Navigating Political Dynamics and Health Inequities: Challenges to Precision Medicine in a Rural Health Setting

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Abstract

In this era of dramatic, rampant, and incessant political change, predictions about the future can no longer be based either on conventional wisdom or historical precedent. We are, after all, in the middle of a paradigm shift that is shredding prognosticators and their prognostications with voraciousness – especially in the acquisition and distribution of health services to the consumers. Health status has improved dramatically in the Philippines over the last 40 years: infant mortality has dropped by two-thirds, the prevalence of communicable diseases has fallen and life expectancy has increased to over 70 years. However, considerable inequities in health care access and outcomes between socio-economic groups remain. Thus, this paper primarily sought to investigate and determine the barricades and challenges towards the attainment of precision medicine in small-scale locale study. This qualitative study utilized small group discussions, key informant interviews, and review of secondary data. Thematic and case analysis were utilized by the researcher to analyze data as deemed and provided by the respondents. Results were based on political history and dynamics, municipal health budget, implementation of programs via the municipal or rural health unit and linkage between the municipal health sector and local government unit. Overall, delivery of health services to the public was being compromised since health workers were less knowledgeable, undertrained, and underpaid and received minimal budget allotment, consequently leading to an imprecise delivery of health goods.

Keywords: health financing, political dynamics, health services

Introduction

Recent political and economic developments and associated changes in the practice and delivery of health and social care have led managers and professionals to recognize the importance and links between problem

solving and decision-making skills. In particular, assessing the impact of political, economic, socio-cultural, environmental and other external influences upon health care policy, proposals and organizational programs is becoming a recognizable stage of health service strategic development and planning mechanisms. Undertaking this form of strategic analysis therefore is to diagnose the key issues that the organization needs to address (Iles & Sutherland, 2001).

Despite the importance of political institutions in shaping the social environment, the causal impact of politics on health and its inequities have been understudied (Beckfield & Krieger, 2009; Navarro et al., 2006). Even when considered, the political system is generally not credited with a direct impact on health care access or is seen to have an indirect influence on utilization via its effect on economic conditions (WHO, 2007). Furthermore, studies tend to focus on formal political institutions at the local level, in particular, in a municipal arena.

This article argues that political institutions can have an important impact at the individual level through informal practices. Focusing on the municipality of Ayungon, the researcher utilized key informant interviews, focus group discussion and secondary date gathering to show that political organizations use access to health care as a strategy to gain and reward support, leading to potentially detrimental effects on the most vulnerable and exacerbating health disparities.

This study primarily aimed to seek the influence of political dynamics in relation to the health care delivery system in the municipality of Ayungon, Negros Oriental. Specifically, this study aimed to accomplish the following:

1. study the political history and structure of the municipality;
2. identify health-related programs mentioned by the key informants;
3. investigate the linkage between the health sector and the local government unit (LGU); and
4. propose recommendations for future program proposal attempts.

Related Studies

Political Institutions and Health Inequities

Although health is an important aspect of social policy and is highly valued by people around the world, there is only a limited literature on the relationship between politics and population health (Beckfield & Krieger, 2009). Most studies come from the social science literature on "welfare

states," which tends to focus on advanced, industrialized countries (Bambra, 2007 ; Esping-Andersen, 1990). In general, studies in this vein contend that political institutions affect population health and health inequities only through shaping welfare policies and determining the resources devoted to social services. Nevertheless, the literature is far from reaching a definitive conclusion (Cavelaars et al., 1994).

Health Reform as Shifting the Balance

In a recent paper on public health, Sterman (2006) explains the sources of policy resistance: We seek to bring the state of the system in line with our goals. Our actions alter the environment but policy resistance arises when we fail to account for the so-called 'side effects' of our actions, the responses of other agents in the system (who may have conflicting goals) and the unanticipated consequences of these responses, the ways in which experience shapes our goals, and the time delays often present in these feedbacks.

In health reform, policy resistance is often referred to as difficulty in "shifting the balance. Policy changes can be in response to shifts in real or perceived threats to a system which is considered unresponsive or built for past challenges. Several significant long-term transitions have been described, including the epidemiological transition from acute epidemics to chronic disease and the demographic transition from younger to older patients based on dramatic improvements in life expectancy and subsequent reduction in fertility rate in developed countries. Another key shift has been in the perceived role of government, shifting from maintaining the welfare state to incenting individuals to solve their own societal problems, the dominance of democratic capitalism around the world.

