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Policy Directions for Health in the 1980s

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The Philippine health situation at the start of the 1980s is characterized by achievements due to the institution and/or intensification of programs stressing the concept of accessibility and decentralization. These programs include the Restructured Rural Health Care Delivery System, the Medical Care Program, Rural Health Practice Program, Community Medicine Focus of Medical and Nursing Schools, Community-Based Health Programs and a newer development, the Primary Health Care. But despite these programs, problems on health per se and those of access to health resources still exist. The agenda for health in the 1980s should therefore consider these facts. It should also be made within the context of the nations's total economic, social, and political situation. The health policy should specifically aim at the promotion of health and the prevention of disease, the provision of adequate health care particularly to the poor, recognition and support to indigenous systems, and preparations to face problems of health and access brought about by increasing industrialization and urbanization. Many of these policy directions are already included in the present programs. They must be reiterated and underscored and new policies must be pointed out to complement them.

Introduction

The health situation of the Philippines as it enters the decade of the 1980s is marked by achievements as well as by continuing problems. On the positive side, life expectancy at birth is over 60 years, and many Filipinos can thus look forward to a ripe old age denied to their cohorts in other Third World countries. The crude birth rate, the crude death rate, and the infant mortality rate have steadily decreased. Meanwhile, there have been increases in health resources, i.e., health professionals as well as hospitals, pharmacies, and other facilities.

These achievements have been made possible by the continuation of conventional health efforts, coupled by the institution or intensification of programs in the seventies. Some of these are substantive in nature; for instance, the expansion of dimensions of maternal and child health into the full-blown programs of nutrition and family planning, and the creation of a major facility for the treatment of cardiovascular diseases. These join earlier programs devoted to the prevention and control of tuberculosis, leprosy, schistosomiasis, and malaria. Also, in view of the negative incursions of modernization, the control of pollution and the regulation of dangerous drugs have been tasks intensively assumed in the last decade.

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Other efforts touch on aspects of how the population, especially the poor and those in the rural areas, can have greater access to health care services. This has been a major concern since the health service was started by the American government in the Philippines at the turn of the century. Created then as presidential sanitary divisions, rural health units (RHUs) were strengthened and created in every municipality by the Rural Health Act of 1953. The RHUs utilized the health team concept whereby physicians, nurses, and paraprofessionals (like midwives and sanitary inspectors) would play distinct but complementary roles. It also instituted a three-tier referral system. This conserved the expertise of physicians and hospitals for the most demanding and difficult cases. At the same time it authorized midwives, sanitary inspectors, and nurses (1) to deal with simple cases that require immediate attention, and (2) to educate the community into more healthful habits and practices. From the beginning then, these basic units of the health system stressed the importance of the promotion of health and the prevention of disease, dimensions of health care that are often ignored by people who seek medical attention only when in need of cure or rehabilitation. This group is not necessarily a small percentage of the population since the image of modern western medicine has often been equated with hospital-based highly sophisticated care.[1]

In line with the desire to be responsive to the people's health needs and to be as close to the grassroots as possible, the health service was among the first departments to create regional offices. This decentralization effort was made as early as 1958.

Other programs were instituted in the seventies to further improve access. These include the following:

(1) The Restructured Rural Health Care Delivery System
(2) The Medical Care Program
(3) The Rural Health Practice Program
(4) The Community Medicine Focus of Medical and Nursing Schools
(5) Community-Based Health Programs.

The Restructured Rural Health Care Delivery System (RRHCDS)

The RRHCDS was introduced in 1975 as part of the Population I Loan Program of the International Bank for Reconstruction and Development (IBRD). The RRHCDS created barangay health stations (BHSs) and thus extended the coverage of the poblacion-based rural health unit, the municipal-level office of the Ministry of Health. The BHSs are manned by midwives who have received special training to enable them to be first-level health workers in the existing referral system that links the BHSs to RHUs and the different hospitals. The structures to house the BHSs were also constructed under the RRHCDS.

The RRHCDS concept has a long history. The RHU expansion, for instance, was first put forward in the Evans Report of the 1960s, a study conducted by the joint World Health

[1] International Bank for Reconstruction and Development, *Health: Sector Policy Paper* (Washington, D.C.: IBRD, 1980), p. 18.

Organization (WHO) Philippine team to evaluate the results of the Rural Health Act. Its immediate predecessor is the pilot study of the province of Rizal (1973) which provided guidelines and manuals for the restructuring of the rural health system. In many ways then, the RRHCDS is simply a step in the further expansion of public health practice. The contribution of RRHCDS lies in its provision of a system of deployment and reeducation which makes that expansion administratively feasible.

