	11	2.56
Total	430	100.00	430	100.00
Mean	33.75		9.59	
Nearest private Laboratory				
less than 30 minutes	9	2.09	320	74.42
30 - 60 minutes	164	38.14	102	23.72
61 - 90 minutes	2	0.47	4	0.93
91 - 120 minutes	5	1.16	0	0.00
121 - 150 minutes	0	0.00	0	0.00
151 - above	30	6.98	0	0.00
No data given	220	51.16	4	0.93
Total	430	100.00	430	100.00
Mean	37.19		15.6	

Nearest Government Center/RHU	f	%	f	%
less than 30 minutes	165	38.37	411	95.58
30 - 60 minutes	13	3.02	6	1.40
61 - 90 minutes	0	0.00	0	0.00
91 - 120 minutes	2	0.47	0	0.00
121 - 150 minutes	0	0.00	0	0.00
151 - above	30	6.98	0	0.00
No data given	220	51.16	13	3.02
Total	430	100.00	430	100.00
Mean	23.4		7.84	
Nearest Private Hospital	f	%	f	%
less than 30 minutes	8	1.86	232	53.95
30 - 60 minutes	164	38.14	98	22.79
61 - 90 minutes	2	0.47	0	0.00
91 - 120 minutes	5	1.16	2	0.47
121 - 150 minutes	0	0.00	0	0.00
151 - above	30	6.98	0	0.00
No data given	221	51.40	98	22.79
Total	430	100.00	430	100.00
Mean	45.62		16.29	
Table 3 continued..				
Nearest Drugstore	f	%	f	%
less than 30 minutes	5	1.16	408	94.88
30 - 60 minutes	166	38.60	16	3.72
61 - 90 minutes	2	0.47	0	0.00
91 - 120 minutes	35	8.14	1	0.23
121 - 150 minutes	0	0.00	0	0.00
151 - above	0	0.00	0	0.00
No data given	222	51.63	5	1.16
Total	430	100.00	430	100.00
Mean	33.09		8.33	

Using vehicle, there were more respondents who claimed that it will take less than 30 minutes to reach private clinic (96.05%), private laboratory (74.42%), private hospital (53.95%) drugstore (94.88%) and RHU (95.58%).

It can be inferred from these data that in terms of travel time, RHU is more accessible compared to private clinics and laboratories. Hence, the respondents can readily go to the RHU or barangay centers nearest to their area.

Access is central to the performance of health care systems around the world. Etymologically, access is defined as a way of approaching, reaching or entering a place, as the right or opportunity to reach, use or visit. Within health care, access is always defined as access to a service, a provider or an institution, thus defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs (Jean-Frederic Levesque, Haris & Russel 2013).

Accessibility of health services. Table 4 shows that in terms of waiting time until attended by the physician, the mean was 97.03 minutes or more than one and half hour. Examining the data, respondents almost tied in “91-120 minutes” (35.35%) and “30-60 minutes” (33.95%) waiting time. This is equivalent to half hour to two hours of waiting. As to the length of time the doctor spends for each patient during check-up, the mean was 17.12 minutes. More than half (51.40%) answered “less than 30 minutes” while 47.67 percent answered “30-60” minutes. As to results of diagnostics tests, the mean waiting time was 120.28 minutes or more than two hours with 62.79 percent claiming that the waiting was “91-120 minutes”.

The above data show that from the waiting time up to being checked-up by the doctor, the respondents have to spend an average of almost two hours. Another two hours will be added if there will be diagnostic tests. Hence, it can be inferred that the patients have to spend several hours queuing before receiving the needed medical care. For mothers who are burdened with household chores and caring of children, several hours of queuing may pose as hindrance in seeking medical care.