Policy and Health Reform Implications

Health policy reform is dominated by the scope of its political acceptability and fashioning a single-issue constituency with the capacity for collective action. There is a plethora of quick fix "fad" changes, which are usually couched in vague and ambiguous language, often to hide the actual details of who receives, who pays for what, and who decides. Many solutions are simplistic and wrong, with excessive distortion and manipulation to maintain and protect vested interest groups. One commentator described the escalating conflict between regulation and commercial incentives and practices as "dissolving like acid the cultural values of public service and

social solidarity ” (McDonell and Dewdney, 2006).

Impact of the Political Climate on the Quality of Healthcare Services

The impact of the political climate or landscape on the quality of healthcare services in communities or Local Government Units (LGUs) has been widely studied and documented in the literature. Political factors, such as governance structures, resource allocation decisions, and leadership priorities, play a crucial role in shaping the accessibility, affordability, and effectiveness of healthcare delivery.

Research by Sheikh et al. (2017) highlights the significance of political will and commitment in driving healthcare reforms and improving health outcomes. The study underscores the importance of strong leadership and governance frameworks at the local level to address systemic challenges and inequities in healthcare access. Similarly, a study by Bossert (1998) emphasizes the influence of political factors on health policy formulation and implementation, highlighting the need for participatory decision-making processes and accountability mechanisms to ensure the effective delivery of healthcare services.

Furthermore, studies have examined the impact of political instability and conflict on healthcare provision in conflict-affected regions. Research by Patel et al. (2015) explores how political violence and insecurity disrupt healthcare delivery systems, leading to gaps in service provision and exacerbating health disparities among vulnerable populations. The study underscores the importance of addressing political instability and conflict resolution mechanisms to safeguard healthcare access and mitigate adverse health outcomes in conflict-affected areas.

Moreover, the role of political patronage and clientelism in healthcare service delivery has been a subject of investigation in the literature. Studies by Berman (1998) and Savedoff and Hussmann (2005) have examined how political patronage networks influence resource allocation decisions and undermine the equitable distribution of healthcare services. These studies have emphasized the need for transparent and accountable governance structures to mitigate the negative impacts of political patronage on healthcare provision.

Additionally, research has explored the intersection of politics and health financing, highlighting how political decisions on budget allocation and expenditure priorities affect healthcare service delivery. Studies by Mills et al. (2002) and McIntyre et al. (2006) have analyzed the implications of political economy factors on health financing policies, emphasizing the

importance of evidence-based decision-making and stakeholder engagement in shaping health financing reforms.

The literatures underscore the multifaceted impact of the political climate or landscape on the quality of healthcare services in communities or LGUs. Political will, governance structures, conflict resolution mechanisms, patronage networks, and health financing policies all play pivotal roles in shaping healthcare access, affordability, and effectiveness. Addressing political determinants of health requires a holistic approach that emphasizes transparency, accountability, and participatory decision-making processes to ensure equitable healthcare provision and improve health outcomes for all.

