

Challenges to Sustaining Primary Health Care in the Philippines

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INTRODUCTION

Primary Health Care (PHC) is a commitment that many countries of the world made at the Alma Ata Conference in Russia in 1978. The international conference defined the global priorities to attain health for all in the year 2000 and subscribed to the PHC approach as key to attaining this goal (Azurin 1988: 55).

Forging the application of the PHC approach has spelled significant modifications in the governance of health development, encouraging the partnership of government with various segments of civil society such as nongovernment organizations (NGOs) and people's organizations (POs) among others. This enables other sectors to take an active role in responding to the health requirements of the community. Second, it emphasizes the involvement of various programmatic areas to ensure effective management of health, weaving health into socio-economic development, making for an integrated perspective. Third, it advocates giving priority

attention to promotive and preventive aspects of health, rather than investing resources mainly on curative care. Thus, as early as 1978, there was a convergent effort to give priority attention to the eight essential elements of health care such as: (1) education on prevailing health problems and the methods of preventing and controlling them; (2) promotion of adequate food supply and proper nutrition; (3) basic sanitation and promotion of an adequate supply of safe water; (4) maternal and child care, including family planning; (5) immunization against the major infectious diseases; (6) prevention and control of locally endemic diseases; (7) appropriate treatment of common diseases and injuries; and (8) provision of essential drugs (Azurin 1988: 58).

Three broad periods describe the evolution of PHC as a government initiative in the Philippines (Bautista 1999). The pilot testing years commenced in 1979 to 1981 when PHC was implemented in pilot provinces for each of the 12 regions, covering a total of 98 municipalities. These pilot areas were selected on the basis of need (i.e., low health to population ratios, absence of province-wide PHC-related activities, inaccessibility to the regional center), receptiveness of the local government unit (LGU), poor peace and order condition and functional organizations that could implement projects at the provincial and municipal levels.

The second period or institutionalization years prior to devolution commenced in 1981 until 1990. This launched PHC on a widescale basis, after capability building activities among health workers to interface with local chief executives, other government sectors, NGOs and the community. In addition, health workers were to motivate the participation of volunteers (called Barangay Health Workers or BHWs) to serve as active partners in the delivery of the impact programs of the national health office (then called a ministry, now the Department of Health). Innovative programs were introduced to ensure that local technologies were integrated into the health service delivery package. Such technologies included herbal medicine and the setting up of village drugstores (*Botika ng Barangay*) so that medicines were accessible and affordable to the different barangays.

The third period for PHC occurred when devolution took place, with the role of PHC delegated to LGUs, particularly those of municipalities and *barangays*. The Local Government Code of 1991, in effect, transferred substantive responsi-

bilities of the Department of Health (DOH) to LGUs, aside from transferring field health personnel. Devolution posed a big challenge to DOH to ensure the advocacy of PHC by local chief executives who had no orientation to PHC, as well as ensuring that devolved health workers continued to imbibe recent trends in health management. This is the situation in LGUs at present.

Considering the importance of PHC as an innovative governance principle, this paper focuses on: (1) the country's policies and systems with respect to primary health care (PHC); (2) how the policies, systems and organizational structures for PHC have changed since it was globally declared as a policy in 1978; (3) what PHC has achieved; (4) emerging challenges in the health sector and implications for PHC.

1. OVERVIEW OF CURRENT POLICIES AND SYSTEMS OF PHC

National Policy

While the Philippines has delegated the responsibility for PHC to LGUs, explicit definition of the term is not in the Implementing Rules and Regulations of the Local Government Code of 1991. Thus, even the DOH saw the importance of advocating the significance of the PHC philosophy through the issuance of the *Policy on Primary Health Care for Community Health Development* in 1996 (Community Health Service-DOH 1996a) which stressed the vision of “putting Health in the Hands of the People” through PHC to enable the people “to serve as active participants in attaining their own health needs” and not as “mere beneficiaries of development efforts”) (CHS 1996: 1).

To fulfill this mission, the policy paper also reiterated that “health is made accessible, available, acceptable and affordable at all times within the context of an effective and efficient devolved health care system that leads towards self-reliance, sustainability and indigenous efforts” (CHS 1996: 1). The policy paper reinstated the importance of propagating such strategies as community organizing to prepare the community for effective interface with government; convergence of civil society groups and other government agencies, apart from health; partnership with the

community; focused targeting of marginalized sectors; utilization of the basic needs information system as a tool for planning; setting up community information systems for transparency; and indigenization to recognize local resources.

The DOH sponsored the Training on Health in the Hands of the People to enrich the role of national health workers, especially the DOH Representatives to the Local Health Board (LHB), as DOH sentinels in the local technical body. Some batches also involved local officials and local health workers in this training program on the essence of PHC philosophy—stressing the importance of the approach, apart from the promotive and preventive aspects of health.

Health Sector Organization and Reform

Organization. With devolution, the key responsibility for PHC is lodged with the municipality and city (Bautista, Joaquin and Santiago 2000: 3). Each also assumes the burden of implementing programs in promotive and preventive health care such as maternal and child-care, communicable and non-communicable disease control services, and purchase of medicines and medical supplies. Each municipality and city extends assistance to the lowest political boundary of the *barangay* which is responsible for the maintenance of Barangay Health Stations (BHSs), although the lack of resources hinders each LGUs' capacity to respond effectively to this role (Bautista, Legaspi, Santiago and Juan 2001). It may also maintain some hospitals in each LGU level (i.e., city or municipality).

In the case of the province, the highest political subdivision of the LGU, its basic responsibility is for curative services through the provincial hospitals maintained in the locality. The province is also charged with the provision of other support services under the provincial health offices that oversee the operation of the different hospitals in the locality.

A total of 46,000 health workers were devolved by 1997, representing 75% of the field personnel of the DOH in that year (Brillantes 1998: 55).

Health Sector Reform Agenda. Since the devolution, the DOH has the role of “steering” LGUs towards PHC. Thus, it undertook major reform measures to enable the national office to perform an advocacy role, rather than as the

implementor of health programs. The *Health Sector Reform Agenda* spelled out the key reform areas in national and local health management, as:

- Hospital systems at the national and local levels through the promotion of fiscal autonomy by enabling them to collect socialized user fees and to convert them to public corporations to become more self-sufficient;
- Public health systems to ensure long-term funding for programs to eliminate infectious diseases and to ensure promotive and preventive measures in health;
- Local health systems to ensure the improvement of local structures by establishing local health zones to promote local sharing among LGUs and provision of incentives for private sector participation in local health networks;
- Health regulation by strengthening the capabilities of health regulatory agencies to ensure that quality health care is delivered by both public and private facilities; and,
- Health financing to attract more members to participate in the National Health Insurance Program, particularly the poor sector and the informal sector, who lack the means and are often marginalized in accessing quality health care.

The thrust of the *Health Sector Reform Agenda* is to establish quality health care centers (or *sentrong sigla*) by giving these facilities seals to signal their ability to meet the standards of the DOH. Of significance is the inclusion of standards on the “attitude” of health workers consonant with the requirements for PHC.

954 seals had so far been extended to RHUs/HCs and government hospitals by the DOH Bureau of Local Health Development with 59 or 6.2% extended to hospitals towards the end of 2001. Altogether, there are 3,004 government hospitals and RHUS/HCs (based on the data of the Bureau of Health Facilities and Services of DOH as of year 2000). *The total number of 954 constitutes 30% of the total health facilities that have been extended seals. 30% of health facilities owned by government received sentrong sigla seals.*

An important feature in the reform agenda is the move to consolidate public health and hospital systems in an integrated referral network. No less than the

current Secretary of Health, Dr. Manuel Dayrit, stressed this point in his Ten Principles of Good Governance when he said:

The provision of health care is a seamless effort which encompasses preventive and curative interventions. We must synergize efforts across the spectrum of interventions, affordable and quality health care must be integrated geographically (Dayrit 2001).

