Bounded Pluralism: Politics and Participation in Health Policymaking

ENRIQUE NIÑO P. LEVISTE

Abstract

This article describes the dynamics of politics and participation in a Philippine locality by examining how the health policy process works in the context of decentralization. Data from key informant interviews and observations of actual health policymaking and implementation activities show that the rise of new venues of power in a locality, such as the professional, educational, socio-civic or cultural, and religious sectors, will not necessarily translate to active private sector involvement in health policy-making. This is primarily due to the nature of everyday politics.

Introduction

Decentralization refers to the deconcentration of power, functions, and responsibilities to the regions and lower level political communities to facilitate the attainment of development goals and objectives (Legaspi 1995). This arrangement ideally legitimizes pluralism or the distribution of power among various interest groups, and provides specific mechanisms for the flourishing of non-government participation in government affairs. Likewise, decentralization reflects the desire to involve the people, suggesting the expediency of decentralization in making significant inroads insofar as multisectoral involvement in public sector endeavors is concerned (Brillantes 1990). Scholars (Karaos 1997; Porio 1997; Tapales 1996) further state that decentralizing government functions affords local officials and other stakeholders relative autonomy in both administrative and political matters. They hint that this devolution of administrative and political power will subsequently give other venues of power increasing recognition.[1]

Policy analysts such as Aziz and Arnold (1996) also recognize the urgency of people-initiated programs and policies. They assert that popular participation is needed in order to effectively address social issues. Aziz and Arnold (1996) maintain that a decentralized governance system provides a helpful environment for arriving at conclusions that are consistent with the general welfare. They posit that non-government intervention could neutralize the detrimental impact of excessive politicking in the public sector, since various private sector groups will be scrutinizing domestic policies and programs that public officials are funding and implementing.

On a similar note, Burns, Hambleton, and Hoggett (1994) underscore the need to encourage public involvement and improve communication and responsiveness among government and private sector participants. Hence, the enactment of the Philippine Local Government Code of 1991 (LGC) rests upon the fundamental premise that governance should be a shared undertaking among national and local-level administrators, as well as public and private stakeholders. The LGC was established to empower local government units (LGUs) to function effectively as separate administrative and political entities from the national government, and ensure that decision-making safeguards the welfare of those who are likely to be affected by such decisions.

Concomitantly, however, efforts within the context of the 1991 LGC to increase local participation, operate in the context of, and are to a certain degree stymied by, socioeconomic and political factors beyond its control. These raise doubts among certain sectors as to the efficacy and sustainability of decentralization. As Angell, Lowden, and Thorp (2001: 223) caution, the optimism surrounding efforts to devolve administrative functions should 'be tempered with equal recognition of the continuing obstacles to this happening in all places or at all times'.

Delving into the health policy process in the City of Calapan in the Province of Oriental Mindoro, this paper then intends to examine private-sector participation in policymaking as regards health initiatives, identify the major stakeholders in policymaking, and come up with insights on shared health governance. While the paper acknowledges the importance of evaluating the impact of devolution on the implementation of specific health programs and projects, it is however, limited to an exploration of the dynamics of health policymaking in Calapan.

Data

I made use of both primary and secondary data for this study. Primary data were derived through semi-structured interviews with 35 key informants (KIs). The key informants—people either directly or indirectly connected with city government and barangay (or community) health sectors—included the City Health Officer (CHO), community health administrators [barangay health workers (BHWs), barangay nutrition scholars (BNSes) and midwives], the Mayor, barangay officials, and other community leaders.

The interview schedule comprised topics on local health issues, city-level and barangay-level health programs and projects, and actual health policymaking in the City of Calapan. Data on devolution, local politics and 'influentials' (people

perceived to be influential in their respective fields), and non-government participation vis-à-vis health activities were also documented.

Secondary data such as annual health reports and policy papers were obtained from the City Census and Health Offices. To further supplement knowledge on the workings of the local government health sector in the area, I also attended several health policy planning sessions with the CHO, members of the Local Health Board (LHB), and barangay health committees (BHC).

I chose two rural barangays or communities —Canubing II and Parang— as specific research areas. These barangays were selected in view of the high number of potential key informants residing in these areas, and health programs and projects being implemented therein.