Table 4. Accessibility of Health Services

Waiting time till attended by doctor	f	%
less than 30 minutes	44	10.23
30 - 60 minutes	146	33.95
61 - 90 minutes	0	0.00
91 - 120 minutes	152	35.35
121 - 150 minutes	0	0.00
151 - above	83	19.30
No data given	5	1.16
Total	430	100.00

Mean	97.03	
Waiting time till checkup by doctor	f	%
less than 30 minutes	221	51.40
30 - 60 minutes	205	47.67
61 - 90 minutes	0	0.00
91 - 120 minutes	0	0.00
121 - 150 minutes	0	0.00
151 - above	0	0.00
No data given	4	0.93
Total	430	100.00
Mean	17.12	
Waiting time for the result	f	%
less than 30 minutes	0	0.00
30 - 60 minutes	63	14.65
61 - 90 minutes	0	0.00
91 - 120 minutes	270	62.79
121 - 150 minutes	0	0.00
151 - above	94	21.86
No data given	3	0.70
Total	430	100.00
Mean	120.28	

Imahsunu (2014) claimed that long waiting time in any hospital (or clinics) is considered as an indicator of poor quality and needs improvement. He recommended that effort should be geared towards developing appropriate techniques by which healthcare administrators can reduce patient queues and improve efficiency of services rendered. In order to aid accurate capacity planning and assure quality and service, healthcare management should put place a proper record system that will capture all vital information about patients. Information on age, sex, time of admission, time of transfer and, time and reasons for discharge is vital to planning process. This helps to determine service performance parameters such as arrival rate, length of stay, probability of delay, average time spent in the queue and system, number of patient in queue and system and rate of rejection or turn-away.

Availability of health personnel. It is shown in Table 5 that general practitioner, nurse and midwife are available in barangays and rural health units across the sampled provinces except

province A where a general practitioner is not available in barangay. Looking at the details, it can be noted that a general practitioner is available 4.67 days a week and an average of 5 hours a day for both barangays and rural health units. Nurses on the other hand are available on 2 days a week and 9 hours each day in barangays and 6 days a week and 23 hours each day in rural health units. Midwives were available 5 days a week and 9 hours each day in barangays and 7 days a week, 9 hours on weekdays and 12 hours on weekends in rural health units.

Table 5. Availability of Health Personnel in Barangays and Rural Health Units

Province	General Practitioner				Nurse				Midwife				
	No. of day/week		No. of Hours/Day		No. of day/week		No. of Hours/day		No. of day/week		No. of Hours/day		
	Brgy	RHU	Brgy	RHU	Brgy	RHU	Brgy	RHU	Brgy	RHU	Brgy	RHU	
												M - F	Sat - Sun
A		5		9	2	6	9	23	5	7	8	9	12
B	5	5	8	9	5	6	9	23	5	7	9	9	12
C	4	5	1	9	5	6	9	23	5	7	9	9	12
D	5	5	9	9	5	6	9	23	5	7	9	9	12
Mean	4.67	5	6	9	5	6	9	23	5	7	9	9	12

The above data show that there are more health personnel available in rural health units than in barangays. Residents of barangays can get the services they need in the rural health units nearest in their area of residence.

Health services needed. In terms of health services needed, it can be noted on Table 6 that the top three services needed were medication, consultation and hospitalization. Examining the details show that the top three morbidity that need medication were those related to gastrointestinal problems ($f=441$), neurologic disorders ($f=201$) and fever ($f=191$). Gastrointestinal problems include abdominal pain, diarrhea and dehydration. Neurologic disorders were those related to dizziness, eye problems and fatigue.

Table 6. Respondents' perceived needs of health services

Nature of Morbidity	Health Services Needed							
	Medication		Consultation		Lab test		Hospitalization	
	f	Rank	f	Rank	f	Rank	f	Rank

Gastrointestinal Problem	441	1	286	1	8	3	44	1
Musculoskeletal	3	10	3	9	3	5	3	7
Respiratory Problem	112	4	110	4	26	1	26	2
Skin Problem	6	7	6	6	6	4	6	6
Circulatory Problem	23	5	18	5	12	2	16	3
Cardiovascular	6	7	6	6	0	8	2	8
Urological Problem	7	6	6	6	0	8	7	5
Neurologic	201	2	160	2	2	6	14	4
Dengue	6	7	2	10	0	8	0	10
Metabolic	2	11	0	11	0	8	0	10
Fever	191	3	151	3	1	7	1	9
*multiple response	998		748		58		119	

When it comes to morbidity that needs consultation, the top three were gastrointestinal problem (f=285), neurologic disorders (f=160) and fever (f=151). On the other hand, the top three morbidity that requires laboratory tests were respiratory problem (f=26), circulatory problems (f=12) and gastrointestinal problems (f=8). X-ray is often required in respiratory problems while blood tests and stool exam were often required in circulatory and gastrointestinal problems.