Conflicts amongst World Views

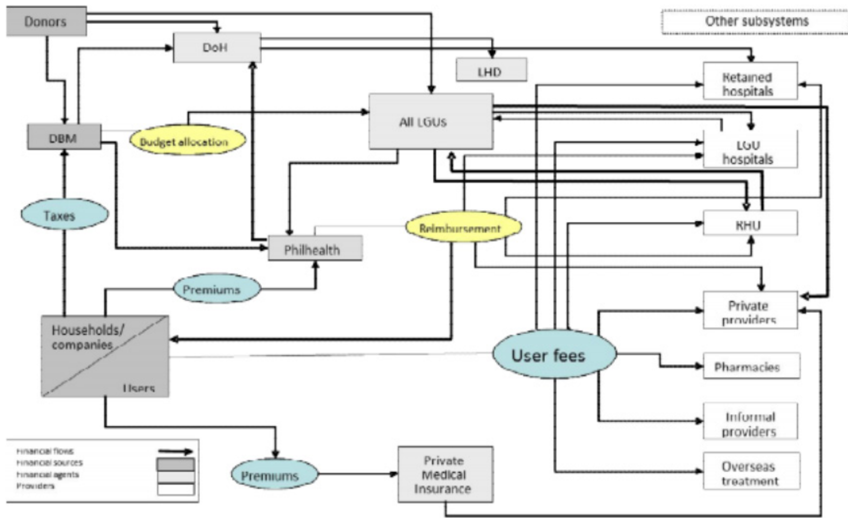
Given the obvious difficulty of understanding the complex interrelationships among the components and institutions of healthcare, it is little wonder that there is policy resistance and gridlock. There are fundamental conflicting goals, for example, with expenditure. As an industry and profession, more demand and more expenditure should translate into more profit and salaries. As a government public good more expenditure and demand implies more government liabilities and taxation subsidies. Therefore, for prosperity, the government subsidizes healthcare as an industry, then tries to find ways not to pay for it as a public good for its own citizens. Also for general wellbeing, rather than prosperity, the state needs to intervene to maintain social cohesion and reduce inequity. Here are three conflicting goals within the one institution. Cost shifting and blame shifting workarounds consume more effort than attempts to fundamentally change structures and policies at the systems level. It should also be apparent that due to its size and complexity, there is a fundamental loss of strategic control of the health system, and there is no single locus or control mechanism in operation; indeed there are several conflicting and inconsistent control mechanisms that constantly interfere with each other, operating at different levels of aggregation, from the overall system level to individual health behaviours (McDonell & Dewdney, 2006).

Healthcare System in the Philippines (adopted from Department of Health)

Health Financing

The health financing system in the country is complex as it involves different layers of financial sources, regulatory bodies, and health service providers. Figure 1 shows the financing flows for health as to sources and uses. In general, there are four main sources of financing: (1) national and local government, (2) insurance (government and private), (3) user fees/out of pocket and (4) donors.

Figure 1
Health Financing in the Philippines



Source: HSRA Monograph on Health Care Financing, Department of Health

The Philippine health care system has rapidly evolved with many challenges through time. Health service delivery was devolved to the Local Government Units (LGUs) in 1991, and for many reasons, it has not completely surmounted the fragmentation issue. Health human resource struggles with the problems of underemployment, scarcity, and skewed distribution. There is a strong involvement of the private sector comprising 50% of the health system, but regulatory functions of the government have yet to be fully maximized.

Health Facilities

Health facilities in the Philippines include government hospitals, private hospitals and primary health care facilities. Hospitals are classified based on ownership as public or private hospitals. In the Philippines, around 40 percent of hospitals are public (Department of Health, 2009). Out of 721 public hospitals, 70 are managed by the DOH while the remaining hospitals are managed by LGUs and other national government agencies (Department of Health, 2009). Both public and private hospitals can also be classified by the service capability (see DOH AO 2005-0029). A new classification and licensing system will soon be adopted to respond to the capacity gaps of existing health facilities in all levels. At present, Level-1 hospitals account for almost 56 percent of the total number of hospitals (Department of Health, 2009; Lavado, 2010) which have very limited capacity, comparable only to infirmaries.

Health Human Resource

The health human resources are the main drivers of the health care system and are essential for the efficient management and operation of the public health system. They are the health educators and providers of health services. The Philippines has a huge human reservoir for health (see Table 1). However, they are unevenly distributed in the country. Most are concentrated in urban areas such as Metro Manila and other cities.

Table 1

Number of Government Health Workers, Philippines, in 2008

Area	Number of Government Health Workers			
	Doctors	Dentists	Nurses	Midwives
Philippines	2838	1891	4576	17437
NCR	590	498	723	1135
CAR	89	40	131	637
I	159	105	259	1014
II	97	65	196	839
III	278	176	441	1662
IVA	238	189	472	1818
IVB	83	68	142	555
V	157	85	273	1072
VI	234	123	401	1775
VII	177	117	328	1534
VIII	155	94	201	904
IX	100	44	203	697
X	138	74	241	1052
XI	75	69	127	743
XII	113	56	194	878
ARMM	76	30	130	507
CARAGA	79	58	114	615

Satisfaction with Health Facilities

Based on a survey by the Social Weather Station in 2006, majority of Filipinos specifically the low income households prefer to seek treatment in a government hospital if a family member needs confinement. Affordability is the main reason for going to a government medical facility, while excellent service is the main reason for going to a private medical facility (Department of Health, 2010). The net satisfaction with services given by government hospitals has slightly improved from +30 in 2005 to +37 in 2006. Excellent service and affordability are the main reasons for being satisfied whereas poor service is the main reason for being dissatisfied with the services given by government hospitals (Social Weather Stations, 2006).