To set up an integrated approach to promotive and curative health care is the agenda for advocacy of DOH which is realized through the concept of the District Health System or Inter-Local Health Zone (Bautista, Legaspi, Santiago and Juan 2001: 34-35). This is characterized by collaborative arrangements among the different LGUs to set up a structure by which an integrated health plan is formulated, incorporating two levels of the health care system: the referral hospital and the health centers, with the satellite BHSs. This move is reinforced by the mandate to establish a National Health Planning Committee which institutionalizes the covenant among the Secretaries of the DOH, Department of the Interior and Local Government, and the Department of Budget and Management; Health Committee Chairmen of the Senate and House of Representatives; representatives of the private sector; and, the president of the league of provinces. The advantage of the district health system is the cost sharing of the programs in health among the different participating LGUs. It also enables efficient use of resources across the different LGUs, reduction of outpatient load at the district hospitals and improvement of the referral system.

Low-income families were found to use public health facilities more often. Of those who sought health services (reported in the 1993 Family Income and Expenditure Survey cited in DOH 1999a:4) 82% depended on public health facilities with 61% consulting the RHUs/BHSs and 20% going to the public hospital.

A more recent survey contracted by the World Bank to Social Weather Stations (2001: 13) discloses that 37% of both public health facilities and government hospitals were accessed by respondents in the bottom 30% in expenditure class. However, this survey supports earlier findings that those in the higher classes depend on private clinics/hospitals. In particular, the study shows that those in the middle

30% and top 40 % in expenditure class rely for the most part on private clinics/hospitals (with 42% and 60%, respectively, having utilized these facilities in the past twelve months).

Financial Systems

Government Budget. Budgetary expenditures for health by the national government declined slightly through the years from an average of 3.4% for the years 1988-1991 (pre-devolution) to an average of 2.6% from 1992-1999 (under devolution) (See Table 1).

During devolution (from 1991-1999), the health expenditure has shown an annual average of 3.2% of Gross National Product (GNP) (Gañac and Amoranto 2001: 15) (See Table 2). This is much smaller than the recommen-

Table 1. Budget Of Expenditures In Health In Billions

<u>Year</u>	<u>Total Budget</u>	<u>Health Budget</u>	<u>Percent</u>
1989 (Actual)	173.3	6.5	3.8
1990 (Actual)	255.8	7.9	3.1
1991 (Current)	298.9	9.5	3.2
1992 (Actual)	286.6	9.9	3.5
1993 (Actual)	313.7	7.0	2.2
1994 (Actual)	327.8	7.9	2.4
1995 (Actual)	372.1	8.4	2.2
1996 (Actual)	416.1	11.2	2.7
1997 (Current)	493.5	15.0	3.0
1998 (Actual)	537.4	13.5	2.5
1999 (Current)	593.6	15.1	2.5
2000 (Proposed)	651.0	14.7	2.3
2001 (Proposed)	483.8	11.3	2.3

Source: Department of Budget and Management, *Budget of Expenditures and Sources of Financing, FY 1991-1992, 1994-1998, and 2000.*

Note: The annotation of "actual" shows the actual expenditure of the government; "current" means that the budget is the one operating at the year of reckoning and "proposed" means that it is yet to be implemented.

dation of the World Health Organization for a net allocation for health expenditures of an average five percent (5%) of the GNP.

Table 2. Health Expenditure as % of GNP

<u>Year</u>	<u>Amount in Billion</u>	<u>% of GNP</u>
1991	35.9	2.86
1992	39.6	2.88
1993	47.4	3.16
1994	54.6	3.14
1995	65.2	3.33
1996	76.2	3.37
1997	87.1	3.44
1998	95.7	3.40
1999	108.3	3.43

Source: Gañac and Amoranto 2001: 15.

Comparing the national and local government expenditures for health, local government expenditures grew by as much as P17.971 billion from 1991 to 1999 while national government's share only grew by P3.594 billion (Gañac and Amoranto 2001). In 1991, the amount of LGU expenditure was only P1.380 billion, rising to P19.361 billion in 1999 (Gañac and Amoranto 2001: 25). The national government had

...the commitment to public health care was below par...

P12.431 billion in 1991 and P21.702 billion in 1999. The total allocation for health is considerably higher for the national government than for LGUs, even if the latter implements most of public health requirements. Nevertheless, the annual growth of national

government expenditure from 1991-1999 was not as fast as the growth rate for LGUs, as the former registered 4.3% while the latter, 37.8% (See Table 3).

Public Health vs. Personal Care Expenditure. On the whole, government spending was only 2% short of the targeted 40% of the total spending for health care in 1999 (Gañac and Amoranto 2001: 23). However, the commitment to pub-

Table 3. National/Local Expenditure for Health (in Billion Pesos)

Year	National Expenditure	Local Expenditure
1991	8.853	1.380
1999	12.447	19.351
Average Annual Growth Rate	4.35%	37.8%

Source: Gañac and Amoranto 2001: 25-26.

lic health care was below par as only 12% was channeled to this in 1999 while the target was 20%. On the other hand, personal health care of government overshoot its target of 10% by 8% or 18% altogether (See Table 4). The PNHA distinguishes personal and public health care using facility as the basis for the distinction. Thus, services received from hospitals and dental clinics are classified as personal health care services. On the other hand, goods and services provided by RHUs/HCs, BHSs, puericulture centers and other government clinics are included in the definition of public health care (Gañac and Amoranto 2001: 4-5).

Table 4. 1999 Health Care Spending of Government (Target v.s. Actual in %)

Use of Funds	Target	Actual
Personal Health Care	10.0	18.0
Public Health Care	20.0	12.0
Others	10.0	8.0
Total	40.0	38.0

Source: Gañac and Amoranto 2001: 23.

Public-Private Mix in Health Financing. The biggest source of spending for health in 1999 was from private sources, amounting to 57.23%. Out-of-pocket share was the major origin for the contribution (46.3%), with the remaining amount obtained from insurance and other sources (Gañac and Amoranto 2001).

Government expenditure was the second biggest source, shouldering about 38% of health expenditures with more than half (20%) coming from the national government and close to 18% from LGUs (Gañac and Amoranto 2001).

The contribution of social insurance was quite low with a total of 4.9% in 1999, although this was an improvement over the previous year's contribution of 3.7% (Gañac and Amoranto 2001) (See Table 5).

Table 5. 1991/1999 Distribution of Health Expenditure by Source of Fund (% Share)

Source of Fund	1991	1999
Government	38.51	37.91
National	34.66	20.04
Local	3.85	17.87
Social Insurance	5.44	4.8
Medicare	5.17	4.61
Employee's Compensation	0.27	0.26
Private Sources	56.05	57.23
Out-of-Pocket	47.69	46.26
Private Insurance	2.66	2.14
Health Maintenance Organizations	1.25	3.84
Employee-based Plans	3.41	4.01
Private Schools	0.82	0.99
TOTAL	100.00	100.00

Source: Gañac and Amoranto 2001.

Equity Considerations in Health Financing. One of the most important features of the *Health Sector Reform Agenda* is motivating LGUs to help support indigent families by taking care of both their public health requirements and cura-

tive care services, with the PhilHealth Corporation. Localities which can complement their *sentrong sigla* facilities with universal coverage for insurance are given recognition as *sentrong sigla plus*.

For instance, a *sentrong sigla* awardee like the Health Center of Amlan in Negros Oriental introduced the Hospitalization Plan called *Singko (Five Pesos) for Health* (Bautista et al. 2001: 180), enrolling each family member for the amount of P5.00 per month with a guarantee of P2,000 per year of hospitalization benefits for each member and P1,000 worth of medicines for the entire family per year. Each *barangay* is encouraged to give a P10,000 counterpart while the municipality gives the same amount to each *barangay*. Contribution to the plan also entitles household members to free outpatient care in the provincial hospital. Support to indigents is extended through the P60,000 allocated by the municipality, the national government's contribution of P100,000 and PhilHealth's contribution of 90% of the requirements of the indigent families. The LGU provides assistance in the identification of the target 100 poorest families by using a community-based information system such as the Minimum Basic Needs (MBN) composed of 33 indicators, started in the Social Reform Agenda program under the Ramos administration in 1995.

In spite of the generally weak picture of insurance (both government and private) in relation to other sources of support for health, health insurance grew through the years (Gañac and Amoranto 2001: 19). For instance, Health Maintenance Organizations (HMOs), which combine both curative and promotive/preventive aspects of health expanded in coverage from 1.25% in 1991 to 1.96% in 1995, and to 3.84% in 1999. This is better than private insurance which focused mainly on curative care and which begun with a 2.66% share in 1991, declining to 1.77% in 1995 and rising to 2.14% in 1999.

