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Reconstructing the Functions of Government: The Case of Primary Health Care in the Philippines

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The worldwide commitment to primary health care (PHC) declared in Alma Ata in 1978 influenced the Philippines' public administration system to "reinvent government." PHC was immediately propagated in the Philippines by pilot testing its methodologies (i.e., participatory development and intersectoral collaboration) in marginalized provinces beginning in 1979. With the institutionalization of PHC in 1981, additional mechanisms were implemented. Devolution, which was launched in 1991, created new challenges to the national health office in propagating PHC. Various problems concerning PHC implementation include: changing thrusts of the top leadership of the national health agency, provision of incentives which could contradict the essence of volunteerism, the preparation of local chief executives for participatory development, and national/local government's preparation for process monitoring/assessment in addition to output/effects/impacts assessment.

Background

Primary Health Care (PHC) is one of the innovative strategies implemented by the Philippine government immediately after its declaration as a commitment by participating institutions at the Alma Ata conference in Russia in 1978. This approach has indeed influenced the perspective of many countries, including the Philippines. Its innovativeness is indicated by the call for participatory development management since community members are expected to take an active role in managing their own health requirements, instead of merely depending on the government. This therefore implies the importance of organizing the community to enable the residents to operate independently and effectively interface with government. PHC also gives importance to the participation of various sectors of government and the private sector in local health activities since health is assumed to relate with other socioeconomic considerations.

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It is argued in this article that this worldwide commitment has inspired the Philippines to introduce innovations in the Philippine administrative system to respond to the requirements of making a top-down service delivery system cope with the mission of empowerment. Thus, long before Osborne and Gaebler wrote about *Reinventing Government* in 1992, in the area of health, the Philippine government already started charting its course for reinventing. While the path was not smooth and easy, many approaches were introduced providing "seeds" to pave the way for accommodating new perspectives in a traditional bureaucracy.

Osborne and Gaebler outlined key features or approaches to reinvention to mean evolving: (1) a catalytic government that mobilizes other sectors to participate in service delivery rather than perform the function itself; (2) a community-oriented government that inspires the citizenry to assume an active role in governance rather than merely depend on government; (3) a competitive government concerned with measures of performance and outcomes using cost-effective measures; (4) a mission-oriented government committed to attaining new thrusts rather than merely complying with rules and regulations; (5) a results-oriented government which highlights accomplishments and effects on the community or target beneficiaries rather than merely assessing the economical and efficient use of inputs; (6) an anticipatory government that aims to prevent problems and not just to react to their occurrence; (7) a customer-oriented government that provides choices or alternatives not packaged programs; (8) an enterprising government, conscious about earning money, not just spending it; (9) a decentralized government which restructures the opportunities for decisionmaking at lower levels in the bureaucracy to enable itself to cope and be consistent with the mission of empowerment; and (10) a market-oriented government which actively scans or even creates demands like a business enterprise to ensure that the community's needs are immediately responded to or provided the requirements they need to prevent pressing problems.

This article focuses on the role of the Department of Health (DOH) as the key institution in introducing modifications in its system in order to harness the PHC approach. This also discusses the facilitative role of DOH under different periods, highlighting the role it played in interrelating with various sectoral offices, local government units and people's organizations. A subsequent part deals with the problems encountered in the implementation of PHC. The last part focuses on conclusions and issues confronting the implementation of PHC in the Philippines. Data were drawn from review of literature on the topic and actual involvement of the researcher in the propagation of PHC approach.

Periods in PHC Implementation and Approaches to Reconstruction

The implementation of PHC in the Philippines may be broken into various phases. The first phase, pre-devolution, was carried out under different dispensations. From 1979-1986, overall management of the executive branch of government was under the dictatorship of President Ferdinand Marcos. This is an interesting period of PHC history since it appeared inconsistent with the approaches and vision of a top-down mode of administration. Despite this setup, the DOH managed to introduce innovations and perhaps gained some headway, though not completely, because it was a technical bureaucracy which could have obtained the confidence and support of the President. As will be pointed out later, the repressive nature of the regime could partly account for the difficulty in launching the full essence of PHC. Nevertheless, many groundworking activities had been undertaken to modify some of the perspectives of the bureaucracy in dealing with the community and other sectors, both public and private. Thus, the process of reconstructing government was not a swift task. In the process, it installed new mechanisms which appeared inconsistent with the regime.