Health Reform Initiatives in the Philippines

Health reforms in the Philippines build upon the lessons and experiences from the past major health reform initiatives undertaken in the last 30 years. The adoption of primary health care (PHC) approach in 1979 promoted participatory management of the local health care system. The goal was to achieve health for all Filipinos by the year 2000. It emphasized the delivery of eight essential elements of health care, including the prevention and control of prevalent health problems; the promotion of adequate food supply and proper nutrition; basic sanitation and adequate supply of water; maternal and child care; immunization; prevention and control of endemic diseases; appropriate treatment and control of common diseases; and provision of essential drugs. To implement PHC, EO 851 was issued in 1983 integrating public health and hospital services (World Health Organization, 2011).

Theoretical Foundation and Previous Studies

In a study conducted by Chen and Melani (2012) at Lebanon, they concluded that individuals with higher political activism had better access to health services than others. Informal, micro-level political institutions can have an important impact on health care access and utilization, with potentially detrimental effects on the least politically connected. A truly universal health care system that provides access based on medical need rather than political affiliation was needed to help to alleviate growing health disparities in the Lebanese population.

In Mexico, for example, a study by González-Rossetti and Bossert (2000) found that local political structures and the relationships between health officials and political leaders substantially affected the allocation and efficiency of health services. Those with stronger political ties or activism were more likely to receive better health care services. In Nigeria, Olatunji (2013) noted that political patronage played a significant role in the distribution of health resources, where health interventions were often used as tools for political gain rather than for addressing the population's health needs comprehensively.

Moreover, in a review of health systems in Sub-Saharan Africa, Anyangwe and Mtonga (2007) highlighted that political instability and poor governance often led to disparities in health service delivery, with rural and politically marginalized areas receiving fewer resources and lower quality care compared to urban and politically influential regions.

The consistent theme across these international studies is the detrimental effect of political dynamics on health equity. Health systems that operate under the influence of political favoritism tend to exacerbate health disparities, undermining efforts to achieve universal health coverage. To mitigate these issues, there is a need for health systems that prioritize medical needs over political affiliations, ensuring equitable access to health services for all population segments.

Another study conducted in the Philippines by Ramiro et al (2001), decentralization has been associated traditionally with participation and empowerment in local decision-making. This study of four cases analyzed the role of local health boards in enhancing community participation and empowerment under a decentralized system in the Philippines. Local government units (LGUs) with functioning local health boards were compared with LGUs whose health boards were not meeting regularly as mandated by law. The study found that there were more consultations with the community, fund-raising activities, health initiatives and higher per capita health expenditure in LGUs with functioning local health boards. Only the mayors and municipal health officers felt empowered by devolution. In general, awareness of devolution and their potential roles in health decision-making was low among members of the community.

Upon reviewing the interview transcripts, several statements suggest that politics played a significant role in the inefficiency or poor quality of healthcare services in Ayungon Municipality. For instance, the observation that additional health services were often provided during election periods indicates a potential link between political motives and the delivery of healthcare. Similarly, the limited engagement of the municipal mayor in

health-related matters, along with ineffective communication channels, may reflect political priorities taking precedence over healthcare needs. Additionally, published essays and journals often highlight the impact or influence of politics on the delivery of health services. Research has shown that political factors, such as resource allocation decisions, bureaucratic inefficiencies, and patronage networks, can all contribute to challenges in healthcare provision. Political interference in healthcare policymaking, budgeting processes, and staffing decisions can further exacerbate these issues, leading to disparities in access to quality care and compromised health outcomes.

In my informed opinion, politics undoubtedly plays a significant role in shaping the landscape of healthcare delivery in Ayungon Municipality, as it does in many other contexts globally. The intertwining of political interests, power dynamics, and governance structures can create barriers to effective healthcare provision, hindering efforts to address the diverse health needs of communities. To improve healthcare quality and access in Ayungon, it is crucial to address political factors that may be impeding progress by promoting transparency, accountability, and community engagement in healthcare decision-making processes among others. Additionally, fostering partnerships between local government, healthcare providers, civil society organizations, and other stakeholders can help mitigate the negative impacts of politics on healthcare delivery, ultimately leading to better health outcomes for residents.