Management and Control of Government Expenditures for PHC. On the whole, management and control of expenditures for PHC is directly lodged with LGUs. The advocacy of the DOH is that priority consideration be extended to PHC, both at the government and private sector levels. The introduction of innovative measures for health financing by the government has broadened the coverage of insurance to indigent families, and to incorporate promotive and preventive components in health care as well. The growth of HMOs in the private sector

signals the role of promotive and preventive aspects of health since these are components encompassed by the coverage of this organization.

A key issue raised regarding devolution is the capacity of LGUs to finance basic services in PHC (Perez 1997). Perez claims that 18% of 1,473 municipalities require assistance from the national government while 67% or 973 municipalities, need some support to cover the cost of devolved functions. Only 15% can fully finance all their obligations.

Human Resource Systems

Human Resource Development Plan. The Health Manpower Development Training Services (HMDTS), now the Health Human Resource Development Bureau (HHRDB) of the DOH, takes charge of human resource planning and career development management. One of the key objectives of this office is to install an information system to determine the competencies required of national and local government offices to effectively respond to the demands of the different health facilities (FGD of HMDTS, July 13, 2001).

One of the key projects of the Health Human Resource Development Program is an inventory of health manpower including doctors, nurses, medical technologists and dentists. The objective is to ascertain how many are practicing in a locality and so determine whether there is adequate deployment in a given area. The target is to complete the inventory by year 2004.

At present, the difficulty in obtaining information about the number of health professionals (both public and private) is the lack of direct control over LGUs by the DOH.

According to Key Informants (FGD of HMDTS, July 13, 2001), obtaining information about the supply of professionals could help the academe determine to what extent particular curricular programs need to be emphasized. The availability of health manpower produced by these schools could in turn impact on public/private facilities.

Health Manpower Distribution. The data on health manpower resources show an inequitable distribution of health workers in the different regions of the country (Data from Philippine Health Statistics, DOH, 1997 in Bautista, et. al.

2001:15). If the total health manpower is seen in terms of their ratio to the population per region, the poorest ranking regions are found in Mindanao (Regions XI and XII) and in Regions III (Luzon) and V (Visayas). The regions with the most number of health resources are found in Luzon (Cordillera Administrative Region or CAR, Region II, and the National Capital Region or NCR), with only one from the Visayas (Region VII).

In terms of curative care, the doctor to population ratio is 1:22,907 although the ideal is 1:20,000. The problem with lack of dentists can be seen with a ratio of 1:40,145, although the ideal is also 1:20,000. NCR has an oversupply of both dentists and doctors with a ratio of 1:17,943 and 1:13,632, respectively. The ideal ratio has not been achieved for these two health professionals in all other regions. The number of doctors and dentists to population falls below the standard.

In the case of nurses and midwives who take charge of public health care, the ratio of health worker to population is more promising, with both achieving the ideal standard for the entire Philippines (1:14,653 for nurses with a standard of 1:20,000; and 1:4,572 for midwives with a standard of 1:5,000). The most marginalized region in terms of these two health professionals is Region XI in Mindanao. All other regions have complied with the standard.

Data on private health manpower is not reflected here. Interviews with the various associations of professionals (i.e., Philippine Medical Association, Philippine Private Hospitals and Philippine Hospitals Association) revealed that statistical data on private health personnel are not available. The Professional Regulations Commission claims to have a long list of accredited and licensed professional health personnel. However, this roster does not indicate if they are in active service and if they serve in the public or the private sector. This lack of information indicates an inability to effectively match manpower availability to actual need. The latest information on private sector manpower by Herrin (1997) revealed that the majority of health workers opted to work in the private health than in public health sector. This is borne out by the following data:

- 87 % of physicians worked in hospitals (where 65% were in private hospitals and only 22% in government hospitals);

- 74% of dentists worked in private hospitals and other private medical establishments, while 10% were in government hospitals and other health facilities;
- 78% of nurses worked in hospitals and related medical facilities where 49% were private and 29% were public; and
- 75% of midwives worked in hospitals, 42% of which were private and 35% public (Herrin 1997: 162).

Responding to Equity Issues. The Doctors to the Barrios Program (DTTBP) where doctors are deployed by the DOH to doctorless municipalities was intended to respond to the lack of doctors in LGUs. Part of the training is an orientation to PHC. The Doctors to the Barrios are offered incentives in the form of a salary grade level of 24 and board and lodging, with the option of being absorbed by the LGU after one year. To ensure that their salary grade is maintained by the LGU, any difference in the salary is made up by the DOH. They are also extended continuing medical education through the Association of Philippine Medical Colleges. To date, about 30% of Doctors to the Barrios had been absorbed by the LGUs (FGD of HMDTS, July 13, 2001). Most of the doctors in this program are deployed in the RHUs/HCs, with a few deployed to hospitals.

To supplement the lack of health manpower in LGUs, there is a Rural Health Team Practice Program composed of about five health practitioners in each region who have just passed the board examination. They could be of varying combinations of doctor, dentist, nurse, midwife, medical technologist, physical therapist and nutritionist to assist an RHU/HC in need. They are given the assignment for about eight months with a stipend of P10,000.00 per month.

There is also Surgeons to the Province, a program jointly undertaken by the DOH, the Philippine College of Surgeons and UNILAB (the largest Filipino-owned pharmaceutical company in the country). The objective of this program is to supply the surgeons required by provincial hospitals. UNILAB pays the salaries of the surgeons, the Philippine College of Surgeons takes care of their recruitment while DOH identifies the areas where these surgeons could be deployed such as, for instance, Batanes and Davao del Sur which have facilities but lack surgeons and

anesthesiologists. HMDTS is hoping to interface with other foreign funding institutions to support this program.

Brain Drain of Health Workers. HMDTS officials concede that while the country has an oversupply of graduates in medicine and nursing, they tend to practice in the urban than rural areas (FGD with HMDTS, July 13, 2001). However, there is also a common impression that health workers prefer to go abroad for employment. In a study on Philippine labor migration (Go 1998: 15), it was noted that the bulk of worker outflow in the mid-seventies was mostly of professionals (53.5%) including health workers, other than performing artists or entertainers (38.1%) and service workers (22%). However, this pattern changed by 1995, as professional workers who went abroad constituted only 20.5%, with the bulk made up of construction workers (38.2%) and housekeeping service workers (38%).

Health Facilities

There is a total of 15,486 government and private health facilities in the country. Most are located in Region IV (1,913), followed by Region III (1,602) and Region VI (1,382). In contrast, the Autonomous Region of Muslim Mindanao (ARMM) has the least number (455) of health facilities (Data from Bureau of Health Facilities and Services, 2000).

In terms of ratio to population, NCR has the least number of government and private facilities to population with a ratio of 1:16,188. This is followed by Region II (1:10,700).

Private hospitals number 1,089, and government hospitals, 623. Thus, private hospitals constitute more than half of the total number of hospitals in the country. Region IV has the most number of both government and private hospitals.

The ARMM is the most deprived in terms of population served per bed available in all public and private hospitals, as it has a ratio of 1 bed to 5,967 persons. The regions with the most number of beds available to the population are CAR (1:404) and Region XI (with 1: 907). Hospital distribution is uneven with seven in the top ten ranking provinces with a high population to bed ratio being concentrated in Mindanao (i.e., Bukidnon, North Cotabato, South Cotabato, Davao del

Norte, Basilan, Lanao del Sur, Sultan Kudarat and Sarangani) (Bautista, Legaspi, Santiago and Juan 2001).

Only 27% of *barangays* have access to BHSs. Region IV is host to 1,364 BHSs while NCR has only 2. The low number of documented BHS in NCR could be attributed to the fact that it has city health centers serving different barangays. As to the distribution of RHUs/Health Center, NCR has the highest number (467) as against 54 RHUs in Region XII.

However, the data for ratio to population of BHS show that the largest population served by the BHS are located in NCR and Region IV (1:5,245,000 and 1:8,360, respectively). The least number served are in CAR with 1:2,571 and CARAGA with 1:4,397. For RHUs, the most number served are in Regions XI (1:55,054) and XII (1:46,111). The least number of population served is in CAR (1:15,168).