The 1991 Local Government Code and Health Service Delivery

Some Changes Brought About By Devolution

Prior to the 1991 LGC, government functions were centralized—the national government was essentially an overarching institution that supervised, if not monopolized, a multitude of activities ranging from the identification of priorities to the generation of funds for the implementation of programs and projects. Such highly integrated system of governance made LGUs 'mere agents for the implementation of national policies' (Tapales 1996: 214). Likewise, since no legitimate mechanism provided public sector institutions with administrative autonomy to craft their own policies and programs, these LGUs were unable to fend for themselves. Non-government sectors also remained at the fringes of development and lacked a voice in governance because they did not have a guiding principle that allowed involvement in public sector undertakings. Simply put, local participation, dramatized mainly as private sector intervention in government, was minimal, if not entirely non-existent.

Health service delivery during pre-devolution years was likewise vastly centralized. Atienza (2004) points out that the Department of Health (DOH) presided over a national delivery structure that catered to all local government units, with the exception of a few chartered cities. In addition, the early attempt to establish community-based health programs (CBHPs) and legitimize the participation of non-government sectors in service delivery fell short of realizing its full potential because of the dearth of institutional imperatives to support it and the sociopolitical climate during the Marcos regime.

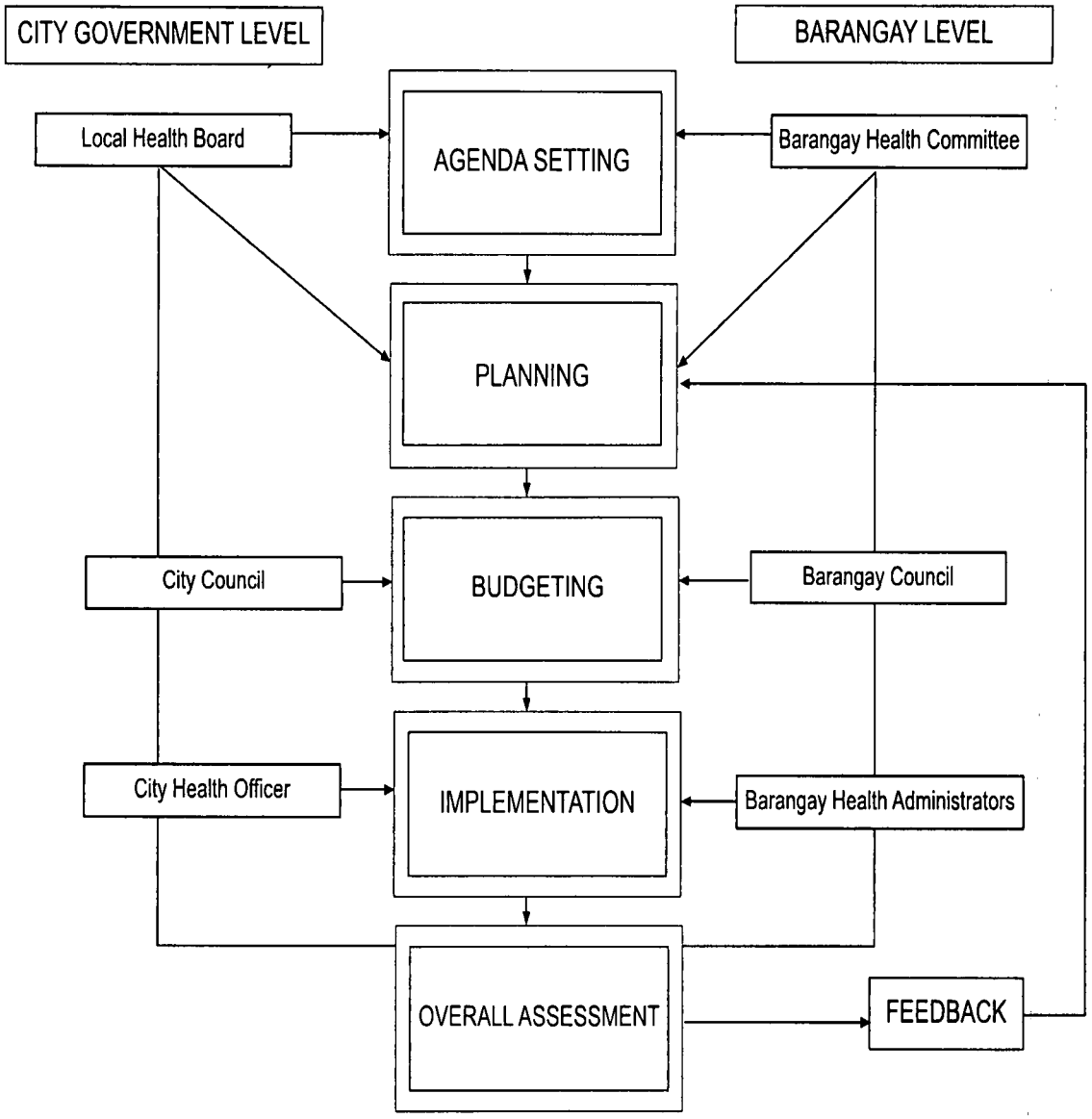
Academicians and political observers (Atienza 2004; Bossert and Beauvais 2002; Lieberman 2002; Brillantes 1999) claim that the 1991 LGC was a response to the limited prospects for social development brought about by overly centralized government mechanisms and that it was a necessary first step toward democratization. When the 1991 LGC took effect, decentralization ensued albeit gradually. Key government functions, including health service delivery, were eventually devolved to local government units, providing these institutions with substantial political and administrative authorities to function effectively. While the national government, through Congress, remained considerably in control of the preparation and distribution of general appropriations, local government units were now capable of financing and implementing domestic social programs through internal revenue allotments (IRAs)[2]. Certain provisions contained in the 1991 LGC also allowed the participation of non-government sectors in governance.