Methods

Study Area

Ayungon is a second-class municipality located on the northern part of Negros Oriental. According to the recent census conducted by the National Statistics Office (NSO) last May 2010, it had a population of 46, 146 comprising of 24 barangays. On the same census, the said barangay was found out of having 1, 837 residents. Ayungon is located on the midriff of Oriental Negros' northern stretch, approximately two hours from Dumaguete City. It was selected as the venue for study since it was accessible for the researcher for it is his hometown.

Figure 2
Map of Ayungon, Negros Oriental

Research Design

The study employed a cross-sectional descriptive type which involves one-time interaction with groups of people with its primary aim of identifying and determining the role of political dynamics in the healthcare system in the municipality of Ayungon. The researcher conducted formal and informal interviews with municipal nurses, barangay health workers, selected members of the barangay council and inhabitants through focus group discussions and the like. In addition, secondary data- gathering was also done to supplement the information provided by the respondents.
Sampling Procedure

A total of 20 respondents were interviewed for this study. The respondents were selected based on their involvement and knowledge of healthcare services in Ayungon Municipality. Among the respondents, there were healthcare professionals including nurses and barangay health workers, local government officials, community leaders, and residents. The age range of the respondents varied from 25 to 60 years old. They had diverse professional backgrounds and experiences related to healthcare and governance.

Procedures for Data Analysis

The data analysis procedure involved transcribing interviews,

familiarizing with the data, initial coding, theme development, data reduction, cross-case analysis, and interpretation. The researcher identified recurring themes or patterns, clustered similar codes into broader themes, summarized key points, compared findings across cases, and interpreted the implications within the research context. Thematic and case analysis techniques were used iteratively to organize qualitative data and derive meaningful insights, leading to a comprehensive understanding of the research topic.

Ethical Considerations

The study ensured, as much as possible, to maintain confidentiality and safeguard the respondents' privacy throughout the study. Anonymity was totally guaranteed. A signed informed consent (PIC) form was secured prior to the administering the questionnaires to the respondents, who were assured that any information or data gathered from them would be treated with confidentiality and would be properly disposed of two (2) years after the completion of the study. In addition, the respondents were provided with adequate information about the study and were assured that they had the power of free choice, to consent or decline participation voluntarily. It was emphasized by the researcher that failure to volunteer would not result in any penalty or loss. Moreover, even after consenting, the respondents were given the freedom to withdraw from the study and decline from providing any specific piece of information.

Results and Discussions

Political History and Structure of Ayungon, Negros Oriental

During The first political election of 1928, Julian Villanueva was called President and was replaced by Maximo Enardecido who became the mayor when World War II broke out. The municipal government and townfolks evacuated to the mountains of Pangi, a village southwest of Poblacion and part of Brgy. Gomentoc. The guerrilla movement was led by Capt. Eugenio "Kusgan" Antonio, liberation came in October 1944. Below (Table 2) is the list of appointed and elected town leaders.

Appointed Town Leaders	
Name of Leader	Year/Term
Benito Sanchez	1924-1927
Apolonio Deguit	1927-1928
Elected Town Leaders	
Julian Villanueva	1929-1939
Maximo Enardecido	1940-1951
Juan Taburaza	1952-1959
Ireneo Tubio	1960-1963
Martin Garol	1964-1967
Ricardo Garcia	1968-1977
Nenimico Enardecido	1977-1986
Martin Garol (Appointed) Office-In-Charge	1986-1988
Lorenzo G. Dy	1988-1998
Edsel G. Enardecido	1998-2017

Hon. Edsel G. Enardecido had his last triennium (2016 – 2017 service as municipal mayor. As shown in Table 2, Hon. Enardecido was the town mayor for almost two decades now. As reflected during the informal interviews with selected inhabitants and observed during elections, Enardecido usually gained higher votes in the upland areas compared to the barangays in the highways. In addition, Hon. Erwin Agustino, the incumbent vice-mayor of the town, was soon going to replace and follow the footsteps of Hon. Enardecido as mayor after his term.