On the whole, there is inequity in the distribution of facilities around the country, with ARMM being the most marginalized in terms of both public health and hospital facilities. On the other hand, CAR has been the most benefited in terms of both public health and hospital facilities. The data also show that NCR is not necessarily the most benefited in terms of facilities since the huge population in NCR overwhelms both its hospital and health centers.

Essential Drugs and Traditional Medicines

The provision of drugs for vertical programs is one of the responsibilities of the Office of Supply, Procurement and Logistics Services of the DOH national office. Examples of these medicines are those needed for the treatment and control of malaria and schistosomiasis.

In the case of essential drugs (i.e., drugs necessary for emergency situations as well as those that cover common diseases and injuries in any community), responsibility for their procurement is lodged in the different regional offices. This implies that the allocation is directly released to them by the Department of Budget and Management (DBM).

The region's role was to "augment" and not supply all the requirements for public health. The procurement by the region of these drugs was done looking at those LGUs with the largest population, poor health performance and lack of resources (Interview of NCR Planning Officer on July 18, 2001). With devolution, this responsibility was assumed by LGUs, with the exception of some drugs such as those for tuberculosis, ORESOL (Oral Rehydration Solution), and vaccines. The eight essential drugs expected to be available in public health facilities are: contrimoxazole, amoxicillin, rifampicin, INH, pyrazinamide, paracetamol, oresol and nifedipine.

Alternative medicine is also encouraged as a modality for healing. To date, only three herbal medicines are available in tablet form in the local market. A managing director of an industry engaged in alternative medicine observes that the Philippines is "very rich in biodiversity but lags behind in proper research and development inputs" (Gomez 2001: 7). He claims that only 120 plants have been scientifically validated for safety and efficacy, out of the total of 13,500 species of plants, with 1,500 of these being used by traditional healers. However, only 10 of the 120 herbal plants are promoted by the Philippine Institute for Traditional and Alternative Health Care of the DOH (Gomez 2001: 7). The total investment for research and development of such herbals as *lagundi* and *sambong* by the Philippine Council for Health Research and Development was P35 million from 1977 to 2001 (Gomez 2001: 7). Gomez (2001) further claims that this pales in comparison to the investment of the United States at \$150 million for each plant.

Alternative medicine is encouraged as a modality for healing.

DOH also tries to ensure that health care is affordable by procuring medicine through parallel importation (Mendoza 2001:10). Parallel importation is a scheme in which medicines imported from abroad have a registered counterpart in the country. Medicines acquired through this scheme cost a fifth of the price of brands distributed locally. Nevertheless, there is a lack of medicines in public health facilities while those available at private pharmacies are usually very expensive and inaccessible to the poor (Mendoza 2001: 10).

The village drugstore or *Botika ng Barangay* (BnB) is being revived by the DOH as an outlet for disseminating affordable medicines. DOH has formulated and passed guidelines to ensure that the BnBs are set up according to not-for-profit principles. These are to be established according to principles of participatory management whereby community members take an active role in managing the facility after being trained to dispense the medicines.

2. BRIEF DESCRIPTION OF POLICIES, SYSTEMS AND STRUCTURE SINCE ALMA ATA (BEFORE DEVOLUTION)

Policies

The Philippines was the first country in Asia to embark on the challenge of implementing Primary Health Care since its declaration in 1978 at Alma Ata in Russia. Pilot municipalities in each of the twelve regions in the country were introduced to the strategy of PHC (see Bautista 1999). Health workers and other service implementors were oriented to the concept of intersectoral planning and to the importance of allowing the interface of community participants. Trainors from pilot provinces per region were also trained on the PHC philosophy and strategy. Volunteer health workers (Barangay Health Workers or BHWs) were identified and trained to assist health professionals in health education and to serve as first aiders and as referral persons to hospitals, doctors or other health service delivery systems. Structurally, PHC advocacy and implementation was lodged with the national government, through the Department of Health, until the devolution of health services in 1991.

PHC was institutionalized as an approach in 1981. It was clear in the policy statement by the Minister of Health that PHC was an outlook which health workers and other service implementors should possess. This outlook stressed the importance of “developing self-reliance” among the members of the community, reliance on available community resources, focus on underserved and unserved localities and the need to reach out to other sectors promoting a supportive environment for health (Azurin 1988: 69). Thus, these basic principles imply that PHC necessitated community organizing and an integrated approach to development. The first

level of health care was also emphasized, considering the need to integrate promotive and preventive health care with curative and rehabilitative needs (Azurin 1988: 69). Other support strategies were also forged to ensure mobilization of the PHC strategy. These included: developing effective support mechanisms such as provision of essential drugs, strengthening of the public health and hospital network, improvement of managerial capabilities and the conduct of relevant researches to support PHC.

While the policy declaration was clear that community empowerment was the essence of PHC, this was not translated as effectively into reality. Assessment studies on its implementation revealed that the focus was on imparting the impact programs for the community with the assistance of the volunteer workers. Thus, while participation was harnessed for community projects, the main thrust of mobilization was the delivery of services (Torres 1986 and Bautista 1988).

Structural Improvement

Consistent with the policy of PHC, a major structural modification was undertaken in 1982 to integrate public health and medical care systems in the different health offices of the department (Bautista 1999: 18-21). For instance, the Integrated Provincial Office was designated as responsible for extending both curative and public health care services in the province, thus consolidating the efforts previously undertaken by the Provincial Hospital and Provincial Office, respectively. At the municipal level, the District Hospital was designated to consolidate the efforts of both the public health delivery and hospital care systems under the jurisdiction of the Rural Health Units/Centers (RHUs) and their satellite stations (the Barangay Health Stations) and the District Hospitals, respectively. This was the situation prior to devolution, which was reconstituted under the District Health System or Inter-Local Health Zone in the *Health Sector Reform Agenda*, although the current move is to integrate the local chief executives as the key persons administratively responsible for PHC.

The national office also decentralized the planning and utilization of resources to the Integrated Provincial Health Offices, instead of passing through the national

and regional health offices. This reorganization move gave more power to the provincial offices to control and manage the funds in their catchment areas.

PHC commitments were to be planned, monitored and advocated through the PHC Committees at all levels: national, regional, provincial, municipal/city and *barangay*. The PHC Committees were constituted by health workers, other service delivery workers and the local chief executive. At the lowest political boundary, BHWs were included in the PHC Committees. Documentation of the PHC Committee's performance in earlier years indicated that apart from health workers, the most valuable involvement from other sectors were those from the Ministry of Social Welfare and Development, the Ministry of Agriculture and the Population Commission (Torres 1986: 43).

Through the years, DOH was able to motivate the active involvement of BHWs, covering a total of 96.6% of *barangays* with a ratio of 9 BHWs per *barangay* by 1988 (Bautista 1999: 22). However, fast turnover of BHWs was reported as a common problem in PHC assessments (Bautista 1999: 29).

A landmark piece of legislation was passed on February 15, 1995 with the intention of motivating the BHWs to sustain their work for the community. Republic-Act 7883, otherwise known as the BHW Benefits and Incentives Act, mandates the provision of monetary benefits to BHWs located in high risk areas, in addition to a subsistence allowance while on duty. Other non-monetary benefits include: credits for services rendered for higher education, opportunities for capability building, tuition fee benefits for a child and free legal service for any lawsuits arising from one's work.

Active Involvement of NGOs in Community Mobilization

Even before the launching of PHC in the country, NGOs were already active in implementing the approach (Tan 1987). However, their initiatives were mainly undertaken independent of government. When PHC was officially declared as a strategy by the national government, there was a clear intention on the part of the DOH to converge with NGOs. NGO interface was invited through the different PHC committees constituted at the level of the national government to the *barangay*

(Azurin 1988: 85). Committees were tasked with the responsibility of planning and overseeing the implementation of the PHC principles and outlook.

This opportunity became more prominent in the 1986 Constitution which enshrined the important role of “nongovernmental, community-based or sectoral organizations to promote the welfare of the nation”. It paved the way for more vigorous efforts to tap NGOs as partners in advocating the PHC philosophy. Because of the observed weakness of community participation at the lowest level of the *barangay*, a program called Partnership for Community Health Development (PCHD) was launched, capitalizing on the track record of NGOs in community organizing. An additional feature of PCHD was the provision of priority support to LGUs which were “depressed, underserved, hard-to-reach and critical communities” (Bautista 1996: 32).