Under Marcos, pilot testing of PHC was conducted in selected areas around the country, until it was launched nationwide two years later.

The overthrow of the dictatorship through People Power Revolution saw the re-emergence of democracy in the Philippines and the installation of Mrs. Corazon Aquino as President in 1986. A new administrator at the DOH continued the effort to propagate PHC, although with a different mode or approach in implementation, this time highlighting the potential of nongovernment organizations (NGOs). A significant achievement of Aquino before the end of her term in 1991 was the passage of the Local Government Code which transferred many basic services functions to local government units. PHC was one of the functions devolved under the Code.

The assumption of leadership by President Fidel Ramos in 1992 carried many challenges since development initiatives started to be directed by local chief executives. Thus, the onset of the second phase of PHC history commenced with the implementation of devolution. Meanwhile, the DOH, instead of directly taking a hand in the mobilization effort, employed various strategies to "catalyze" local executives to assume the responsibility for overseeing the implementation of PHC. Three different executives at the DOH assumed the secretary's post. They had varying commitments to PHC which affected the technical and financial support for it. Nevertheless, professional civil servants continued to propagate the strategy indicating their motivation to sustain the effort inspite of the variable perspectives of their top executives.

Pre-Devolution

Pilot Testing Stage

Area Selection on the Basis of Need. The introduction of PHC commenced in 1979 by pilot-testing the methodology in one province in each of the twelve regions. A documentation of the implementation of PHC during this period by a study team (UPCPA 1982) revealed an important approach to ensure that the outreach of government was made in underserved areas. This was done through the selection of the twelve provinces on the basis of "need" such as low health personnel ratio, absence of any province-wide PHC activities and inaccessibility to the regional center. The second criterion was the receptiveness of the local government since a new methodology was to be implemented necessitating its support. The third was the presence of functional organizations for managing projects at the provincial and municipal levels. Still another was peace and order condition.

The identification of areas on the basis of need signified the conscious concern for addressing the issue of equity.

Social Preparation. Since the methodology was new, preparatory activities were conducted by the Department of Health among health and other sectoral implementors to highlight the need for collaboration with non-health sectors for effective utilization of resources. *This meant shifting gears to change the paradigm of a bureaucracy that was attuned to delivering services on its own to one that draws active support from other sectors.* Trainers were also identified at the provincial levels in order to echo the essence of PHC at the succeeding subnational level, the municipality. Thereafter, municipalities were expected to mobilize barangays, the lowest political unit of the local government.

Identification of Volunteers. An important component of preparatory activities for PHC was the identification and mobilization of voluntary health workers from the community. More popularly known as Barangay Health Workers (BHWs), these volunteers were envisioned to take charge of mobilizing the community to have an active role in health and related development activities at the level of the barangay. However, initial training modules only prepared BHWs to serve as health educators, first aiders and as referral persons to the public health delivery system (UPCPA 1982). Some of them even doubled as managers of the local drugstores called *Botika sa Barangays* despite initial difficulties encountered in operating them because fund support originated outside of the community such as barangay development funds and excess funds of an emergency hospital or local private capitalists.

Creation of Intersectoral Structures. Another mechanism to open up interface with the community, nongovernment organizations, local executives and other sectoral implementors of national departments was the mobilization of primary health care committees at the national and local levels. This was to ensure that planning, implementation and assessment of activities were drawn from the initiative of the community. However, the initial assessment of the extent of community participation during the earlier years of pilot testing revealed that community participation was not fully mobilized because packaged programs were the ones implemented at the barangay level like the then Ministry of Health's promotive and preventive health care projects (i.e., immunization and environmental sanitation, herbal gardening and disease control activities); Ministry of Education's mothers' classes, day care and feeding programs; and Ministry of Agriculture's income generating projects such as piggeries and fishponds. Community participation mainly came in the form of providing free labor or contributing monetary/material resources (UPCPA 1982: 63).

Some initiatives had already been documented on the interface of NGOs in DOH effort to mobilize the community. For instance, a religious organization called the World Vision was tapped to assist in the conduct of orientation seminars for BHWs and in identifying the BHWs in Region IV (UPCPA 1982: 23). In Region VIII, the U.P. Institute of Health Sciences served as the institutional base for health manpower training (UPCPA 1982: 27). In Region XI, the Davao Medical School Foundation, a consortium of medical schools and hospitals, was involved in the training of BHWs (UPCPA 1982: 30).