Requiring hospitalization were those associated with gastrointestinal problems (f=44), respiratory problems (f=26) and circulatory problems (f=16).

It can be inferred from the foregoing data that medication is the top rank health care the respondents needed. This is consistent with findings from previous studies (Wilconson, 2001 and Yanagisawa, Mey & Wakai, 2004) that medication is the first recourse of health seekers.

Membership to and unitization of Philhealth. As to number of years of membership to PHILHEALTH, the mean was 3.77 years and almost 50 percent was below this mean, being members for a period of 1 to 3 years. The shortest was one year while the longest was 16 years. It can be recalled that it was in the year 2013 that PHILHEALTH coverage was extended to indigents thus giving them more access to health services (Table 7).

However, only 203 or 47.21 percent have used PHILHEALTH. One hundred five or 24.42 percent used PHILHEALTH for treatment of their children while 63 or 14.65 percent for their own

treatment. One hundred seventy eight (41.4%) availed in-patient services which include hospital confinement ($f=102$), surgery ($f=6$), and childbirth ($f=75$). Only 25 (5.81%) availed of out-patient services including treatment of heart disease and respiratory diseases like asthma, bronchopneumonia and flu.

It can be noted that utilization of PHILHEALTH is significantly lower than the identified health services needed in the data presented in Table 5. While there is a slight difference in terms of the need for hospitalization ($f=119$) and the actual utilization ($f=102$), there is a wide difference between the identified need for consultation ($f=748$) and the actual utilization ($f=25$). Thus, it can be inferred while the respondents considered having consultation, they still do not avail the services even if these can be accessed for free in rural health units in their area. This is consistent with the data presented in the Annual Review of Economics by Dupas (2011) that households in low-income countries in Asia invest little in preventive health care. It is possible that people simply need more time to adapt to new information or to the availability of new technologies. Indeed, without education, it might be difficult for households to process information even if it is easily accessible.

Table 7. Respondents' membership to and utilization of PHILHEALTH

Number of Year as Member of Philhealth			Who used the PHILHEALTH		
Member of Philhealth	<i>f</i>	%	Who used the PHILHEALTH	<i>f</i>	%
Less than 1 year	17	3.95	Self	63	14.65
1-3	212	49.30	Husband	7	1.63
4-7	48	11.16	Child	105	24.42
8-11	22	5.12	Father	8	1.86
12-15	7	1.63	Mother	10	2.33
No data given	124	28.84	No data given	237	55.12
Total	430	100.00	Total	430	100.00
Mean: 3.77 years			Services Availed		
Usage of PHILHEALTH			In-patient		
Yes	203	47.21	Hospital confinement	100	23.26
No	197	45.81	surgery	7	1.63
No response	30	6.98	childbirth	75	17.44
			Sub-total	182	42.33
			Out-patient		

Total	430	100.00	Asthma treatment	4	.93
When was the last time	f	%	Bronchopneumonia	3	.7
2015			UTI	2	.47
2014	59	13.72	Heart disease	6	
2013	39	9.07	Flu	2	.47
2012	22	5.12	LBM/Dehydration	2	.47
2011	4	0.93	Cataract	2	.47
2010	3	0.70	Sub Total	21	4.91
2009	3	0.70			
2007	2	0.47			
2002	1	0.23			
No data given	264	61.40			
Total	430	100.00			