The Medical Care Program

Started in 1969, Medicare is a system of health insurance which aims at "providing the people with a practical means of helping themselves pay for adequate medical care."[2] It has also constructed a number of emergency hospitals in medically depressed areas. The coverage of the medical program is still extremely limited in terms of both beneficiaries and benefits. It only pays for hospital confinement, for example, and provides benefits for employed persons and their families. Nonetheless, it has provided access to medical facilities which were previously unavailable.

The Rural Health Practice Program (RHPP)

To augment medical manpower in rural areas, the government, starting in 1974, required service in rural areas for all medical and nursing graduates as an added qualification for licensure. In terms of sheer augmentation of manpower, the RHPP could be adjudged successful. However, questions have been raised relative to its efficiency, effectiveness, effects on the morale of regular personnel and efficacy as a training device for underboard nurses and doctors.[3]

The Community Medicine Focus

In 1964, the Ramon Magsaysay Memorial School of Medicine (University of the East) stressed preventive and social medicine and rural medical practice, instituted a live-in community development course, and established a community health project in Limay, Bataan as the locale of its rural internship program. Since then, similar programs have mushroomed in both medical and nursing schools, each choosing a particular barangay or municipality as a site for pregraduation public health practice. This has been coupled with changes in the curricula aiming to put more stress on Philippine medical problems. These changes were spearheaded and/or encouraged by professional associations like the Association of Philippine Medical Colleges and the Philippine Medical Association.[4] Graduates of the late 1960s and the 1970s are

[2]Philippines (Republic), Philippine Medical Care Commission, Office of the Public Relations Officer, *The Medicare Program of the Philippines* (Quezon City: PMCC, October 1974), p. 1.

[3]Mila A. Reforma, "The Rural Health Practice Program: An Evaluation of the Rural Service Requirements for Health Professionals," Occasional Paper No. 9, January 1978, College of Public Administration, University of the Philippines; and Dennis A. Borelli, "An Assessment of the Efficiency, Productivity, and Effectiveness of Rural Health Unit Employees, Benguet Province (1978)," (unpublished M.P.A. thesis, College of Public Administration, University of the Philippines, March 1980).

[4]Ledivina V. Cariño, "The Philippines: Patterns from the U.S.A." in Thomas H. Sliock, *Professions in Southeast Asia* (Canberra: The Australian National University, 1977).

thus expected to be more cognizant of, and better equipped to deal with health realities in the country.

A program which aims at relevance and full utilization of medical education is the medical program of the Institute of Health Sciences, University of the Philippines, at Tacloban City. This provides for a stepwise system by which students are graduated as midwives at the third and as rural physicians (with a Bachelor of Science in Rural Medicine) after two or more years of study.[5] The curriculum is supplemented by the community practice in Carigara, a depressed area in the province. The program combines features of community-based health programs and the community medicine approach of the other medical schools.

Community-Based Health Programs (CBHP)

There are probably as many as a hundred barangays participating in community-based health programs. Although subject to several variations in the field, a CBHP generally involves the people of the community in meeting their own health needs, assisted by physicians and/or nurses fielded by CBHP sponsors or by the government health office in the area. Usually, a barangay resident is trained as a health worker who gives first aid, teaches health education, provides sanitation attention, and serves generally as the person the community can first turn to in cases of illness. The members of the entire community are supposed to participate in the planning, implementation, and evaluation of the health program. They are encouraged to be self-reliant and to be responsible for the promotion of their own health. In view of this, the CBHP emphasizes the importance of personal hygiene as well as of clean water, toilet facilities, and other aspects of environmental sanitation. Rarely, however, does a CBHP involve itself only in health since people's needs are interrelated with, say, economic concerns which are difficult to separate from health problems. Because their concern is for the community and the development of the whole man, they are flexible in the programs they pursue. Thus, where a community considers that income-generating activities have priorities over their health needs, projects along the former line will be pursued first. CBHP advocates also regard the community as a total system with the health structure and problems providing a microcosmic view of the entire society's condition.

It takes time to build self-reliance and capabilities. Thus, many CBHPs today are still under the tutelage of community organization workers and still dependent on their sponsors (although grants for CBHPs are usually minimal). Also, because many have not developed regular linkages with the health services of the government, they tend to be ad hoc — functioning in small pockets of the country but not having a nationwide impact.