A total of 151 NGOs participated in the partnership meetings called by DOH in 1990 (Bautista 1995: 184). A recent compilation of the NGOs engaged in the mobilization of PHC activities documented a total of 485 operating in the different regions of the country in 1997 (Bautista, Legaspi, Santiago and Juan 2001: 48). Mindanao had the most number of active NGOs with 37.5% (182), while Luzon had 34.6% (168) and Visayas, 27.8% (135).

Financial Management

There was a progressive increase in the financial allocation for health as percent of GNP prior to devolution years, reaching a high of 6.6% in 1989, surpassing the 5% requirement of WHO. Health expenditure as percent of GNP in devolution years ranged between 2.86 and 3.44 and did not surpass the 5% requirement achieved in pre-devolution years (Ganac and Amoranto 2001: 15).

As focus was given to PHC, its allocation in relation to the health budget varied during pre-devolution (see Pesigan et al. 1992) PHC received 38.5% of the DOH budget in 1983 but dropped to 7.7% in 1984 and to 7.3% in 1985. In 1986, this rose to 42.2%, dropped to 5.8% in 1987, and again rose to 74.5% in 1988, only to slide to 64% in 1989 (See Table 6).

The pattern in terms of source of expenditures for health remained the same before and during the devolution years, being mainly from out-of pocket. This took

54.5% of total expenditures in 1985, declining to 42.5% in 1988, and rising again to 53.9% in 1991 (Herrin et al. 1993: 39).

Table 6. FINANCIAL RESOURCES OF THE HEALTH SECTOR (In Million Pesos)

<u>Year</u>	<u>Total PHC Allocation</u>	<u>% of Total Health Budget</u>	<u>Total Health Budget</u>	<u>% of GNP</u>
1983	978	38.5	2,540	2.6
1984	168	7.7	2,180	2.2
1985	171	7.3	2,340	2.5
1986	1,383	42.2	3,270	3.7
1987	241	5.8	4,140	4.6
1988	3,718	74.5	4,990	5.3
1989	4,299	64.0	6,710	6.6

Source: Data on budget culled from Pesigan et al. 1992: 12-13. Percentage of Health Budget and GNP computed from the data of Pesigan et al.

Public spending for health was variable in pre-devolution years as 38.5% of total expenditures for health came from this sector in 1985, up to 50.5% in 1988, and declining to 36.3% in 1991 (Herrin et al. 1993). Private/compulsory insurance had an insignificant share through these years, not taking more than 11% (from 8.1%, then 6.9% and then 10.1%, respectively for the same years).

Alternative Technology

The DOH was a strong advocate of alternative health technology even during the early years of PHC. Then Minister Azurin introduced herbal medicines, acupuncture and homemade oral rehydration solutions as options for dealing with health needs. These were envisioned to “solve existing shortage of supplies and the prohibitive cost of essential drugs, especially in the rural areas” (Azurin 1988: 80). Herbal processing plants for herbal medicines were established in three regions of the country. A group of acupuncturists were upgraded on their acupuncture skills

in 1984. A local product, oral rehydration solution (ORESOL), was formulated and distributed to prevent dehydration resulting from uncontrolled diarrhea that caused many unnecessary deaths.

Botika ng Barangay (BnB), a village drugstore, was set up to enable communities to access drugs at cheaper rates. This was to be supervised by the local PHC committee to monitor how village volunteers managed the store. Unfortunately, this program met with difficulties (i.e., lack of medicines, poor management, and low utilization rate by the community) despite its good intentions.

The passage of the Generics Act in 1988 enabled manufacturers to compete with multinational corporations which dominated production of drugs and medicines. This law required medical practitioners to write the generic names of drugs prescribed to provide the consuming public with drug options within their budget. Documentation of the prescribing patterns of medical practitioners showed a decline in the use of generic terminology in drug prescriptions from 90% in 1990 to 65% in 1993, indicating a waning compliance with the law (Varela 1997).

Facilities

In 1980, of 1,679 hospitals licensed by the Ministry of Health, only 29% were government-run (Azurin 1988: 93). However, there were more hospital beds available in the government sector in relation to the population than was provided by private hospitals. There were 83 beds per government hospital as against 36 beds per private hospital. The regions that had the most bed capacity were located in Region IV with 34,788 beds, while the rest of the regions had 2,615 to 6,647 beds, indicating an inequity between the primate region and other regions. On the whole, bed to population ratio was better in 1980 (1:632) as against 1:930 in 2000.

Human Resources

Physician to population ratio was better prior to devolution. One doctor could attend to less persons in 1981 (6,714), 1986 (6,352) and in 1990 (8,350). By 1997, the ratio was 1:22,907.

The ratio of dentist to population was worse off in the 1980s since this was 1:45,445 in 1981 and 1:50,003 in 1986. In 1997, this improved to 1:40,145.

The situation of nurses during the pre-devolution years was similar to the doctors. There were more nurses available in relation to the population. The ratio was 1:5,136 in 1981, rising to 1:5,277 in 1986 and up to 1: 6,042 in 1990. By 1997, each nurse had nearly three times the number covered in 1981 with a ratio of 1:14,653.

On the other hand, the situation of midwives improved as compared to the earlier years, with the midwife attending to more than the ideal ratio of 1:5,000 prior to devolution. By the year 1997, the ratio improved to 1:4,572.

3. WHAT THE PHC APPROACH HAS ACHIEVED

Contributions

What has PHC contributed to the Philippines?

First of all, the policy on PHC conferred nationwide recognition of the value of participatory governance and mandated its replication nationwide, a very bold step undertaken by a single department. This is indeed an innovation in governance, considering that Marcos was still in power when it began.

PHC recognized the role of community volunteers in the delivery of basic health services and in motivating community members to engage in health activities. BHWs were a visible presence in all *barangays* in the country, helping augment the resources of government for basic health services.

Furthermore, NGOs also actively participated in the PHC Committees and were particularly visible in the mobilization of communities.

Indigenous resources like herbal medicines were harnessed, which led to more research on the identification of herbal plants used by local people and in the packaging of some of these in tablet form. A related feature was harnessing alternative practices like acupuncture and the dissemination of drugs and herbal plants through the BnB. The BnB sell essential drugs at lower cost and advocate rational drug use through trained BnB operators. They are different from small entrepreneurial stores in villages or *barangays* that sell medicines as part of their wares.

PHC has also pioneered in enabling the interface of local chief executives in PHC Committees by tapping the *barangay* councils as active partners in the PHC Committees even prior to devolution, providing local officials greater substantive responsibility.

Impact assessments disclosed a marked improvement of PHC advocacy from being “community-oriented in the first decade” to a more aggressive posture in forging a “community-based” approach in the its second decade of operationalization. More attention was given to harness community involvement in the different stages of the program cycle (i.e., planning, implementation and monitoring/evaluation) so that these communities then became more than mere beneficiaries and participants in implementing programs in health, which was the more common form of advocacy in the first decade.

A most important contribution was the improved health condition of communities actively involved in managing their health condition, particularly in the promotive and preventive aspects of health.

Impact studies conducted by research and academic institutions through the years were consistent in disclosing that improvements in the health condition of the population occurred when there was adherence to the participatory approach in the management of basic health services at the community level. An evaluation by Torres in 1986 involving 552 *barangays* compared 12 model *barangays* against other *barangays* (540) and found that the former had only 11% of households who complained about coughs and colds as against 22% in non-model areas. 6.9% vis-à-vis 11.6% reported intestinal diseases while about 4.1% as against 8.1% complained about influenza, respectively.

The same assessment disclosed that PHC motivated volunteers to assist in health education and community mobilization for projects such as environmental sanitation and immunization, helping the community understand and be aware of the importance of good health, and in providing more effective and systematic health services (Torres 1996).

In 1988, an assessment of sampled respondents in 12 *barangays* from three regions revealed that model areas in PHC reported a lower morbidity rate with an

average of 139 per 1000 population as against 153 per 1000 population in non-model areas, for all types of illnesses (Bautista 1988).