The health devolution in 1991 altered immensely the structure of the public health system, with local governments gaining significant powers and responsibilities particularly in overseeing the operation of health institutions such as public hospitals, rural health units (RHUs), municipal health centers, and barangay health stations (BHSs). Health devolution also paved the way for the establishment of mechanisms that would legitimize non-government participation in the policy process. The formation of advisory bodies such as the LHB and BHC offered certain sectors, other than public officials, an opportunity to participate in decision-making and created a much wider base from which to obtain concrete steps at addressing local concerns. Lieberman (2002) links the potential benefits of decentralizing health service delivery to 'the closer interaction between health service providers and consumers which would lead to the provision of health services that are more differentiated and better targeted to local needs'.

The Health Policy Process Under a Devolved Set-up

Devolution empowers LGUs to create local health policies and programs according to specific community demands. Tordecilla (1997) notes that the devolution of the planning process was one of the major reforms introduced by the 1991 LGC. Under a devolved system, there are two interdependent health policy processes at the local government level—health policymaking at the provincial, city or municipal government and barangay levels. For this study, I focus on health policymaking at the city government and barangay levels. Figure 1 presents the aforementioned processes, highlighting the stages and the participants in each stage.

Figure 1. City Government-level and Barangay-level Health Policy Processes



Source: City Health and Sanitation Department, City Government of Calapan

The first stage in city-level health policymaking is setting the agenda. In this initial stage, the LHB, which is the policy advisory and recommending body, holds a special meeting to identify specific health programs to be prioritized. The CHO, serving as the Mayor's deputy and vice-chairperson of the board, and the chairperson of the city health committee, are asked to provide a detailed assessment or evaluation of the health sector's performance during the previous year. With this assessment comes the identification of projects, as

well as aspects of health service delivery that require further improvement. Once problem areas are identified, members of the LHB then plan appropriate and viable measures to be taken and draft a city health plan. The health plan's contents include objectives and projected outcomes of health programs, proposed budgetary allotments for each health project, the agencies involved in implementation, the timetable of operations, and the intended beneficiaries. The planning stage culminates when the LHB submits the City Health Plan to the *Sangguniang Panlungsod* (SP) or City Council for preliminary budget evaluation. This document later becomes an integral part of the City Development Plan, a comprehensive outline of the City Government's infrastructure and social development agenda.

Budgeting, undeniably a critical stage, occupies most of the City Council's work. It is further divided into sub-stages that include budget preparation, budget authorization, and budget execution. After the budget has been executed, the final stage—the implementation of health projects—commences upon the LCE's approval.

Barangay-level health policymaking follows a similar pattern. Agenda setting and planning are the first two stages of the process. The BHC, a body composed of barangay officials and health administrators (barangay health workers, barangay nutrition scholars, and midwives), acts as a community counterpart of the LHB, providing baseline information on a variety of topics, from domestic health issues to feasible health programs. As an advisory body, the BHC oversees the setting of priorities with regard to health, as well as the crafting of the Barangay Health Plan. Like the City Health Plan, the Barangay Health Plan also presents the health projects the community intends to pursue, as well as the beneficiaries, goals, and objectives of the programs, the timetable, and the estimated costs of the projects. After finalizing the details of the plan, the BHC submits it to the *Sangguniang Barangay* (SB) or Barangay Council (BC) for initial deliberation, a prelude to budgeting.