Primary Health Care (PHC)

A new development occurred at the close of the decade. With Letter of Instructions 949 (series of 1979), the

[5] Armando F. Bonifacio, "The Institute of Health Sciences: A Strategy for Health Manpower Development," *Development of Health Manpower for the Rural Areas: Report on the Philippine Experiment Part I*, XXXII World Medical Assembly Scientific Session, College of Medicine, University of the Philippines, n.d., pp. 12; 17.

Philippines committed itself to the approach called Primary Health Care. Strengthened by the Alma Ata (USSR) Declaration of 1978,[6] PHC is the new catchword, although the concept itself has long been guiding the public health experience of the country, under the aegis of both the government sector and private initiatives. In many ways, PHC maintains many of the important defining characteristics of RRHCDS: the comprehensive integrative approach delivered by a team that stresses prevention and the value of a healthy individual and a healthful environment. As the name implies, PHC also recognizes and reiterates a complex system of health care that starts at the community level and extends to embrace the specialists' role in curative and rehabilitative situations. However, more than the RRHCDS, PHC links the barangay through all the local levels to the region and the center. In addition, it creates an institutional framework for health care delivery which is inter-disciplinary and inter-sectoral, involving not only the Ministry of Health, but also local governments and other national agencies.

Its basic innovative thrust has a close resemblance to the CBHP movement. Thus, the community under PHC is no longer just a group acted upon by the health agency in its drive toward the systematic elimination of the causes of disease. Rather, the community is its full partner and techniques of community organization and community development (CO and CD) are accepted as vital weapons in the arsenal of health care. The role of the individual and his family is further emphasized so that they recognize the need to be self-reliant in health as vital members of the health team. Again, the role of the professional members of the team as educators is stressed so that they do not only minister to the sick but also communicate and teach the practice of good health as something understandable and capable of being attained by the laymen. As they do so, the PHC approach thus indigenizes medicine, legitimizing traditional practices and herbal solutions when these are scientifically efficacious, or at least not harmful, and leading people to immunizations and other modern techniques when these have no substitutes. In this connection, it may be pointed out that the country already possesses a large body of works concerning the efficacy — as well as problems — related to the use of herbal medicine.[7]

Health Problems

Despite these strides and new thrusts, many health problems remain unsolved. Again these involve two prongs — not only health per se, but also problems of access. The incidence of malnutrition and communicable diseases, as well as poor environmental sanitation and population growth are listed by the National Health Plan as the chief health problems of 1978-1982. Consider these figures:

[6]World Health Organization and United Nations Children's Fund, *Primary Health Care*, International Conference on Primary Health Care, Alma Ata (USSR), September 6-12, 1978.

[7]Michael Tan, "Philippine Medicinal Plants in Common Use: Their Phytochemistry and Pharmacology," *A Community-Based Health Program Handbook* (Alay Kapwa sa Kalusugan, May 1978).

Table 1. Ten Leading Causes of Mortality and Morbidity in the Philippines, Rates and Ranks for 1970-1974; 1979 (Rate per 100,000 population)

Disease	Average 1970-1974		1979	
	Rate	Rank	Rate	Rank
Ten Leading Causes of Mortality				
Pneumonia	116.0	1	114.1	1
Tuberculosis (all forms)	74.0	2	55.8	3
Diseases of the heart	44.9	3	61.5	2
Gastroenteritis and colitis	38.7	4	46.4	4
Diseases of the vascular system	33.5	5	39.3	5
Avitaminosis and other nutritional deficiencies	29.9	6	30.5	8
Accidents	29.1	7	28.8	9
Malignant neoplasm	27.2	8	35.7	6
Bronchitis, emphysema, asthma	23.3	9	16.8	10
Tetanus	9.2	10	—	—
Certain diseases of early infancy	—	—	31.3	7
Ten Leading Causes of Morbidity				
Influenza	815.9	1	1,317.8	1
Gastroenteritis and colitis	576.3	2	1,054.9	4
Tuberculosis (all forms)	353.4	3	375.3	9
Pneumonia	233.4	4	373.4	10
Malaria	71.8	5	—	—
Measles	58.3	6	—	—
Whooping cough	57.7	7	—	—
Dysentery (all forms)	52.1	8	—	—
Malignant neoplasm	27.7	9	—	—
Tetanus	11.2	10	—	—
Mental disorder	—	—	994.4	5
Accidents	—	—	1,119.1	3
Bronchitis	—	—	1,272.9	2
Diseases of the heart	—	—	683.2	6
Avitaminosis and other nutritional deficiency states	—	—	544.9	7
Diseases of the vascular system	—	—	477.8	8

Sources: Philippines (Republic), Ministry of Health, *An Overview of the Ministry of Health*, 1978, pp. 25-26, 28 and *Annual Health Plan*, 1979. pp 3-4

(1) As much as 5 percent of under-six children surveyed in June 1977 were suffering from third degree malnutrition.[8] Statistics put avitaminosis and other nutrition deficiencies as the eighth highest cause of deaths in 1979 (See Table 1).