Impact of Devolution

A key issue with respect to devolution is the determination of the extent to which it has facilitated or hampered the implementation of PHC (Bautista 2000). Data on the yearly average improvement of five impact indicators on health between pre- and devolution years reveal that positive changes have taken place on three indicators. An improvement can be seen in the yearly average performance in infant mortality rate in post-devolution (with an average annual decline of deaths by 1.5 infants per 1000 live births per year) as compared with pre-devolution of 0.3 per 1000 live births. IMR in 1978 was 60 per 1000 live births, declining to 56.9 in 1990 and then further down to 49 in 1995. However, the latest estimate on this indicator pales in comparison with the situation in 1997 of such countries as Malaysia (10), Thailand (31), Singapore (4) and Japan (4) (UNDP 1999: 168-169).

There is a slight improvement in fertility control in terms of average yearly decline in live births per 1000 population from 0.7 in pre-devolution years to .66 under devolution (Bautista 2000). Live births per 1000 was 30.3 in 1980, then 26.3 in 1990 and in 1994, was down to 24 per 1000.

Life expectancy has also improved by a yearly average of 0.3 in pre-devolution years to 0.45 during devolution. Life expectancy in 1982 was 62.2, and up to 64.9 in 1990. This rose further to 69 by 1999. However, this falls short of the situation in Malaysia (72.2), Thailand (69.9), Singapore (77.4) and Japan (80.8) in 1999 (UNDP 2001: 141-142).

Rate of improvement in number of deaths per thousand population appears to be uniform between pre- and during devolution years as the average improvement per year is the same for both periods (0.1 per period). The death rate was 6.2 in 1980 and was down to 5.1 in 1990. By 1994, this was 4.7.

It is only in nutrition where improvements slowed down during the devolution years as yearly percentage improvement of malnourished children declined from .9% to .2% during devolution. The per cent of underweight children was 17.2%

in 1982, then down in 1990 with 9.8%. In 1995, the percentage of the malnourished was 8.4%, indicating the slow pace of improvement (See Table 7).

On the whole, in spite of achievements in health, the situation in the country pales in comparison with other countries. This could be attributed to the marked shift in the management of PHC from the national to a devolved set up of government, where key local executives assume a role without sufficient orientation to the approach. The country has also been affected by political upheavals (i.e., impeachment of President Estrada and poor peace and order situation in Mindanao) and natural calamities which have led to a set back in economic development, and ultimately, investments in health care. However, the other way of looking at these difficulties is that the health situation could have been worse if PHC had not been harnessed.

4. EMERGING CHALLENGES IN THE HEALTH SECTOR AND IMPLICATIONS FOR PHC

Challenges in the Health Sector

One of the biggest challenges in the country is how to curb infectious diseases. Seven of these diseases (i.e., diarrhea, pneumonia, bronchitis, influenza, tuberculosis, malaria and measles) which were among the top ten leading causes of morbidity in 1983 have remained in the top ten by the 1990s. This pattern indicates a problem in forging promotive and preventive health care. Additionally, degenerative diseases have emerged which have to be effectively responded to. (Bautista et. al. 2001:25) (See Tables 8 and 9).

Primary causes of death are diseases of the heart, malignant neoplasm and accidents. A preventable disease (tuberculosis) is still in the list (See Table 10).

A big challenge is how to motivate local chief executives to assume leadership in implementing basic health services with a participatory approach to health development management. A basic knowledge of PHC as a philosophy and an approach remains lacking among local chief executives who regard PHC merely in its promotive and preventive aspects.

**TABLE 7. AVERAGE IMPROVEMENT IN BASIC INDICATORS ON HEALTH,
COMPARING PRE- AND DEVOLUTION YEARS**

PRE-DEVOLUTION	POST-DEVOLUTION	
1. INFANT MORTALITY RATE		
Baseline data: 1978 - 60/1000 live births Source: National Statistical Coordination Board as cited in DOH 2000	End of Deconcentration: 1990 - 56.9/1000 live births Source: Reodica: 1997	Recent Data: 1995 - 49/1000 live births Source: Reodica: 1997
Average improvement per year: 0.3	Average improvement per year: 1.5	
2. PER CENT OF UNDERWEIGHT CHILDREN		
Baseline data: 1982 - 0-6 children, 17.2% Source: UNICEF 1982 citing National Nutrition Survey of Food and Nutrition Research Institute (FNRI)	End of Deconcentration: 1990 - 0-5 children, 9.8% Source: Reodica 1997 citing Cecilia Florencio, "Nutrition Problems in the Philippines," FNRI, 1995.	Recent data: 1995 - 0-5 children, 8.4% Source: Reodica 1997 citing Cecilia Florencio, "Nutrition Problems in the Philippines," FNRI, 1995.
Average improvement per year: .925%	Average improvement per year: .19%	
3. LIVE BIRTHS PER 1000 POPULATION		
Baseline Data: 1980 - 30.3 Source: National Statistical Coordination Board 1999	End of Deconcentration: 1990 - 26.3 Source: National Statistical Coordination Board 1999	Recent Data: 1995 - 23 Source: Philippine Health Statistics 1995.
Average improvement per year: .7	Average improvement per year: .66	
4. NUMBER OF DEATHS PER 1000		
Baseline Year: 1980 - 6.2 Source: National Statistical Coordination Board 1999	End of Deconcentration: 1990 - 5.1 Source: National Statistical Coordination Board 1999	Recent Data: 1994 - 4.7 Source: National Statistical Coordination Board 1999
Average improvement per year : .11	Average improvement per year: 0.1	
5. LIFE EXPECTANCY		
Baseline Year: 1982 - 62.2 Source: National Statistics Office 1992	End of Deconcentration: 1990 - 64.9 Source: United Nations Development Program and Human Development Network 1994.	Recent Data: 1999 - 69 Source: United Nations Development Program and Human Development Network 2001.
AVERAGE IMPROVEMENT PER YEAR: .34 AVERAGE IMPROVEMENT PER YEAR: .45		

Source: Updated version of Bautista 2000: 11.

Table 8. Ten Leading Causes Of Morbidity, Number And Rate Per 100,000 Population (1997)

	Causes	Number	Rate
1.	Diarrhea	845,203	1,322.3
2.	Pneumonia	638,682	999.2
3.	Bronchitis	591,171	924.2
4.	Influenza	548,407	858.8
5.	TB, respiratory	143,753	224.9
6.	Hypertension	87,706	135.3
7.	Malaria	69,112	108.1
8.	Chicken Pox	61,456	96.1
9.	Diseases of the heart	56,833	89.3
10.	Measles	15,586	55.7

Source: PHS, 1997, Cited by DOH 1999a in Bautista et al. 2001: 25.

Table 9. Ten Leading Causes Of Morbidity, Number And Rate Per 100,000 Population (1998)

	Causes	Number	Rate
1.	Diarrhea	931,655	1273.0
2.	Pneumonia	646,789	883.8
3.	Bronchitis/Bronchiolitis	635,089	867.8
4.	Influenza	563,674	770.2
5.	Hypertension	158,992	217.2
6.	TB, respiratory	131,456	179.6
7.	Diseases of the heart	72,309	98.8
8.	Malaria	70,859	96.8
9.	Dengue-Fever	44,532	60.8
10.	Chicken Pox	32,613	44.6

Source: <http://www.doh.gov.ph/national%20health%status.htm> in Bautista et al. 2001: 25.

Table 10. Ten Leading Causes Of Mortality, Number And Rate Per 100,000 Population (1991-1995 And 1996)

Causes	5-Year Average 1991-1995			1996		
	Number	Rate	% of Total Deaths	Number	Rate	% of Total Deaths
1. Diseases of the heart	48,909	73.4	15.5	53,865	77.0	15.6
2. Diseases of the vascular system	36,707	55.1	11.6	41,511	59.3	12.1
3. Pneumonia	35,226	52.9	11.1	33,319	47.6	9.7
4. Malignant Neoplasm	25,665	38.5	8.1	30,339	43.4	8.8
5. Tuberculosis, All Forms	25,019	37.5	7.9	27,408	39.2	8.0
6. Accidents	13,253	19.9	4.2	16,554	23.7	4.8
7. Chronic Obstructive Pulmonary Disease	10,174	15.3	3.2	12,482	17.8	3.6
8. Diabetes Mellitus	5,057	7.6	1.6	7,677	11.0	2.2
9. Nephritis, Nephritic Syndrome & Nephrosis	5,690	8.5	1.8	7,364	10.5	2.1
10. Other Diseases of the Respiratory System	6,755	10.1	2.1	7,333	10.5	2.1

Source : <http://www.doh.gov.ph/national%20health%20status.htm> in Bautista et al. 2001: 26.