Municipal Health Budget or Health Financing

The Department of Health (DOH) is responsible for developing health policies and programs, regulation, performance monitoring, and standards for public and private sectors, as well as providing specialized and tertiary level care. The DOH Centers for Health and Development (CHDs) are the implementing agencies in provinces, cities and municipalities, and link national programs to Local government units (LGUs). The CHDs are the DOH offices at the regional level. They assist the LGUs in the development of ordinances and localization of national policies, provide guidelines on the implementation of national programs at the LGU levels, monitor program implementation, and develop support system for the delivery of services by

LGUs.

Health service delivery has evolved into dual delivery systems of public and private provision, covering the entire range of interventions with varying degrees of emphasis at different health care levels. Public services are mostly used by the poor and near-poor, including communities in isolated and deprived areas. Private services are used by approximately 30 % of the population that can afford fee-for-service payments. The service package that is supported by the government is outlined by PhilHealth. Coverage is reported by PhilHealth to be 74 million or 82% of the population at the end of December 2011. However, the services covered are not comprehensive, copayments are high, and reimbursement procedures are difficult.

The dominant private sector is made up of large health corporations and smaller providers. Health maintenance organizations are also present. Professional organizations contribute to continuing education, clinical practice guidelines development, advocacy, and influence policy and regulation. Opportunities for community participation in health are coursed through the barangay health workers who come from the local community, and representatives from civil society and the private sector who participate in LGU policy-making local health boards.

As deemed by most informants, the budget intended for health is dependent on the so-called Internal Revenue Allotment (IRA) coming from the national level. Allotted budget is divided equally to each barangay, leaving only around fifteen to twenty thousand for each barangay per annum, which is deemed to be very small and inadequate. It is also noteworthy to point out that during the conduct of health services, health workers solicit food for consumption since food is not part of the budget. Even transportation is not part of the said budget, if there would be a subsidy, it usually took weeks to months for them to get the reimbursement of their expenses.

A major driver of inequity is the high cost of accessing and using health care. The Philippines has had a national health insurance agency – PhilHealth – since 1995 and incrementally increased population coverage, but the limited breadth and depth of coverage have resulted in high-levels of out-of-pocket payments. In July 2010, a major reform effort aimed at achieving 'universal coverage' was launched. Providing a more comprehensive benefits package and reducing or eliminating co-payments, the reform focused on increasing the number of poor families enrolled in PhilHealth.

In addition, there was a low supply of health workers in the municipality since available "items" were very limited and dependent on the decision of the municipal mayor. Health supplies were also inadequate, compromising the health care delivery system of the municipality.

Municipal Health-related Programs

Prenatal for pregnant women, immunization for children, fasting blood sugar, wound dressing, blood pressure and weight taking are programs pronounced by the key informants. These programs are scheduled and will usually occur every first Tuesday (prenatal) and every last Wednesday of the month (fasting blood sugar) while the rest are available anytime at their respective barangay health units. These programs are mandated by the Department of Health (DOH).

However, services were limited due to the fact that some of the health workers were appointed by their respective barangay chairmen with no means of qualifications. There were even some barangay health workers who were not cognizant of their job , did not posses enough essential knowledge, and were therefore not skilled enough to perform their tasks and duties. It was also pointed out that some barangay chairmen usually appointed individuals who were very close to them or were their relatives and friends.

When asked if there were programs being implemented at the municipal level, most of the informants and respondents answered "no." Health services and programs were dependent on the national level as deemed by many. Medical missions and other related health activities usually occured when election was fast approaching.

Linkage between the Municipal Health Sector and Local Government Unit (LGU)

The interviewee's statement highlights several critical issues related to the engagement and effectiveness of local government in health service delivery.

Firstly, it was gleaned that the municipal mayor's engagement and participation in the health sector was limited or minimal. For instance, the municipal mayor would only attend the supposed monthly health meetings only once a year. This indicates a lack of consistent overseeing of and involvement in health-related matters by the local executive. The rare attendance suggests that the mayor may not be fully aware of the ongoing challenges and needs of the health sector. This limited engagement can lead to inadequate support and delayed decision-making on critical health issues.

Secondly, the communication channels were ineffective. There was an absence of effective communication channels for disseminating important information, such as details about seminars and training opportunities.

This deficiency hindered the health workers from keeping abreast with the best practices and advancements in their field. Without proper information flow, health workers may miss out on essential trainings and seminars, thereby leading to gaps in essential knowledge and skills and ultimately affecting the quality of health services they provide .