(2) Among the leading causes of morbidity and mortality are communicable diseases, namely: tuberculosis, pneumonia, gastroenteritis and colitis, and bronchitis, that can be prevented and controlled by good health habits

[8] Philippines (Republic), Ministry of Health, *Annual Health Plan 1979* (Manila, 1979), pp. 9-10.

and clean physical surroundings.[9] The high incidence of tuberculosis is distressing especially if one considers that neighboring Asian countries have much lower TB mortality rates, or have managed to cut down their deaths from TB tremendously, despite having death rates in earlier periods comparable to or higher than those of the Philippines initially. For instance, in 1965, the Philippines had a mortality rate from TB of 88.7 per 100,000 population, roughly comparable to the Republic of Korea (84.0) and much lower than Sarawak in East Malaysia (131.0). By 1971, (the latest year for which data are available for all three areas), the Korean figure is down to 14.2, Sarawak to 21.0 but the Philippine figure, although lower than that in 1965 is still high (68.7).[10]

(3) Adequate water and toilet facilities are still luxuries. In 1977, safe water was available to only 45.3 percent of the population.[11] Households with sanitary toilets comprise a similar proportion, only 45.4 percent of the population.[12]

(4) Despite a decreasing birth rate, population growth remains rapid. Thus, the dependency ratio is high. Moreover, density of population is quite high in Manila and other urban centers, resulting in further problems related to housing shortages, unhealthy environments, and possible social deviances.

Other health problems are suggested by studying the remaining causes of death and illness (See Table 1). These include, aside from those already mentioned, diseases of the heart and the vascular system, malignant neoplasms (cancer), and accidents. Leading causes of illnesses include, in addition, mental disorders. While these diseases are multi-causal, it has to be recognized that an important factor in their increased incidence could be economic growth and urbanization of the country, with their concomitant stresses and pressures, problems wrought by the use of machines at home, on the road and in factories and offices, changed dietary habits, and so on.

In addition to health problems per se, the Philippines continues to face problems related to access to health resources and personnel. Resources devoted to health are rather low. The Ministry of Health received 3.7 percent of the national budget in 1980 compared to 9.2 percent devoted to education and 12.9 percent to defense.[13] There is a slight decrease since 1977 when health expenditures accounted for 4.13 percent of the budget but constituted only .6 percent of the gross national product in 1977.[14] This compares with a still

[9] *Ibid.*, pp. 3-4.

[10] World Health Organization, *World Health Statistics*, Vol. 1 (1977); and United Nations, *Demographic Yearbook*, 1964, 1965, 1977.

[11] Philippines (Republic), Ministry of Health, *Annual Health Plan 1979*, p. 8.

[12] *Ibid.*, and Philippines (Republic), National Economic and Development Authority, *Philippine Statistical Yearbook 1978* (Manila, 1978), p. 71.

[13] Philippines (Republic), Ministry of the Budget, *Bridges to the Future: The President's Budget Message for 1980* (Manila, July 23, 1979), pp. 47-51.

[14] Philippines (Republic), Ministry of Health, *Annual Health Plan 1979*, p. 7 and Philippines (Republic), National Economic and Development Authority, *op. cit.*, p. 120.