This lack of commitment of local chief executives for PHC affects their willingness to allocate resources for health. Case studies of *sentrong sigla* LGUs indicate a better performance in financial allocation where the local chief executive demonstrates commitment to health as this is followed by willingness to introduce innovations such as insurance schemes and enabling the interface with civil society (Bautista, Legaspi, Santiago and Juan 2001).

The lack of BHSs in the country prevents access to primary level of health care (Bautista, Legaspi, Santiago and Juan 2001: ii). Hospital distribution is uneven

with seven of the top ten provinces with the highest population to bed ratio in the Mindanao areas.

Another challenge is the impoverished situation of many LGUs which have limited resources to invest on health (Bautista et al. 2001: iv). About 60% of municipalities (1,500) are in the fifth and sixth income class levels, indicating the poor financial capacity of the majority of the LGUs tasked to attend to PHC.

The national health insurance program has not been fully established. This is indicated in the insignificant share of insurance in the expenditure for health. Many undocumented and unregistered workers in the informal labor sector pose a problem as they are difficult to locate and have to be convinced of the value of investing on health insurance. Thus, ensuring the protection of indigent members can take a big toll on government coffers if there are not enough who can afford to invest on health insurance. Families often resort to out-of-pocket expenditures.

The political upheaval in the country which led to the ouster of former President Estrada negatively affected the economic situation in the country, resulting in less investments in PHC. A political analyst attributes political uncertainty as a factor for the low net foreign direct investment in the Philippines which stood at \$2.1 billion in 1998 but was down to \$1.1 billion in 2000 (Wallace 2001). On the other hand, China had \$35.8 billion of net foreign investment in 2000 while Singapore had \$4.5 billion for the same year.

As the DOH performs a critical role in “steering” health service delivery, it has the responsibility for regulation, policy advocacy and social mobilization. Performing these roles well is a continuing challenge which DOH should be able to assess. New indicators for performance must be crafted which highlight processes, in addition to health service delivery and impact.

Role of Globalization on PHC

A study assessing the implications of globalization on health service delivery in the Philippines, particularly in the pharmaceutical industry, led the researchers to conclude that such policies as General Agreement on Trade and Tariffs (GATT), General Agreement on the Trade of Services (GATS) and Trade-Related Aspects of Intellectual Property Rights (TRIPS) can subvert Philippine health policies as

these impose laws to conform to the agreements. The imposition in GATT to implement “least restrictive measures” could enable the entry of hazardous products (Banzon and Uko 2001). Earlier, regulatory mechanisms like limited access and advertising bans for particular commodities have given way to market-oriented mechanisms such as “voluntary” and “individual responsibility”. The study noted that the capability of government to raise revenues or to mitigate the health impacts of products like alcohol and tobacco through taxation, may also be constrained by the GATT. The capacity of government to motivate local health-related industries could be limited by GATT restrictions on subsidies, import quotas and domestic preference rules for investors.

Thus, domestic health-related industries may find it difficult to compete with multinational companies which have all the resources to invest on research and development. This was the same concern Gomez raised earlier (2001) concerning alternative medicine.

How National Policies Respond to Health Threats

Innovations in development management have provided a lot of opportunities for PHC advocacy. The enactment of the Social Reform and Poverty Alleviation Act in 1997 enabled the formal adoption of the Minimum Basic Needs (MBN) approach to respond to the basic requirements of the poor. The MBN approach institutionalizes the adoption of 33 indicators as bases to rationally determine the condition of families in a locality. Furthermore, the MBN approach is in effect, responded to by a flagship program called the Comprehensive and Integrated Delivery of Social Services (CIDSS) that subscribes to a participatory approach, like PHC, in three poorest *barangays* in all fifth and sixth class municipalities.

The *Health Sector Reform Agenda* formulated measures to strengthen LGUs for PHC through competition. By extending *sentrong sigla* seals and awards to facilities able to fulfill the basic standards for quality care, LGUs are motivated to emulate the achievements of other localities extended such recognition as well as to sustain the achievements of those which have been granted seals.

How PHC Can Adapt to These Challenges: Policy Agenda

Under a devolved set up of government, the major responsibility for PHC resides in the LGUs. Advocacy for PHC depends mainly on well-informed and motivated devolved health workers with social mobilization skills to steer the community and the LGU, especially the local chief executive. Inasmuch as PHC considers the value of intersectoral collaboration, forging a participatory development process could not suffice with health as an entry point for community mobilization. Problems which may not be related to health could be viewed by the community as more important.

Thus, imparting the essence of PHC must be a multidisciplinary effort among government workers and NGOs, the latter having a long track record in community mobilization in the Philippines which antedated the Alma Ata declaration.

Many institutions could serve as allies and partners to promote a participatory process. One could be the Department of Interior and Local Government, through the Local Government Academy which oversees the training of newly installed local officials. At present, the Local Administrators Development Program is handled by the University of the Philippines' Center for Local and Regional Governance of the National College of Public Administration and Governance, which incorporates a module in participatory governance.

Another entry point is the National Anti-Poverty Commission (NAPC) which uses a participatory approach in its CIDSS program. Health intervention is a major component which serves as "a menu" for the community to select from, after identifying the unmet needs in their locality. Other partner institutions in the NAPC could apply the same outlook since the MBN approach serves as the core strategy that should permeate other programs and projects.

Parallel to the government sector are the basic sector representatives of fourteen (14) marginalized groups (i.e., women, children, youth, persons with disabilities, farmers, fisherfolks, etc), represented in the council. These sectors also take an active role in the different anti-poverty committees that can be constituted in the different LGUs. The representation of these sectors in national and local development processes could enrich the opportunity for community interface in governance, realizing the essence of PHC.

In the World Summit for Social Development in 1995, the 20-20 agreement was entered into by participating countries and donor institutions. Participating countries agreed to allocate 20% of their expenditures to human priority requirements while donor institutions will allocate 20% of their official development assistance for this purpose. Human priority expenditures cover basic education, primary health care, family planning and low-cost water supply and sanitation. However, in 1997, only 14% of their ODA have been allocated by donor institutions for this purpose (Reyes 1998: 28).

PHC as a perspective necessitates the formulation of strategies sensitive to sustainability issues. While basic health indicators have already been incorporated in MBN, sustainability indicators still have to be identified.

Responsiveness to the poor and marginalized is one of the contributions of MBN through the application of focused targeting strategies. Families that need priority attention in CIDSS areas could be identified through objective indicators such as the MBN.

Thus, many developments in the country consistent with PHC, although not necessarily labeled as PHC, can be used as leverage to fulfill the mission of PHC.

Considering these different developments in the country, a new paradigm for PHC entails broadening possible entry points for participatory management. Health need not be the only way to advocate community participation which PHC represents. At the community or village level, participatory development management can help various stakeholders look at other needs as bases for prioritizing programs and projects. Thus, a broader label of *participatory development management* could be adopted as a more generic term by WHO. This implies that a more basic responsibility is ensuring the mobilization of the community for more active participation in the different phases of governance—in situation analysis, planning, implementation and monitoring/evaluation. Instead of imparting a package of services for localities to implement, organized groups in the community take an active role in defining what projects and services they need.

Donor institutions have an important role to play in advocating PHC or more broadly, participatory development management, by ensuring that the approach becomes a basic feature in their support to the Philippines.

Conclusion

The history of PHC in the Philippines has changed in terms of advocacy and actual implementation. In the first decade, these responsibilities were lodged with the Department of Health. With the onset of devolution, the responsibility for implementation was transferred to local chief executives. A key challenge posed by devolution is the lack of knowledge and/or commitment to the essence of PHC by the local chief executives. Thus, DOH tries to continue with its advocacy function by integrating PHC as a key feature in its standard setting functions for health facilities. Other opportunities for integrating the PHC approach such as the Social Reform commitments to poverty alleviation, applying the Minimum Basic Needs Approach and tapping nongovernment organizations as active partners in community mobilization have been recognized by DOH.