In some instances, community leaders such as the *imam* in Muslim areas were even tapped to serve as the chairman of the PHC. This experience was documented for Region XII.

Institutionalization

Bureaucratic Innovations. Nationwide implementation of PHC took place in 1981 under Marcos through the vigorous effort of the top leadership (Minister Jesus Azurin) at the health agency. Meanwhile, administrative innovations started to be put in place which could have facilitated the implementation of PHC. Undertaken on 2 December 1982, these enabled local field offices of the then Ministry of Health to have greater unity in pursuing health activities (Azurin 1988: 42-43). A key feature of the administrative context in the early years of PHC implementation was the integration of public health and medical services under one authority to oversee health management. Formerly, medical and public health teams had their separate enclaves and were not able to work together. Integration facilitated more

rational planning and maximization of services since duplication of efforts was avoided.

Apart from modifications in structural arrangements, allocation of resources was delegated to field health officers based in provinces and districts to give them a greater hand in the use of resources. Direct releases of the budget were made to the province and from the province, to the district manning a group of municipalities. This gave flexibility in the use of resources within the province and the district. These administrative innovations implied

> personnel movement within the service hierarchy and prevented the calcification of skills at the peripheral units. The decentralization of management, on the other hand, relieved central and regional staff of routine administrative work and enabled them to devote more time and effort to setting standards and monitoring and evaluating programs and projects (Azurin 1988: 45).

Identification/Preparation of Volunteers. Orientation programs for health workers were conducted nationwide. Three years after its institutionalization, PHC was initiated in 99 percent of the barangays (Azurin 1988: 68). Inspite of the existence of a repressive regime under President Marcos, a volunteer corps was tapped in every barangay through the Ministry of Health's initiative. A ratio of 1 BHW to 70 households was recorded as early as 1982. This even improved to 1:29 in 1986, at the close of the dictatorial rule (Bautista 1996b: 20). Assessments though of the nature of activities engaged in by BHWs revealed that rather than performing their role as community mobilizers they served merely as appendages of the national department's health workers in implementing the national health office's impact programs. As in the pilot testing years, BHWs assisted the field health workers in conducting health survey; the implementation of health programs like herbal gardening, planting vegetables, and cleaning surrounding areas; giving referrals for treatment to public health delivery system; and even extending simple cures for the sick. Nevertheless, inspite of this deficiency, the Ministry (now Department) of Health, could be remembered for having mobilized volunteers from the community who rendered services for free.

However, areas where BHWs actively mobilized the community to serve as active participants in local development activities were noted to have had better impact than areas which were not mobilized. For instance, twelve model barangays with high participation contrasted with 540 non-model barangays, demonstrated lower incidence of diseases (i.e., 6.9 percent of sampled households with intestinal diseases vis-a-vis 11.6 percent in non-model areas; 4.1 percent with influenza for the former as against 8.1 percent for the latter) (PCF 1986: Table 42). Subsequent assessment in twelve rural barangays also demonstrated better quality of life for sample households which were active participants in community projects related to health (Bautista 1988). Data

revealed 139 being ill per 1000 population who were actively engaged in community activities as against 153 per 1000 among those who were inactive (Bautista 1988). However, of the surveyed respondents in these barangays, only 20 percent had active involvement in community activities and only half of them were involved in the planning process. Thus, if ever there was involvement among members of the community, this was mainly in the area of implementation, and little in planning and monitoring/evaluation.

Perhaps, the initial effort of developing the capabilities of BHWs did not lead to their lackluster posture in community mobilization. Tapping volunteers who assisted regular healthworkers may be the most DOH could achieve under a repressive dispensation which began to be lambasted for witchhunting among community organizers of community-based health care initiated by NGOs.

Monitoring Using Indicators of Interface with the Community. A key contribution in PHC effort was the monitoring of the level of interface of the community in the conduct of activities. This indicated concern for process and results rather than inputs in assessing accomplishments. PHC was monitored until the last days of the Marcos administration. Information on level of PHC was gathered by the volunteer workers in cooperation with the field staff of the national health ministry. These indicators demonstrated measures on various levels of involvement of the community in local development management. For instance, Level I indicated exposure of community leaders and residents to training programs on PHC. Level II was marked by the existence of coordinative structures to steer community activities. Level III was distinguished for the existence of community projects. Level IV was indicated by the inclusion of community projects in the budgetary commitments of local government's development council, signifying the willingness of the local government leaders to commit their resources for health and related activities.