(slightly) higher proportion devoted to the Department of Health in 1970 (4.55 percent).[15]

Low resources are further aggravated by the insufficiency and maldistribution of health facilities and resources, and the high cost of medical care. Statistics show that health manpower has increased by 15 percent between 1973 and 1977. There have also been increases in the number of hospital beds from 51,447 in 1973 to 56,561 in 1976.[16] Nevertheless, severe access problems remain. In 1970, a survey of the Association of Philippine Medical Colleges (APMC) found that only half of the municipalities were served by more than one physician while almost one-fourth did not even have one doctor. About two-thirds of the poorest municipalities (fifth to seventh class, 20 percent of all municipalities)[17] had no resident doctors. Meanwhile, physicians tended to congregate in urban areas with 33.8 percent of APMC respondents living and working in Metropolitan Manila, 22.1 percent in all other cities and only 44.1 percent in the rural areas.[18]

The situation has not improved over time. As late as 1979, the *Annual Health Plan* would state that despite adequacy in the number of medical professionals and paraprofessionals there would be a problem of maldistribution of these potential health workers because they tend to flock to the urban areas and other centers of population growth.[19] Hospital beds follow a similar lopsided distribution. Of the total beds in 1976, as much as 32.5 percent were in the Metro Manila area.[20]

Even in areas where there are hospitals and physicians, the cost of availing of their services has grown quite prohibitive. The president of the Philippine Hospital Association stated that hospitals could not charge the required increase in the cost of hospitalization because the people cannot afford it. Thus, despite Medicare, less and less people who need it are being hospitalized. Moreover, the cost of medicines and laboratory facilities has also increased. For instance, X-ray film, 14 x 17 inches, has gone from ₱9.55 in January to ₱44.80 in March 1980. Price of drugs has been similarly hiked. Dr. Pacifico Marcos, Philippine Medical Care Commission (PMCC) chairman, summarizes the effect of this on the poor:

> The poor patient is only given a prescription but if he has no money, he has no medicine. Only nature takes care of him.[21]

Some increases can be traced to the high cost of importation, but many analysts have also traced the problem to the control of prices and resources by multinational drug companies

[15] Philippines (Republic), Budget Commission, *Budget for the Fiscal Year 1972.*

[16] Philippines (Republic), Ministry of Health, *Annual Health Plan 1979*, pp. 4, 5, and 6.

[17] Ledivina V. Cariño, "The Role of the Professions in the Philippine National Development," Public Administration Social Studies Series No. 2, College of Public Administration, University of the Philippines, February 1973.

[18] Cariño, "The Philippines: Patterns from the U.S.A.," p. 175.

[19] Philippines (Republic), Ministry of Health, *Annual Health Plan 1979*, pp. 6-7.

[20] *Ibid.*, pp. 4-5.

[21] *Bulletin Today*, "Act on High Cost of Medicare," May 26, 1980.

operating in the country which have not been effectively regulated by government.[22]

Health Agenda for the 1980s

The agenda for health in the 1980s would be suggested by the preceding discussion showing the magnitude of the problems facing us as well as the quality of the responses that have already been effected. At the same time, it should be made within the context of the nation's total economic, social, and political situation. As such it should be informed by the findings that more than half of all families are at or below the poverty threshold level and can thus barely provide for their basic needs.[23] Given the high cost of medical care, a higher percentage may be regarded as medically indigent. The fact of great poverty makes it imperative that the policies should direct critical services to the poor. However, even these may not be enough. Streeten and Burki aver that

> the link between government expenditures devoted to social services meeting basic needs and the accrual of benefits to these poor have been low.[24]

Empirical studies in Benguet, Bicol, and Metro Manila suggest that the Philippines faces the same problem.[25] This is not a simple question of supply management and other administrative measures. Rather, it makes imperative the need for an explicit policy to provide services to the poor with such beneficiaries being identified and directly served.

Related to the problem of poverty is the fact that the Philippines is a nation in the periphery responding to events occurring at, or directed from, the center. Aspects of the health situation that manifest this are: the great share of multinationals of the market on medicines, with concomitant high cost even of drugs with indigenous raw materials,[26] the medical brain drain, with as much as 40 percent of Filipino physicians and 35 percent of nurses living and working primarily in the United States, and, increasingly, Europe and OPEC countries.[27] One can even trace the

[22] Augusto Caesar Espiritu, *et al., Philippine Perspectives on Multinational Corporations* (Quezon City: University of the Philippines, 1978).

[23] Mahar Mangahas and Bruno Barros, "The Distribution of Income and Wealth: A Survey of Philippine Research," Discussion Paper, Institute of Economic Development and Research," School of Economics, University of the Philippines, 1979, p. 65.

[24] Paul Streeten and Shahid Javed Burki, "Basic Needs: Some Issues," *World Development*, Vol. VI, No. 3 (1978), p. 412.

[25] Borelli, "An Assessment . . . "; Ma. Lourdes S. Joves, "Accessibility of Government Health Services in Bicol River Basin Area," Bicol Studies Series No. 10, College of Public Administration, University of the Philippines, 1979; and Antonio Hidalgo, "Evaluation of a Health Program," *Philippine Sociological Review*, Vol. XXVII, No. 1 (January 1979).