Lastly, it was found that the provision of health services was election-driven. This means that additional health services were often provided during election periods, which suggests that health initiatives might be politically motivated instead of being part of a sustained and strategic health improvement plan. The provision of additional services during elections may result in short-term improvements and political gains but do not address the underlying and ongoing health needs of the community. This approach can lead to inconsistent and unreliable health service delivery.

Overall, the interviewee's observations underscore the need for more consistent and proactive engagement from local government officials, better communication and training systems for health workers, and a shift towards a more stable and needs-based approach to health service provision, rather than one driven by political cycles.

Salient Indicators and Questions on The Impact of Politics on Healthcare Services

Respondents consistently noted the limited engagement of the municipal mayor in health-related matters, with some indicating that the mayor attended health meetings only once a year. This lack of consistent overseeing and involvement of the local executive suggests a potential disconnect between political leadership and healthcare priorities.

In addition, many respondents highlighted the absence of effective communication channels for disseminating important information related to healthcare, such as details about seminars and training opportunities. This deficiency hinders the health workers from keeping abreast with the best practices and advancements in their field, thereby indicating a need for improved communication strategies within the healthcare system. Several respondents also pointed out the provision of additional health services during election periods, suggesting a pattern of politically motivated initiatives rather than a strategic and sustained approach to addressing community health needs. This observation raises concerns about the reliability and consistency of healthcare delivery, particularly during non-election periods.

By examining these indicators and questions, it becomes evident

that politics significantly influences the delivery of healthcare services in Ayungon. The findings underscore the need for greater political accountability, improved communication channels, and a shift towards a more needs-based approach to healthcare provision to address the diverse health needs of the community effectively.

Conclusion

Ayungon has experienced significant political stability, with long-serving mayors like Maximo Enardecido and Edsel G. Enardecido. The transition of power from one mayor to another, such as from Edsel G. Enardecido to Erwin Agustino, indicates a continuity in leadership within the municipality. The municipality's health budget heavily relies on the Internal Revenue Allotment (IRA) from the national level. However, this budget allocation is perceived as inadequate, leading to challenges such as limited resources for health workers, insufficient medical supplies, and delays in reimbursement for expenses incurred during health services.

Further, despite efforts by the Department of Health (DOH) and PhilHealth to improve health coverage, there are still significant gaps in healthcare access and quality. High out-of-pocket payments and inadequate health worker supply contribute to inequity in accessing healthcare services, particularly for marginalized communities. Health programs at the barangay level, mandated by the DOH, focus on essential services such as prenatal care, immunization, and blood sugar monitoring. However, challenges such as the appointment of unqualified health workers and the lack of municipal-level health initiatives hinder the effectiveness of these programs.

The limited engagement of the municipal mayor in health-related matters, as evidenced by infrequent attendance to health meetings, indicates a lack of consistent oversight and involvement in addressing health challenges. Ineffective communication channels further exacerbate this issue, leading to gaps in information flow and missed opportunities for training and capacity building among health workers. Also, the provision of additional health services during election periods suggests a pattern of politically motivated initiatives rather than a strategic and sustained approach to addressing community health needs. This approach may lead to short-term improvements but fails to address the underlying health issues facing the community.

Overall, while Ayungon demonstrates political stability and a commitment to essential health programs at the barangay level, there are significant challenges related to health budgeting, service delivery, and

municipal government engagement. Addressing these challenges will require greater collaboration between local government officials, health stakeholders, and community members to ensure equitable access to quality healthcare services and a more sustainable approach to health development in the municipality.

Recommendations

The following measures are highly recommended by the researcher.

To the Local Government Unit of Ayungon

- Additional allotment of funds and budget for healthcare services must be provided.
- Appropriate appointment of health workers is much needed to provide quality service.
- More items for health workers should be opened to make health services more accessible and available to all town people.
- The municipal health officers and workers must work hand-in-hand to provide health programs in addition to the ones identified at the national level

To the Department of Health

- Hands-on trainings and workshops to health workers must be conducted for them to become more skilled and globally competitive.
- Regular meetings and evaluation programs with the LGU must be held to determine whether the program was sustained or not at all.

To the Municipal Health Workers

- Municipal health workers must attend relevant seminars and lectures on health to become more knowledgeable and competent in their field of work .
- They should attend regular meetings with the LGU and Health Officer to assess if programs are properly implemented and if programs are feasible or not.

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