The budget process at the barangay level is just as lengthy as city-government level budgeting. It starts with an assessment of the community's financial capability and ends with a written report to the City Budget Officer (CBO). Execution of the proposed community budget follows upon the endorsement of the City Council in a written resolution and upon the final approval of the Barangay Chairperson.

The City of Calapan: Improvements and Unchanging Patterns in Health Service Delivery after Devolution

The City of Calapan is a predominantly agricultural area located at the

northeastern section of the Mindoro Island, approximately 28 nautical miles off the nearest point of the Province of Batangas. It was converted from a municipality to a city by virtue of Republic Act (RA) No. 8475. It is the capital of the Province of Oriental Mindoro and serves as its center of commerce and education, as well as the seat of government. Calapan has a total land area of 250,006 hectares, or 250.06 square kilometers, and consists of 62 barangays, 22 of which are classified as urban and 40 as rural. The projected total population of Calapan in early 2005 was 116,230, 44 percent (50,894) of which were forecasted to be urban and 56 percent (65,336) rural.

Despite its development potential, Calapan has long experienced administrative neglect. Key informants claimed that infrastructure projects and social development programs in the 1970s and 1980s were few and unsustainable. The delivery of health and other basic services and the monitoring of these activities were also poor. They added that the inability of local officials to govern conscientiously and efficiently, the inadequacy of monetary support, and the prevalence of corruption, further compounded the town's predicament. There was also a high level of indifference among both non-government sectors and residents, and barangays were mere recipients of political good will.

Gradual reforms began in 1995, four years after the 1991 LGC's enactment. A month into his first term, Atty. Arnan Panaligan, then newly elected mayor, attempted to broaden multisectoral participation in local government affairs by introducing a community-based approach in addressing development issues and providing basic services. In line with this new administrative strategy, the mayor made health service delivery one of his top priorities by empowering barangay officials, barangay health workers, and other health personnel. To do this, he institutionalized local training programs and health awareness classes, and funded health infrastructure projects. In 1998, efforts to improve the local health sector intensified with the conversion of the town into a component city and the subsequent augmentation of health appropriations. The mayor and Dr. Basilisa Llanto, the CHO, successfully spearheaded the planning and implementation of various health programs and projects from 1995 to 1999 under a devolved set-up. These health initiatives included environmental sanitation, nutrition (with special emphasis on mother and childcare), dental health care, manpower development, and improvement of health infrastructure. Table 1 summarizes these programs and projects.

According to the CHO, the devolution of health functions in Calapan provided the groundwork for greater cooperation and a more productive partnership

Table 1. Summary of Health Programs and Projects in the City of Calapan, 1995-1999

HEALTH PROGRAM/PROJECT	IMPLEMENTING AGENCY
Environmental Sanitation	
• Food sanitation	CHSD
• Waste disposal	CHSD
• Provision of safe water	CHSD/CEPWD
• Provision of sanitary toilet facilities	CHSD/CEPWD
Dental Health	
• Isang Milyong Sepilyo Program (One Million Toothbrushes)	DOH, Provincial Health Office (PHO)/CHSD
• Dental health education	DOH/PHO/CHSD
• Training of dental health personnel	DOH/PHO/CHSD
Nutrition	
• Food assistance program	CHSD/Department of Education (DepEd)
• Home and community food production	CHSD/DepEd/Office of the City Agriculturist (OCA)
• Micro-nutrient supplementation	CHSD
• Credit assistance program	CHSD/ City Social Welfare and Development Department (CSWDD)
• Nutrition education	CHSD/CSWDD/DepEd/OCA
Health Equipment and Infrastructure Development	
• Construction of laboratory	CHSD/CEPWD
• Purchase of laboratory equipment	DOH/CHSD
• Construction of City Hospital (planning stage)	CHSD/CEPWD
Health Personnel Development	
• Hiring and training of government health personnel, barangay health workers (BHWs) and barangay nutrition scholars (BNSes)	DOH/CHSD
Maternal Care	
• Mothers' classes on maternal care	CHSD
Other Health-related Programs and Projects	
• STD/AIDS Prevention	DOH/CHSD
• Family planning	DOH CHSD

Source: City Health and Sanitation Department, City Government of Calapan
Note: Health programs and projects from 2000-2004 were not available when the research was conducted.

between the local chief executive and barangay officials in health policy-making. While the mayor, through the City Health and Sanitation Department (CHSD), remained at the forefront of health policy implementation, the CHO observed that

there were counterpart initiatives coming from barangays because these entities have been administratively and financially empowered. Barangay officials like Felipe Evangelista and Roberto Garcia agreed with the CHO and emphasized that the development of health programs, and the relatively efficient manner by which these programs were implemented, would not have been achievable without devolution. They asserted that, to a certain degree, the distribution of health functions proved instrumental in terms of enhancing health service delivery in their areas.