[26] Espiritu, *Philippine Perspectives* . . . .

[27] Jose Cuyegkeng, "The (External) Migration of Philippine Medical Graduates — Its Magnitude, Causes and Solutions," *The Filipino Family Physician*, Vol. IX, No. 4 (October-December 1971), pp. 20-23; and Reforma, "The Rural Health Practice Program," p. 6.

If the Annual Health Plan is to be believed, the percentage may be higher, since it lists only 16,123 physicians and 14,544 nurses from a total of 60,708 medical manpower in the country (1977 figures). This appears incredible because the annual output of medical and nursing schools is 1,216 (as of 1978) and 4,500, respectively (National Census and Statistics Office, 1978).

international influence on most of the major health programs with RRHCDS directly traceable to the IBRD, and PHC to WHO, the United Nations Children's Fund (UNICEF) and again IBRD, the population program to the United States Agency for International Development (USAID), and so on. This does not imply that the programs and the concomitant resources they bring should be rejected just because they have exogenous roots. Rather, there should be more conscious evaluation of the need for these programs, their priority relative to the Philippine situation, and the appropriateness of the approaches they recommend. In addition, indigenous policies and approaches should be developed according to locally established prioritizations.

Within the Philippines, also, there is a center-periphery situation with Manila as the hub. The most specialized facilities are located there, although Manila itself does not have enough clinics to deal with the communicable diseases often caught by its poor denizens. Decisions on the health services and resources to be made available to the rest of the country are also made there. This situation is mitigated by a decentralized structure in the Ministry of Health which is one of the oldest such setups among the sectoral programs of the government. Nevertheless, field levels continue to complain about their lack of decision-making power and resources.[28]

[28]Ledivina V. Cariño, Ma. Concepcion P. Alfiler, and Rebecca P. Albano, "The Support for Health Programs: A Functional Analysis of the Ministry of Health," College of Public Administration, University of the Philippines, 1980.

Health Policy Goals for the 1980s

Given these considerations, the health policy for the 1980s should have these goals:

(1) The stress of health policy should be on the promotion of health and the prevention of diseases. This should be the responsibility of the total community, with health professionals and other members of the health bureaucracies supportive of community participation, willing to play an educative and unobtrusive role in the community's activities but available to provide more complex medical services should these become necessary. This citizen involvement would be manifested at all levels of health planning, implementation, and evaluation.

(2) Adequate health care should be available to the entire population, particularly the medically indigent and the poor who often do not have access to health and medical services.

(3) Government should recognize and support indigenous systems of medical care as potential if not actual allies.

(4) Government should be prepared to face problems of health and access to health facilities posed by increasing industrialization and urbanization.

Many of the policy directions these imply are already incorporated in present programs and policies. Our task then is to reiterate and underscore what these are, and to point out what new policies should complement them.

Primary Health Care

As defined at Alma Ata, Primary Health Care is

> essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford; it forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the country.[29]

As such it should be an adequate response to the policy goals enumerated above. As already pointed out, part of PHC is like a restatement of the functions of public health or community medicine as it has been traditionally defined. It departs from previous government practice and policy in three essential points:

(1) In using "means acceptable to them (the people)," PHC signifies the acceptance of indigenous systems of medical care and traditional practices, where these are not harmful to the individuals;

(2) In seeking "full participation of the community," PHC attempts to involve the people in all phases of the health program — planning, implementation, and evaluation;

(3) In regarding itself as "an integral part of overall . . . development of the country," PHC recognizes the role of health as an entry point for development.[30] These issues bear reiteration because, taken to their logical conclusion, they have revolutionary implications not only to the health system, but also to the nation as a whole. The PHC approach implies a devolution of power to the people beyond that which has actually been exercised by barangays and other local governments since the related movements of decentralization and community development of the mid-1950s. It requires the central government to perform only advisory and staff roles in the evolution of community health programs while providing resources to enable these same communities to discover what it means to take responsibility for their own health. It means that health professionals would be willing to share their complex technical expertise (for which they went to great expense to gain) even to the extent of accepting that (1) traditional health approaches may be quite relevant and useful or that (2) good health practices may be relegated to the background by persons whose major worries concern where the next meal is coming from. The record in the Philippines suggests that the approach most similar to PHC — that used by many community-based health programs — has worked best in micro-situations and where the people's capabilities for self-reliant action are encouraged even if they do not look at health as the priority need. At the same time, the long-range success of CBHPs appears to require linkage with a supportive system that allows for flexibility to respond to different community demands while it maintains a reliable system that will provide for health and medical care whenever and wherever it is required. This suggests, then, that the PHC policy does not need to be immediately

[29] World Health Organization and United Nations Children's Fund, *Primary Health Care*, p. 8.