Through the years, PHC has made a significant impact in terms of changing the process of governance in health. This can be seen in the need to motivate volunteer workers to participate in community health management, the recognition of alternative technologies to manage ailments, fostering intersectoral partnerships, enabling the interface of nongovernment organizations in governance and the mobilization of people's organizations to take part in addressing their health and other needs. More importantly, subscribing to a participatory ethic has helped in improving quality of life.

However, national and local governments do not yet give high priority to public health care. There is also a need to seek consistency between the participatory approach of government and the assistance of foreign institutions. Finally, political turmoil and the deteriorating peace and order situation in the country, which have spawned economic deterioration, could adversely affect investments in basic health services.

Note

Data for this report were obtained from various sources including: aggregation of primary data to depict patterns/trends; review of secondary materials (i.e., academic-research institutional studies on PHC and agency reports on policies, plans, programs and accomplishments); and, conduct of focused group discussions and interviews of key informants.

Bibliography

- Azurin, Jesus. 1988. *Primary Health Care: Innovations in the Philippine Health System: 1981-1985*. Makati: J. C. Azurin Foundation and Souvenir Publications.
- Banzon, Eduardo and Ferdinand Uko. 2001. "The Implications of Globalization on Health Service Delivery in the Philippines." Health Research for Action National Forum, June 28-29, 2001, Department of Health in cooperation with University of the Philippines, Manila.
- Bautista, Victoria. 1988. "Assessing PHC as a Strategy in Health Service Delivery." Quezon City: University of the Philippines-College of Public Administration.
- Bautista, Victoria. 1995. "Status Report on Primary Health Care." *Philippine Journal of Public Administration* XXXIX. 2 April.
- Bautista, Victoria. 1996. "Partnership for Community Health Development Appraisal Report: Year III." Metro Manila: University of the Philippines College of Public Administration and Department of Health.
- Bautista, Victoria. 1999 *State-of-the-Art Review of Primary Health Care in the Philippines: Two Decades of Government Initiative*. 2nd Edition. Metro-Manila: National College of Public Administration and Governance-University of the Philippines and Community Health Service-Department of Health.
- Bautista, Victoria. 2000. "Primary Health Care Under Devolution: Issues and Opportunities." *Local Government Bulletin* XXXV, 3-4, July-December.
- Bautista, Victoria, Ernita Joaquin and Eden Santiago. 2000. "Philippine Experience in Health Service Decentralization." Prepared for Health Futures, Research Triangle Institute, North Carolina.
- Bautista, Victoria, Perla E. Legaspi, Eden Santiago and Lilibeth Juan. 2001. "Assessment of Improvement Initiatives of Public Health and Medical Systems in LGUs." Quezon City: UP-National College of Public Administration and Governance and Intem Consulting.
- Brillantes, Alex. 1997. Decentralized Democratic Governance Under the Local Government Code. *Philippine Journal of Public Administration*, 42 (1-2) January-April.

Dayrit, Manuel. 2001. Ten Principles of Good Governance in the Department of Health.

Department of Health

- 1996a *Policy on Primary Health Care for Community Health Development*. Community Health Service-Department of Health
 - 1996b *Philippine Health Statistics of 1996*. Manila: Health Intelligence Service.
 - 1996c Annual Report: National Surveillance Sentinel System. Manila: National Epidemiology Center-DOH.
 - 1999a *Health Sector Reform Agenda 1999-2004*.
 - 1999b *National Objectives for Health 1999-2004*.
 - 2000a *Quality Standards List for Barangay Health Stations*.
 - 2000b *Quality Standards List for Rural Health Units and Health Centers*.
 - 2000c *Quality Standards List for Hospitals*.
 - 2000d Summary List of Functional Local Health Boards: Annual Performance Report. Manila: National Health Planning Committee DOH.
 - 2001 List of Foreign-Funded Institutions. Manila: Bureau of International Health Cooperation.
- Gañac, Virginia and Glenita Amoranto. 2001. "The 1991-1999 Philippine National Health Accounts." Paper presented during the Health Research for Action National Forum held on 28-29 June 2001 at UP-Philippine General Hospital.
- Go, Stella. 1998. "Towards the 21st Century: Whither Philippine Labor Migration." *Filipino Workers on the Move: Trends, Dilemmas and Policy Option*. Quezon City: Philippine Social Science Council and Philippine Migration Research Network.
- Herrin, Alejandro, et al. 1993 *Health Sector Review: Philippines*. Manila: Department of Health, United States Agency for International Development and U.P. Economic Foundation.

- Lariosa, Theresita. 2000. "The Indigent Program of the Philippines' National Health Insurance." Report submitted to the WHO.
- National Statistics Office. 1992. *Philippine Yearbook 1992*. Manila: NSO.
- National Statistical Coordination Board. 1999 *Philippine Statistical Yearbook*. Manila: NSCB.
- Newbrander, William, ed. 1997. "Private Health Sector Performance and Regulation in the Philippines." *Private Health Sector Growth in Asia: Issues and Implications*. New York: John Wiley and Sons.
- Mendoza, Lourdes Didith. 2001. "DOH Set to Implement HSRA Programs." *Philippine Star*. 10 August.
- Perez, Juan. 1998. "Relative Financial Capability of LGUs to Fund Devolved Functions." Manila: DOH (transparencies).
- Pesigan, Arturo, Ruben Caragay and Marilyn Lorenzo. 1992 *Primary Health Care in the Philippines*. Quezon City: Center for Integrative and Development Studies and the University of the Philippines Press.
- Ramiro, Laurie et al. 2001. "Structure, Process and Outcomes of Decision-Making in Health: Case Studies on the Effectiveness of Central-Local Mechanisms in the Philippines Health Post Devolution." Paper presented at the Health Research for Action National Forum, 28-29 June.
- Reodica, Carmencita. 1997. "State of the Nation's Health Address: Third National Health Assembly." Mercure Hotel, 6-7 October.
- Reyes, Celia. 1998. Discussion Paper Series No. 98-06: Poverty Alleviation and Equity Promotion. Manila: Philippine Institute for Development Studies.
- Tan, Jaime Galvez. 1987. "Primary Health Care: Health in the Hands of the People: Restoring Health Care to the Hands of the People." Jaqueline Co. and Michael Tan, eds. Quezon City: Health Action Information Network.
- Torres, Amaryllis. 1986. "Documentation of Specific Area Experiences in Primay Health Care." Taguig: Population Center Foundation.
- United Nations Development Program
- 1999 *Human Development Report 1999*.
- 2000 *Overcoming Poverty*.
- 2001 *Human Development Report 2001*.

- United Nations Development Program and Human Development Network
1994 *Philippine Human Development Report*. Makati: UNDP.
1986 *Philippine Human Development Report*. Makati: UNDP.
2001 *Philippine Human Development Report*. Makati: UNDP.
- United Nations Population Fund (UNFPA) and Government of the Philippines (GOP). 1999. *Country Population Assessment: Philippines*. Manila: UNFPA and GOP.
- University of the Philippines-College of Public Administration (UPCPA) Study Team. 1982. *A Study of the Implementation of Primary Care Program in Twelve Regions*. Vol. 1. Manila: University of the Philippines-College of Public Administration.
- Valencia, Emma. 2000. "Towards Rationalizing the Pharmaceutical Industry." Presented in the Health Research for Action National Forum. UP Manila Social Hall. 28-29 June 2001.
- Varela, Amelia. 1997. "Policy Review and Program Evaluation of the Generics Law and National Drug Policy." Quezon City: University of the Philippines-College of Public Administration.
- Wallace, Peter. 2001. "Does the Philippines Have a Chance?" *Philippine Star*. 21 July.
- World Bank. 2002. *Fighting Poverty for Lasting Results: Projects in Progress and Projects in the Pipeline*. Manila: World Bank Assistance Programs in the Philippines.
- World Health Organization. "Filipino Report Card for Pro-Poor Services." Metro Manila: Environment and Social Development Sector Unit.