Validation of Indigenous Methodologies. Other forms of government support to the community to ensure that indigenous technologies flourish were the efforts to validate herbal medicines and the mechanisms established to propagate them (Azurin 1988: 80-82). Herbal gardening was encouraged to solve the existing shortage of supplies and the high cost of drugs. This program was supported through the dissemination of manuals, seedlings and plants. An herbal processing plant was established with government support in each of the three main islands of the country, allocating about 30 to 40 hectares to each site.

Oral Rehydration Therapy using oral rehydration solution (ORESOL) was a key innovation by the Ministry of Health (Azurin 1988: 81). This simple and inexpensive solution was proven effective in preventing diarrhea-related

deaths. As early as 1978, diarrhea was the second cause of death and illnesses among children below five years old.

Medicinal requirements of the locality were made accessible by further strengthening the Botika sa Barangay (drugstore for the barangays) (see Azurin 1988: 82). Municipal and barangay officials were oriented on the project to obtain their support. Thereafter, training of the Barangay PHC Committee was undertaken to make the community responsible for putting up its own BSB. Posters and leaflets were disseminated in order to propagate the value of setting up the BSB. A community volunteer was also tapped and trained (called the BSB Aide) in order to manage the community drugstore. Operating policies were propagated by the Ministry of Health in the early years of its operationalization such as: the selling price to be not more than 25 percent of the buying price of each drug; setting up capital fund of ₱1,500 by the community; submission of records of sales and purchases by the BSB Aide to the local PHC Committee; and utilization of the profits from the BSB in income generating projects of the community (40%) with the remaining to be divided among dividends for shareholders (35%), honoraria of BSB (35%), honoraria for committee members (10%), maintenance and transportation cost for the BSB Aide (10%), and return to initial capital (10%). However, the first five years of implementation of BSB were marred by such problems as dissemination of clinical samples which should not be sold; non-availability of drugs which should be sold; distribution of free medicines by the public health delivery system; non-availability of herbal medicines; and lack of support by the community (Torres 1985; Tan 1986; Uy and Sustento 1986).

NGOs as Conduits of Funds and as Chief Mobilizers for PHC. When President Marcos was deposed, President Aquino restored democracy in the Philippines in 1986. President Aquino brought about significant innovations in the Philippine administrative system which had ramifications in the implementation of PHC. One of the salient provisions in the new Constitution was the importance given to NGOs in the promotion of the nation's welfare.

At the Department of Health (DOH), the new secretary (Dr. Alfredo Bengzon) experimented on a new approach to implement PHC in the Philippines. This was the Partnership for Community Health Development (PCHD) which entailed the grant of financial assistance to NGOs to mobilize partnership efforts among local government units (LGUs), nongovernment organizations and people's organizations to undertake health and related development activities in the barangays. A peculiar feature in PCHD was the identification of projects which could be funded by DOH after proposals were formulated through the partnership effort of the LGU and the community. Thus, community participation in the preparation of the project proposal was a prerequisite for obtaining financial support for these activities. NGOs served as the conduit for these funds, apart from their role in mobilization of the

community for participation and preparing local government executives to engage in partnership with the community and NGOs.

An important feature of PCHD was the identification of marginalized areas prioritized for this support from the national government. They were the hard-to-reach areas because of the absence of access roads and communication facilities; underserved because of the limited number of health facilities and resources; depressed because of low productivitiy of crops and low income; and in critical condition because of peace and order problem and the existence of diseases.

PCHD also aimed to invigorate the implementation of the participatory strategy which was not fully realized in the previous dispensation because the BHWs served as mere appendages of the health delivery system.

Initial assessment of PCHD for the first two years of implementation of the first batch of provinces extended support, noted the following: established unity among community members as they had been harnessed to participate in planning, implementing and assessing these activities; improved access to health and other basic services in the community through the facilitation of community volunteer health workers who augmented the limited services of the midwives; increased understanding of the nature and prevention of diseases as the community identified and analyzed the root causes of the prevailing diseases; improvement in health condition; improved community environment through the beautification and sanitation projects; acquisition of skills and knowledge by key leaders, volunteer health workers and the barangay residents in organizational and health management and positive attitudinal changes and enhancement of value system for community participation (DPI 1994: 15-17).