[30] On these three points, cf. Andres Angara, "Observations on Rural Health Care Delivery Systems in the Philippines, 1978," World Health Organization, Regional Office for the Western Pacific Bureau, December 1978, pp. 2; 3.

implemented on a national scale but should start at strategic depressed communities. At the same time, the health professionals in these communities should be retrained to deal with their new roles as community educators and advisers as well as dispensers of medical services.

Reform of the Health Organization

In support of PHC, the health organization should have a system of involving private citizens as well as other government agencies in the planning, implementation, and evaluation of health programs at the barangay, municipal, city, provincial, regional, and national levels. Members of these councils should include laymen as well as health professionals so that this system can allow for the continuation of citizen involvement in health programs begun at the community level. The laymen should be knowledgeable about their health needs but not be in awe of medical professionals and technology so that some measure of citizen control could really be effected.[31]

The Use of Traditional Medical Practices

This is part of PHC but requires reemphasis. This involves first a study of how people view health and medicine and their strategies for gaining better health or for getting cured. An Indonesian village study made by a sympathetic physician has revealed that traditional housewives give health care to their children using a process that approximates the Western scientific mode (while utilizing indigenous medicine).[32] It also makes a long list of elements of this medicine that is not harmless and even efficacious for ailments common in that area. Galvez Tan also points out similar elements in Filipino traditional practice and even shows that the "hilot" points in Chinese medicine now avidly studied and close to acceptance in the West.[33] These suggest that a study of these practices would not only serve as a rapport-building device with rural Filipinos but it would in fact have the added value of enriching medicine in general. The study should also include an assessment of the efficacy of herbal medicines, an activity that has been supported by the National Science Development Board, and done by researchers in the University of the Philippines and other academic institutions. Interest should, however, not end there. The *Alay Kapwa sa Kalusugan* has systematized the usage of herbal medicine and retaught this to the people.[34] Since many of these raw materials are common in rural areas, the efforts to disseminate information including indications, dosage, and contra-indications would also decrease the country's dependence on synthetic drugs when they have abundant local substitutes.

[31] Christa Altenstetter and James Warner Bjorkman, "Planning and Implementation: A Comparative Perspective on Health Policy," Discussion Paper Series, International Institute of Management, Berlin, August 1979.

[32] Valerie Hull, "Women, Doctors, and Family Health Care: Some Lessons from Rural Java," *Studies in Family Planning*, Vol. X, Nos. 11-12 (November-December 1979).

[33] Jaime Galvez Tan, "Community-Based Health Programs," Seminar Lecture, College of Public Administration, University of the Philippines, February 25, 1980.

[34] Tan, "Philippine Medicinal Plants...."

The Use of Barangay Health Workers

The policy to recruit and train these barangay health workers and to provide them with adequate authority, resources, and support should be part of the health agenda. Although not a defining characteristic of the PHC, a health worker coming from the community is often expected to be the direct link between the health system and the people.

Related to this, the step-ladder approach being tried out in Leyte should be carefully examined, since it hopefully would develop health professionals who are knowledgeable and responsive to community needs and committed to the work in rural areas.

Prevention and Control of Leading Causes of Death

The prevention and control of tuberculosis and other communicable diseases should be a high health priority. The improvement of personal health habits and environmental sanitation encouraged by primary health care is a step in TB prevention. This should include the construction and proper use of toilets, sewerage facilities and waterworks systems, as well as sustained efforts at health education. Some aspects of these are now the responsibility of public works, education, and community development agencies rather than the Ministry of Health and imply that the program to lick TB and similar communicable diseases requires an intersectoral approach. Its early diagnosis should fall upon the family, schools, offices, and factories which should reemphasize, along with the health centers, the need for regular physical checkups.

Prevention and control of the other leading causes of death also call for better health education and safety and sanitation of one's physical surroundings. This would include, aside from measures already mentioned above, such approaches as campaigns against smoking and reeducation regarding its risks, regulation and establishment of safety standards to reduce occupational hazards, vehicular risks, pollution effects, etc. Research along this line, particularly the production and use of machines appropriate to the build and needs of the Filipino, should be encouraged.