Thus, in this present study, the perceived need for medical consultation did not translate to actual utilization of this health service. However, it can be noted in Table 5 that there was a very high demand for medication especially in problems related to gastrointestinal and respiratory problems. The respondents can possibly resort to self-medication when symptoms like stomachache, diarrhea, colds and cough are present. Citing the study of Cohen et al. (2011), Dupas (2011) noted that in Kenya, the typical response of the residents towards manifestation of malaria is to self-diagnose and buy over-the-counter medication, bypassing the formal health care system altogether. It is further argued that such behavior can be attributed to lack of information on illness prevention or on the cost-effectiveness of preventive behaviors. Likewise, the fact that they buy drugs that are not prescribed can be an outcome of lack of information on the cause and cure of their illness.

Correlation between socio-demographic profile and utilization of health services.

Table 8 shows that two socio-demographic characteristics resulted to significant correlation with utilization of health services. These were age ($r=.105$) and highest education attainment ($r= -1.50$). The positive correlation between age and utilization of health services indicates that the older the respondent the higher the utilization of health services. This may be explained by the natural degenerative process in humans. As the person get older, susceptibility to illness increases. Likewise, an older person is becoming more health conscious, thus, manifestation of symptoms trigger utilization of health services.

On the other hand, the negative correlation between highest educational attainment and utilization of health services indicates that the higher the educational attainment, the lesser the utilization of health services. Though unexpected, there were evidences from the study of Cutler and Muney (2010) who studied the relationship between education and health behaviors. It proposes that health behaviors differ according to educational attainment. In the US, there is lower rate of smoking among better educated individuals. Also, obesity is lower among the better educated group. Hence, more years of education may mean more awareness on how one can take care of one’s health, hence, lesser utilization of health services.

Another similar finding was that of Cohen, and Dupas (2011) who found that households with literate female heads are less likely to comply with the malaria test result. This could be because educated households are more likely to be skeptical of new information.

Furthermore, Levesque, Harris and Russel (2013) argued that the care an individual receives is a function of the demographic, social and economic characteristics of the family as well as characteristics of the environment in which they live. Similarly, the study of Grundy and Annear in Cambodia found that socio-economic status of their respondents was correlated with hospitalization. Lower hospitalization was observed among children from poor households.

Table 8. Correlation between Socio-Demographic Profile and Utilization of Health Services

Variables	Usage of PHILHEALTH	
	r value	VI
Age	.105*	S
Civil Status	0.027	NS
Religion	0.034	NS
Ethnicity	0.079	NS
Highest Educational Attainment	-.150**	S
Occupation	0.009	NS
Monthly Income	0.032	NS
No. of Children	0.047	NS
Ages of Children	-0.040	NS
No. of Household Members	-0.031	NS
No. of Children Working	-0.047	NS
Monthly Income of the Family	-0.005	NS

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

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

Correlation between perceived benefits and utilization of health services. In terms of the relationship between the respondents' perception as to the benefits of health services and the utilization of health services, the computed value of r was .049 which is not significant. This means that the respondent's belief on the importance of health services is not correlated with actual utilization of health services. Respondents of this study believe in the importance of seeking health services including consultation with physicians and undergoing laboratory tests, however, this positive attitude did not result to actual utilization of services.

Conclusion

Based on the findings of this study, the researchers conclude that mothers living below the poverty level recognize the benefits of seeking health care like consultation with physicians when they experience symptoms, taking medicines only upon prescriptions and undergoing laboratory tests and procedures. However these beliefs did not translate into actual utilization of health services. Also, the perceived needs for health services like medication and consultation were significantly higher than the actual utilization. Hence, benefits of their membership to PHILHEALTH were not fully utilized, although members who were older have higher utilization of health services. On the other hand, those who were better educated have lower utilization of PHILHEALTH. Probably, they were better equipped with knowledge about taking care of themselves, hence, lesser needs for health services.

Thus it is established in this study that health seeking behavior of mothers living below the poverty level do not depends on their beliefs of the benefits and perceived needs of the health care services. The enabling support from the government through PHILHEALTH was underutilized and was mediated by their age and level of education.

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