Key informant accounts suggest that the city government, in its efforts to improve health services and hence, the quality of life of the people, took advantage of the responsibilities, opportunities, and powers provided by the 1991 LGC, as well as the benefits of becoming a city. In short, the city's greater administrative autonomy and economic potential permitted a more extensive and efficient flow of health services to barangays.

The Health Policy Process in the City of Calapan: The Politics of Decision-making and Participation

Key informant accounts show that public sector decision-making in the city is highly politicized. Key informants stated that politicians and high-ranking health personnel have noticeably dominated decision-making in crucial stages of the health policy process, for instance, planning and budgeting. Private sector participants, if any, have been limited to private medical practitioners and people perceived to be economically and politically influential. And, notwithstanding significant inroads made in health service delivery, key informants also admitted that politics determines the type of health program or project to be prioritized, the amount to be earmarked, and the extent of private sector participation. They declared that, apart from necessity and sustainability, health programs and projects in Calapan from 1995 to 1999 were planned and funded on the basis of political expediency. Barangay officials allied with the mayor for instance, readily got his nod insofar as lobbying for additional funds for health projects was concerned. Moreover, comprehensive health programs like environmental sanitation and nutrition were more prevalent in densely populated and vote-rich barangays.

Key informants also asserted that the increase in general health appropriations from P6 million to P8.7 million in 1998 indicated the mayor's recognition of the CHO's political influence. They pointed out that the mayor distributed health insurance cards to selected beneficiaries in accordance with the national government's health agenda, and in anticipation of the 2001 local elections. They added that the influx of health projects in communities

likewise ensured political legitimacy for barangay officials in their respective areas of jurisdiction.

In effect, a blurring of the health policy process as envisioned in a devolved health sector has occurred. Accounts of informants show that social forces, more specifically political forces, have frequently, and at times glaringly, compromised health policy-making.

At the same time, certain areas in health policymaking remain inaccessible to non-government institutions despite decentralization. Budgeting, a highly critical stage in policymaking, is still 'a public function exclusive to the local government' (Salvador n.d., as cited in Tumbaga 1997: 29). This implies the confidentiality of matters taken up during budget deliberations. According to key informants, such a limitation occasionally presents problems insofar as ensuring clarity in the allocation of resources for health projects and understanding the underlying reasons for certain discrepancies in fund allotments are concerned. While there have been attempts at extending private sector participation to the 'backroom' of budgeting, key informants confessed that discussions on monetary considerations in city-level and community-level affairs, sensitive issues altogether, were frequently undisclosed. Furthermore, the CHO has acknowledged that such exclusivity gives members of the city and barangay councils more control over the entire budget process.

Besides budgeting, reports of barangay health workers reveal that non-government participants comprised mainly of individuals previously employed in the health sector or people knowledgeable in domestic health issues. The CHO shared a similar observation and stressed that this has discouraged individuals from sectors such as agriculture, business, and education, to develop genuine concern for health matters. Hence, the support base for people tasked to attend to basic health needs has been limited, contradicting claims of the Code's genuine efficacy in empowering the private sector to participate in the process.

The Calapan Influentials: The Participation-Power Disparity

Key informant accounts reveal a huge difference between actual participation in the health policy process and perceived individual influence. These accounts support claims that non-government involvement in health decision-making remains negligible despite devolution. Table 2 presents the number of city-level and barangay-level influentials. In this context, influentials are individuals who are perceived by key informants to be influential in their respective areas of interest or chosen fields. Spheres of influence include political, economic,

Table 2. Classification of City-level and Barangay-level by Area of Influence

Area of Influence	City	%	Barangay	%
• Political	26	15	39	24
• Economic	32	20	15	9
• Professional	46	27	31	19
• Educational	19	11	27	16
• Socio-civic or cultural	21	12	25	15
• Religious	25	15	28	17
TOTAL	169	100	165	100

Source: Key informants (Mayor, CHO, BHWs, BNSes, midwives, *barangay* officials, and other community leaders)

professional, educational, socio-civic or cultural, and religious fields.

The total number of city-level influentials totaled 124[3] and barangay-level influentials numbered 101. Findings show that the highest number of influentials at the city level comprised of individuals who derive their influence from their professional and economic status, whereas political and professional influentials were the majority group at the barangay level. At the city level, educational influentials were the lowest in number while at the barangay level, the economic influentials are the least in number.