Regulation of Prices and Availability of Medicine

When illnesses occur despite diligent efforts towards prevention and control, the price and availability of drugs and treatment become important considerations. Keeping these within the reach of the medically indigent require several approaches:

(1) The utilization of herbal medicine and indigenous systems of care as discussed above under the control and regulation of the Food and Drug Administration or a similar agency;

(2) Research into the systematic packaging of herbal and other locally available medicine, so that they are widely disseminated while meeting high safety standards;

(3) The use of generic drugs in prescriptions which would be just as effective as well-advertised brand names of multinational and local drug companies;

(4) The control of prices of these drugs so that they are within the reach of the masses;

(5) The control of dissemination of dangerous drugs; and

(6) For the dissemination of other drugs: the use of such devices as *botika sa baryo* (village drugstore) so that village people can obtain needed drugs without incurring high transport costs, time losses, and so on.

Again, some of these measures, especially price control and research, are outside the health sector as it is now defined and thus require coordination with these agencies. Other aspects relating to the cost and availability of treatment will be discussed below.

Integration of the Public and Private Health Sector into an Overall Health System

For a long time the government has declared that the delivery of health care is a joint responsibility of the public and private sectors.[35] This is particularly salient in the PHC where the strengthening of program linkage among government and non-government efforts is called for at all local and national levels.[36] An integration of the public and private sectors is thus but a logical extension of existing policy. It is especially urgent because while the country does not have an abundance of health resources, there are areas where they are redundant and duplicative.

A recent study has shown that remote rural health units in Benguet are more efficient, effective, and productive than their counterparts in areas near Baguio City which have access to hospitals, several private doctors in addition to the government health centers.[37] This finding suggests that the government should take private sector deployment of health resources into account when planning its own: where a private practitioner/clinic/hospital exists, government should not duplicate costly resources by locating there also. A system of providing subsidies or grants to private individuals and clinics should be instituted, its size depending on such factors as location, presence of other facilities, uniqueness of service (only facility, specialized care), and so on. At the same time, these facilities should be built into the referral system and be involved in it depending on their level, e.g., physicians would be at the first tier but answering calls of Barangay Health Workers (BHWs), sanitarians and nurses, emergency-type clinics or hospitals at the second tier, and so on, a classification similar to that made for government facilities at present. In areas where the private sector is present, government health activity would be devoted to inspection, regulation, and training. Since the private sector (except for missionaries) would not be expected to go to the really remote barrios or such depressed areas as slums and squatters sites, the government would probably find itself concentrating on

[35] Nestor Pilar, Emma Boncaras, and Grace Santos, "Social Development Policies and Programs in the Philippines: Focus on the Delivery of Health Services," SPAR Series, College of Public Administration, University of the Philippines, September 1976.

[36] Philippines (Republic), Ministry of Health, "Primary Health Care: Philippine Policy Paper," A Draft Position Paper, 1980.

[37] Borelli, "An Assessment . . . ."

direct service to the really poor, assisted by their own BHWs and the communities themselves.

Expansion of Medical Insurance

An expansion of the present medicare system would involve an increase of beneficiaries to include not only salaried individuals and their families but also other workers, particularly those in farming, fishing, and forestry who would not be Government Service Insurance System/ Social Security System members. In addition, expansion should also mean the provision of benefits for medical consultations without hospital confinement. Given the dearth of beds and the high cost of maintaining hospitals (and the high price charged to patients beyond medicare assistance), as well as the need to stress health promotion and prevention, preventive physical checkup and outpatient consultations should be encouraged. To promote maternal and child health, medicare should also be available for pre- and post-natal care as well as deliveries but may be limited to only the first two (or three) pregnancies in the interests of family planning.

This policy can be regarded as a corollary of the public-private integration above. Subsidies may thus be given through individual patients like in the medicare system, or be in the form of grants to institutions (with all individuals able to avail of their resources gratis or on a graduated scale of fees, depending on need). The National Health Service of Great Britain and similar institutions in other countries may be studied as a point of departure for Philippine models in this connection.[38] Attempted along with PHC and the minimization of duplicative resources in many areas, this system would do much to make health care and medical services truly available to all the people, particularly the poor.

[38]Daniel Thursz and Joseph Vigilante, "Meeting Human Needs: An Overview of Nine Countries," *Social Service Delivery Systems, An International Annual,* Vol. I (Beverly Hills: Sage Publications, 1975).