Subsequent studies to determine the impact of PCHD in 64 barangays introduced to the methodology in 1992 pointed to the reduction of preventable diseases (like malaria by 50%, acute respiratory infection by 42%) by 1995 (Bautista 1996a: 64). An important finding was the direct or positive relationship noted between community participation and the reduction in the diseases experienced in these barangays, from the baseline year to the assessment period (Bautista 1996a: 79).

The First National Convention of NGOs was conducted by the DOH in 1991. This was symbolic as it ushered in the DOH Policy on Collaboration Between Public and Private Sectors on Health Policies and Programs through the passage of Administrative Order No. 112 passed in 1991. This policy indicated the significance of "close collaboration between the public and private sectors as an essential thrust in the health field" (Section 9 d1). This was to be expressed in the form of "consultations, participation, partnerships,

alliances and various kinds, levels and scopes of mutual involvement between government entities and entities in the private sector" (DOH 1991). For this purpose, a special unit of the DOH (Community Health Service) was created to strengthen this collaborative effort.

Incentives for Community Involvement. In order to motivate community participation in local governance, various incentives and measures for motivation were implemented by the DOH. Under the term of former Secretary Bengzon (DOH 1994), these included the provision of incentives to BHWs such as free medical and dental check-up, blood typing, supply of drugs and medicines, laboratory examination and tetanus toxoid immunization. Income generating projects were also encouraged through the provision of financial grants to federated BHWs for livelihood as a means to augment their incomes and to prevent turnover.

Nationwide search for innovative efforts of both government and NGOs for participatory development management was also launched through the support of an affiliate organization of the DOH, the Health and Management Information System, a project supported by the German Agency for Technical Cooperation. This paved the way for giving recognition to successful partnerships between government, NGOs and POs in health and related social development activities and implementation of participatory strategy.

PHC Under Devolution

Implications of Devolution on PHC

Close to the end of President Aquino's term, the Local Government Code of 1991 was passed and thus transformed the Philippine administrative system into a devolved setup. This in effect transferred the responsibilities for primary health care, among others, to local government units. Direct responsibility for PHC is now to be assumed by mayors of municipalities and cities. Continuity of PHC can be assured through the transfer of the national health personnel to local government units. Nevertheless, local chief executives still remain to be the chief mobilizers for PHC as mandated by the Code.

One of the fears in devolving PHC was the lack of understanding and appreciation by local chief executives of health services and more so, of PHC as an innovative strategy. A pre-assessment of some 120 municipal/city mayors invited to participate in a seminar on PHC conducted by the College of Public Administration from June to July 1996 showed about two percent having an understanding of PHC and they were doctors. The rest considered PHC as a program for promotive and preventive health care rather than as a management strategy.

An important development under the current administration which could facilitate the implementation of PHC is the launching of the Minimum Basic Needs (MBN) approach as the management technology for supporting the Social Reform Agenda to improve the quality of life of the poorest of the poor. One of the key strategies in the MBN approach is community-based strategy, a major strategy in PHC. Practically all programs of government which could provide services to address the basic needs are mandated to subscribe to the MBN approach, thus making the participatory strategy a general commitment of national and local government units.

Furthermore, MBN approach also espouses convergence methodology, which is akin to intersectoral collaboration subscribed to by PHC. The convergence approach only differs from intersectoral collaboration in the sense that it directs local government units, national government agencies, nongovernment organizations and people's organizations to focus their efforts on agreed upon services to address the plight of targeted groups of marginalized people (e.g., women, children, elderly, handicapped, farmers, fisherfolk, ethnic communities). The MBN—a set of services catering to the problems of survival, security and enabling needs—adopts a common framework addressed across different sectors. A total of 33 requirements to meet these needs were determined from national and regional multisectoral workshops.

MBN is considered important in determining the marginalized individuals and families since it could provide the standards for their determination.

Mechanisms for Propagating PHC Under Devolution

Capability Building. Since the responsibility of the national office is mainly that of advocacy, one of the mechanisms to ensure that local chief executives appreciate the value of PHC is the conduct of workshops to propagate the essence of PHC. At present, the College of Public Administration of the University of the Philippines assists in the conduct of these seminars to convey the meaning of PHC. These seminars incorporate orientations on PHC, community organizing and how PHC is linked with the current program of the government for poverty alleviation, the Social Reform Agenda.