Although political and economic influentials figure prominently in the barangay and city, the considerable number of influentials in areas of activity other than these spheres indicates that there are other perceived venues of influence or power at both city and barangay levels. These figures further hint on the emergence of reputedly influential individuals coming from the professional, educational, socio-civic or cultural and religious sectors, reflecting the existence of relatively new power centers. These new centers 'can potentially compete with and check economic and political dominants' (Miralao and Dacumos 1969: 117). The presence of new power groupings signals that decision-making and involvement in various community activities are not necessarily limited to individuals belonging to the economic and political sectors of society.

Table 3. City and Barangay Participants in Health Policymaking and Other Health Related Activities After Devolution

EMPLOYMENT SECTOR AND POSITION	CITY-LEVEL	%	BARANGAY-LEVEL	%
Public Sector				
• Elected officials	13	36	16	30
• Other officials	12	33	3	5
Private Sector				
• Heads of private institutions/organizations	5	14	0	0
• Business/Professional	6	17	2	4
• Health administrators (BHWs, etc.)	0	0	33	61
TOTAL	**36**	**100**	**54**	**100**

Source: Key informants (Mayor, CHO, BHWs, BNSes, midwives, *barangay* officials, and other community leaders)

However, accounts also reveal that only a few of these influentials were actually involved in health decision-making (refer to Table 3). Only 20 percent of city-level influentials are participants in city-level health decision-making. Two-thirds of these participants worked in the public sector, while the rest were private sector individuals. Half of the public sector individuals were politicians, while the rest were officials in the government health sector and the Department of Education (DepEd). In turn, the private sector participants consisted of private school principals, private medical practitioners, a banker, and an NGO head.

A higher number of influentials (33 percent of the total) participate at the barangay-level health decisionmaking. Thirty-five percent of the barangay participants were public officials (e.g., politicians and national government health employees stationed in the barangay) while the rest were private sector individuals. The private sector individuals were made up of midwives and BHW.

The number of health activity participants suggests that more public sector people, as opposed to non-government individuals, were involved directly in city-level health activities. Decision-making in city-level health activities, however, was distributed among a larger number of people since participants from private institutions and from the business and professional sectors have emerged. Figures further

reveal that the number of non-government participants engaged in barangay-level health affairs was greater than the number of those in government. In spite of private sector involvement, however, decision-making in barangay-level health activities was generally limited to public officials and individuals whose expertise were health-related.

Furthermore, there are overlaps in participation on both city and barangay levels. The overlaps in participation hint on the presence of individuals who have participated in more than one health activity or have performed more than one task. Overlapping is more pervasive in the barangays, where only two groups—public officials and community health personnel—exert influence over barangay decision-making on health affairs.

Accounts likewise indicate that an individual's involvement depends upon the type of issue being addressed or the tasks being performed. Financial matters or issues pertaining to the disbursement of funds for health projects on both levels, for instance, are entirely public sector concerns, while less controversial issues such as project implementation are relatively more open to non-government involvement.

All in all, the aforementioned findings have implied that both city and barangay-level power structures tend to veer away from a strictly elitist condition. The relatively substantial number of city and barangay influentials engaged in various fields of specialization has attested to the emergence of new venues of influence or power other than the economic and political spheres. However, accounts have likewise shown that participation does not necessarily translate to power or that influence does not guarantee active involvement.

In addition, actual involvement in health affairs varies depending on the nature and implication of issues concerned. This discrepancy further suggests that there are instances when private sector participation in health affairs, particularly in health policymaking, is constrained.

Conclusion

Pluralism refers to the sharing of power among various interest groups. It suggests that power is diffused so that no one group wields total power over others. The 1991 LGC was enacted to institute a pluralistic approach to governance. It rests upon the basic assumption that decentralizing administrative and political functions and responsibilities can effectively spur development at different societal levels.

In line with the LGC's major objective, the City Government of Calapan has recognized the significance of creating a direct link, in terms of health policymaking, between the public and private sectors. It

has intended to widen the field of decision-making participants by encouraging non-government intervention in health. However, attempts at institutionalizing a pluralistic approach has remained bounded or limited by social realities the LGC is unable to abate.