Furthermore, the DOH national office also saw the need for its regional PHC coordinators to establish networking activities with local chief executives to appreciate the meaning of PHC. Thus, a retraining program for regional field staff was started and continues to be undertaken at present. This was initiated by the first secretary under the Ramos administration who had a

strong commitment to enforcing "health in the hands of the people." Although the subsequent secretary did not have as much commitment to PHC, strong advocates of PHC among the professional civil servants urged the continuation of this motto.

The retraining incorporates a module on community organizing to ensure that emphasis is given to this critical process in propagating PHC since its real meaning was not fully captured in previous efforts. Another module on social mobilization is also being offered to recast the field staff's role in advocating PHC through local government units, rather than proceeding to the community residents directly. In the social mobilization module, the DOH field staff is equipped with skills in networking, building alliances, policy advocacy, and development of information education communication (IEC) materials.

Support to LGUs Through NGOs. One of the mechanisms DOH continues to maintain is the grant extended to NGOs to undertake Partnership for Community Health Development. The current dispensation sustains its support to PCHD in order to provide assistance to LGUs which are not able to employ the participatory methodology in their area, especially in marginalized locations.

Other functions retained by DOH to propagate PHC was the provision of support for innovative strategies. One such example was the grant extended to cooperatives to engage in the operation of drugstores in order to reduce the cost of drugs in a locality and to generate resources for other health activities in the locality. This was fostered through a memorandum of agreement between the Cooperatives Union and the DOH (Bautista 1996b).

Policy Formulation. One of the chief responsibilities of the DOH is to formulate policies to propagate PHC. One of the policies which had been passed under devolution was the Barangay Health Workers' Incentives Act or Republic Act 7883 of 1995 directing LGUs to provide subsistence allowance for BHWs as they cater to peripheral areas or hazardous areas. Non-monetary incentives are also to be granted like giving credits for BHW experiences for professional education (i.e., nursing and medicine), providing continuing education, tuition fee benefits to a child of a BHW in a state college if not availing of continuing education benefits personally, giving civil service eligibility for five years continuous service, providing free legal service in connection with one's duty, and access to loans for community based activities.

The DOH, through its Community Health Service, facilitated the conduct of dialogues with national/local government representatives, NGOs and people's organizations to formulate the implementing rules and regulations for this policy.

While the monetary incentive was the most contentious among the provisions of this legal mandate because of the opportunity for political maneuverings by local executives, non-monetary incentives did not get as much flak from various sectors.

Research/Documentation. Because of the transfer of responsibility of PHC to LGUs, one of the problems encountered by DOH is the lack of information regarding the status of PHC implementation. At present, it is still advocating the significance of having local government units transmit information about the health situation in their respective localities but this has not been fully responded to at the moment. Thus, one of the mechanisms it has adopted to ascertain the extent of implementation of PHC is the conduct of researches subcontracted to private institutions to determine the status of PHC. This project is in the negotiation stage.

An innovation in research management is the transfer of funds for research to regional offices to give an opportunity for localities in the region to get involved in the conduct of research. In fact, capability building activities were undertaken for academic research and government institutions in the region for health research studies, both in their biomedical and social dimensions.

Problems/Issues

The implementation of PHC has not been spared from problems and difficulties. One difficulty was the political will of the top leadership of the Department of Health for the continued implementation of PHC. Over time, commitment to PHC has not been sustained by some leaders. Some vacillated and did not give their full endorsement to PHC. This was demonstrated by a lack of concrete policy for PHC and by the emphasis given to curative care. Nevertheless, the lackluster posture of some of the top leadership did not mean elimination of continuing effort of offices responsible for PHC, indicating perhaps the internalization of the perspective among the staunch advocates including professional civil servants.

Another problem is the passage of the Barangay Health Workers' Incentives Act. The provision of monetary incentives violated the principle of volunteerism and could be a tool for politicking by local executives since the volunteer workers could be beholden to them instead of the community. On the other hand, provision of monetary incentives could also be a burden to local executives, especially in marginalized areas with meager resources.