The study, in fact, confirms that factors independent of the LGC impinge on the extent of private sector participation in the health policy process in Calapan, hampering devolution. Accounts and actual observation of steps taken in creating health programs or projects in both city and barangay levels have shown that class and politics—viable sources and effective conduits of power—determine the degree of a person's involvement in public sector activities and influence the relationship between policymakers and private sector stakeholders. Specifically, the study reveals that private sector participation in health policymaking and other health-related activities via the LHB and BHC relies heavily on credentials, emphasizing the importance of an individual's educational attainment and familiarity with health issues. Without abandoning the importance of setting strict standards in government to ensure efficiency, various accounts from the study sites have shown that a credentialist approach limits, if not hinders, opportunities for ordinary citizens to participate in the policy process. Fittingly enough, Max Weber's analysis on the relationship of status and power further sheds light on the aforementioned observation, stating that society produces different amounts of prestige or social honor for different groups of people. Status groups, Weber continues, strive to maintain and extend the privileges that distinguish them from other groups. In effect, the distinction medical practitioners and community health administrators hold for practicing their respective professions inadvertently sets them apart and affords them a higher status than ordinary residents. Moreover, their frequent involvement in public affairs, particularly in health policymaking, distinguishes them even more from other sectors. Interviews with city and community officials disclose that the sharing of roles or tasks in decision-making did not necessarily warrant equal distribution of power. This concurs with Weber's assumption that status groups are entities essentially divided, operating and struggling within an arena of conflict and inequality, within a society of institutionalized disparity.

The study also shows that political alliances between public officials and private sector stakeholders are prevalent in Calapan. Establishing close ties with influential people has enhanced an individual's pursuit for power and intensified conflict with others wanting the same privilege all at once. In addition, cultural values sustain these alliances or ties, and influence, adversely at times, the manner

by which public sector undertakings are run. This affirms that social forces represented by traditional values, affect public and private sector transactions. For instance, 'the...pressures brought about by *hiya* (losing face or shame), *utang na loob* (debt of gratitude), *pakikisama* (camaraderie), and *pakikipagkapwa* (empathy)...in the Philippine government system results in...dissonance and... upheavals...' between and among the public and private sectors (de Asis n.d., as cited in Tumbaga 1997: 55).

The presence of these factors offers an explanation as to why the health policy process can be viewed as pluralist at one time, and elitist in another, underscoring Wall's (1996) point that decision-making can be limited to a privileged few or shared by many depending on the type of issue concerned. Looking specifically at the Calapan case, it is clear that a pluralist approach was adopted during the formulation of strategies in addressing health issues and in the actual implementation of health programs and projects. Decision-making on budgetary allocations, however, was entirely elitist or closed. Correspondingly, the policy process of governments 'closes and opens' depending on the type of issue being discussed—issues of high politics or issues pertaining to economic matters such as the budget are usually decided on by a few people, while less controversial matters or issues of low politics such as incremental changes in the guidelines for implementing health projects are more open for discussion and inspection (Walt 1994). This idea that 'policy choice and change is dominated by particular social classes, and that the primary function of the state is to ensure the continuing dominance of these classes' (Walt 1994: 37) challenges the argument that power is widely distributed or dispersed through society rather than being concentrated in a ruling elite (Dahl 1961, as cited in Ham and Hill 1993).

As regards identifying influential individuals in the City of Calapan, the study reveals that there has been an emergence of power centers other than the economic and political areas of activity at the city and community levels. The rise of relatively new venues of power, such as the professional, educational, socio-civic or cultural, and religious sectors, has increased the number of private sector individuals presumed to be influential. Paradoxically though, the findings also indicate that the emergence of new venues or spheres of influence did not necessarily translate to active private sector involvement in health policymaking, emphasizing further that many institutional aspects like political fragmentation, and the collegial manner by which participation in the health policy process is guaranteed somehow impeded the effectiveness of decentralized leadership (Suzuki n.d., as cited in Kurosawa, Fujiwara and Reforma 1996: 454).

In view of these observations, the study shows, for one, that non-government involvement in health service delivery should not be limited to persons traditionally tasked to address this issue. Other groups should actively participate in agenda setting, planning and implementation of local health programs and projects, offering local officials and public sector health personnel substantial support. As well, LGUs should genuinely devise ways to ensure transparency in budgeting. Effective decision-making and monitoring of allocations can only be arrived at if mechanisms that provide non-government individuals more room to scrutinize the same are in place. Finally, empowerment of barangay health workers should be a public sector concern if governance is to become a shared undertaking rather than an exclusive privilege.

Endnotes

This paper is based on my master's thesis entitled, *Process, Power and Health Policy in Calapan City, Oriental Mindoro.* I am grateful to my thesis adviser, Dr. Ricardo Abad, and to Ma. Andrea Soco for their contributions to this article.