The transfer of responsibility of PHC to local chief executives under devolution is definitely not easy. PHC could not be fully achieved if the

bureaucracy itself is not empowered. With devolution, there is greater opportunity to make programs and services more relevant since the chief executive is locally based. Furthermore, linking with the people could also be facilitated since the local chief executive directly controls/oversees the locality. Nevertheless, much effort has to be undertaken in order to shift the paradigm of local executives who are not attuned to social development considerations. Furthermore, making them shift their perspective to serve as "facilitator" and "enabler" of development activities requires time and mobilization cost.

Shifting monitoring and assessments to capture accomplishments about process rather than outputs, short-term effects and impact requires reorientation of national and local government units. PHC as a strategy necessitates appreciation by all sectors and understanding of the participatory methodology infused in the different phases of the management cycle: situation analysis, planning, implementation, and monitoring/evaluation. This also implies appreciation of the problems in the realization of this strategy.

Conclusions

In the implementation of PHC in the Philippines, innovative methodologies were propagated through nationwide commitment to participatory methodology and intersectoral collaboration. This commitment set the tone for the then Ministry (now Department) of Health to initiate modifications in dealing with the citizenry. The commitment of the top leadership of the Ministry of Health facilitated the propagation of these methodologies nationwide. In the early years, these methodologies were pilot tested in peripheral areas. Mechanisms to launch the new methodologies included: preparation of the bureaucracy to change its orientation; the mobilization of the community to select its volunteers as partners of the Ministry of Health in undertaking its activities for promotive and preventive health care; the creation of multisectoral structures at the national and local levels to ensure that health was woven into the socioeconomic development of the community; support of the propagation of indigenous technologies through their scientific validation; and interface of nongovernment organizations in the conduct of capability building activities. Thus, in the pilot testing years, Ministry of Health already pioneered in the reinvention of government which in Osborne and Gaebler's terms was: "catalytic" for interfacing other sectors; "community-oriented" since the citizenry is inspired to assume an active role in governance; "proactive" because of Ministry of Health's emphasis on promotive and preventive health care; and "customer-oriented" as it highlighted the community's indigenous technologies in local health management.

The institutionalization phase which began in 1981, saw the propagation of the aforementioned approaches. New methodologies had been added such as

the formulation by the Ministry of Health of process-oriented indicators for monitoring the status of PHC implementation; harnessing NGOs as the mobilizers of the community as they had notable experience in community organizing; harnessing NGOs as conduits of funds for community-based activities; and providing incentives to voluntary workers to prevent turnover. Thus, additional modes of reinvention which were manifested during this period included Osborne and Gaebler's typologies like provision of incentives/ rewards to community participants and interfacing of other sectors (e.g., NGOs) as mobilizers and conduits of funds. An additional feature was the improvement of monitoring system by inclusion of process indicators.

Launching of devolution through the passage of the Local Government Code at the close of the term of President Aquino in 1991, transferred to LGUs the responsibility of overseeing the implementation of PHC. This implied a new posture for the national office in carrying out its role in propagating PHC. Prior to devolution, it had a direct role to play in mobilizing the community, nongovernment organizations and other national agencies to interface with its field staff for health and related activities. With devolution, mobilization could not be directly undertaken by national agency for the community. Local chief executives are now directly responsible for overseeing the community activities and steering them to self-initiated efforts.

New activities were undertaken by the national health agency under a devolved setup. One activity which was started and is still being carried out at present is the reorientation of field staff of the department to modify its posture in relation to local government units—that its role is to mobilize local chief executives to carry out PHC methodologies. Second, it has also started to link up local chief executives by conducting seminars to orient them on the essence of PHC. Third, it has continued to provide financial grants to nongovernment organizations to facilitate PHC. Other functions it has performed are policy formulation and the conduct of research for PHC. Academic research communities have assisted in the conduct of the latter functions since new management interventions have been incorporated apart from the technical aspect of health.

More challenges are in store in coping with the changing demands of devolution and to ensure that the national agency only "steers" but does not "row the boat" for local government units.

Some critical issues include:

1. How do we maintain the balance between technical support and local initiative? The long history of the national department to implement the PHC methodology provided it much insight towards the effective implementation of the methodology. However, how

much mobilization could be undertaken without stifling local initiative?

2. How much change has to take place in national accounting rules and procedures to accommodate social mobilization efforts of national staff which could often be undertaken beyond regular office hours? Social mobilization requires some accommodation for flexibilities in schedule and modes of operation.

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