[1]Decentralization and devolution are two different processes. Decentralization refers to the transfer of administrative functions away from a central location, while devolution is defined as the transfer of power away from a central location. In this sense, power refers to the capacity or authority to contribute to decision-making. Decentralization and devolution can occur simultaneously, although it is also possible to decentralize administrative functions without devolving powers for decision-making (De Jesus, 2005).

[2]Provinces, cities, municipalities, and barangays (communities) are to receive considerable amounts on a yearly basis for infrastructure projects, social programs, and manpower development.

[3] Since some individuals are perceived as having more than one area of influence, this number would be less than the ones indicated in Table 2. Eighty-seven males and 37 females comprised the city-level influentials. Fifty-nine males and 42 females made up the barangay influentials.

References

Angell, Alan, Pamela Lowden and Rosemary Thorp. 2001. *Decentralizing Development.* Oxford University Press.

Atienza, Maria Ela L. 2004. "The Politics of Health Devolution in the Philippines: Experiences Of Municipalities In A Devolved Set-up." *Philippine Political Science Journal*, 17: 25-55.

Aziz, Abdul and David D. Arnold. 1996. *Decentralized Governance in Asian Countries.* Sage Publications.

Brillantes, Alex B, et al. eds. 1990. *Decentralization: An Imperative for the 90s.* Manila: Jaime Ongpin Institute of Business and Government.

Brillantes, Alex B. 1999. "Decentralization, Devolution and the Development in the Philippines." *UMP-Asia Occasional Paper No. 44*, Urban Management Programme Regional Office for Asia-Pacific.

Burns, Danny, Robin Hambleton and Paul Hoggett.1994. *The Politics of Decentralization: Revitalizing Local Democracy.* Macmillan Press.

De Asis, Gerry. 1997. "Political Decision-making: Perspectives of Top Local Government Officials in Metro Manila." In *Demystifying Local Power*, ed. Letty Tumbaga, 43-57. Ateneo Center for Social Policy and Public Affairs.

De Jesus, Mariel. 2005. "Seeing Like A Decentralized State: Forest Comanagement in the Lower Magat Forest Reserve, Nueva Vizcaya." MA Thesis, Ateneo de Manila University.

Ham, Christopher and Michael Hill. 1993. *The Policy Process in the Modern Capitalist State.* 2nd ed. London: Harvester Wheatsheaf.

Karaos, Anna Marie. 1997. "Urban Governance and Poverty Alleviation in the Philippines." In *Urban Governance and Poverty Alleviation in Southeast Asia*, ed. Emma Porio, 63-86. GURI.

Legaspi, Perla. 1995. *Decentralization, Autonomy and the Local Government Code: The Challenge of Implementation.* Local Government Center.

Lieberman, Samuel S. 2002. *Decentralization and Health in the Philippines and Indonesia: An Interim Report.* World Bank, East Asia and Pacific Region.

Miralao, Virginia A. and Maria Vida V. Dacumos. 1969. "The Use Of The Elitist-Pluralist Continuum in the Study of Community Power." *Philippine Sociological Review*, 17 (July-October): 114-121.

Ocampo-Salvador, Alma. 1997. "Local Budgeting: A Closed Door Affair: The Case of Marikina." In *Demystifying Local Power*, ed. Letty Tumbaga, 29-42. Ateneo Center for Social Policy and Public Affairs.

Porio, Emma, ed. 1997. *Urban Governance and Poverty Alleviation in Southeast Asia: Trends and Prospects.* Philippines: Global Urban Research in Southeast Asia, Ateneo de Manila University-Department of Sociology and Anthropology, Ateneo Center for Social Policy and Public Affairs.

Suzuki, Itoko. 1996. "Metropolitan Governance: An Approach to Decentralization and Cooperation in Large Cities." In *New Trends in Public Administration for the Asia-Pacific Region: Decentralization*, ed. Susumu Kurosawa, Toshihiro Fujiwara and Mila A. Reforma, 440-456. Tokyo: Local Autonomy College, Ministry of Home Affairs.

Tapales, Proserpina Domingo. 1994. "The Philippines." In *The Changing Nature of Local Government in Developing Countries*, ed. Patricia L. McCarney, 195-219. Centre for Urban and Community Studies.

Wall, Ann. 1996. *Health Care Systems in Liberal Democracies.* London: Routledge.

Walt, Gill. 1994. *Health Policy: An Introduction To Process And Power.* London: Witwatersrand University Press.