Assumptions of Global Beneficence: Health care disparity, the WHO, and the effects of global integrative health care policy on local levels in the Philippines.

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Assumptions of global beneficence: Health-care disparity, the WHO and the outcomes of integrative health-care policy at local levels in the Philippines

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Abstract Traditional, complementary and alternative medicine (or heterodox health care) functions as the primary source of health care for a majority of populations in low-income countries. The World Health Organization has promoted the integration of heterodox health-care practices and practitioners into formal state and local biomedical health-care systems. Heretofore, the literature has assumed the beneficence of this policy in reducing health-care disparity, without assessing the outcomes of this policy's implementation. This research examines the impact of health-care integration policy on local health care in communities in four municipalities in the Philippines. Communities in two municipalities that implemented health-care integration (top-down and bottom-up) were compared with two municipalities that did not implement health-care integration. A qualitative design of data collection was utilised. Convenience samples ($n = 500$) of community members, community leaders, health-care providers and key policy actors participated in semi-structured interviews and focus groups to assess the changes in community health-care systems and in community health-care access following health-care integration. The assumptions of beneficence of health-care integration are not supported by this research. Furthermore, this research suggests that health-care integration may not be beneficial to communities if implemented in a manner that ignores the particular needs of a given local context.

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Introduction

Global health policymaking has become a normative paradigm of health care, which necessitates a universalisation of local health-care needs. The intended and unintended outcomes of global health policies on local health-care systems and local populations provides an imperative, yet routinely unexamined, field for investigation. Global health

policymaking concerns orthodox biomedicine, as well as heterodox (non-biomedical) health care. The World Health Organization (WHO) has promoted the integration of heterodox practices and practitioners into formal biomedical health-care systems as a means to achieve 'health for all'; formally presented in the 1978 Declaration of Alma Ata (WHO, 1978; Lantum, 2007). Health-care integration has since remained an unchallenged priority of the WHO's Traditional Medicine Office in Geneva and in WHO's regional divisions.

The Western Pacific Region Office of the WHO (WPRO) has been especially committed to health-care integration (WHO, 2002; Kadetz, 2010). The Philippines, a Member State of WPRO, approved the legislation of a national adaptation of WHO's policy for health-care integration; The Traditional and Alternative Medicine Act (TAMA) of 1997 (Republic of the Philippines 1997). By virtue of TAMA, the Philippine Institute for Traditional and Alternative Health Care, a government corporation affiliated with the Department of Health of the Philippines, was established to help promote and integrate traditional medicine in the Philippines (Mendoza, 2009; PITAHC, 2009).

The literature on health-care integration has predominantly concerned the integration of well-established and government supported heterodox health-care systems such as Traditional Chinese Medicine (TCM), ayurveda and Tibetan medicine. The local heterodox health-care practices of the Philippines offer a marked contrast to these established heterodox systems and thereby can problematise the normative health-care integration discourse supported by these formal, standardised health-care systems. Furthermore, as a result of its varied geography, marked economic disparity, decentralised health-care system and cultural diversity, the Philippines provides a unique context for understanding the impact and challenges of implementing a global health-care policy, such as health-care integration (Tan *et al*, 1988). Decentralisation of health care (devolution in the Philippines's context) has been fully implemented since 1991 down to the *barangay* (community) level (Bautista *et al,* 2002). As a result, health care can only be accurately examined on a community by community basis (Bautista, 1999). Hence, the Philippines further provides a unique context for understanding the challenges of health-care integration policy, by virtue of the marked diversity of Filipino communities' reaction to, interpretation of and implementation of this policy into their local health-care systems.

Within WHO documents, WPRO documents and in Philippine policies, a discourse has evolved, which assumes the beneficence of health-care integration. The heretofore unchallenged assumptions of beneficence of health-care integration include improvements in: physical and financial access to health care; use of heterodox practices and practitioners; standardised training of practitioners; referrals between biomedical and heterodox practitioners; and overall increased safety, efficacy and appropriate use of heterodox practices.

Considering the extensive research and funding appropriated to study heterodox health-care practices for purposes of integrative health care at WHO Collaborating Centers, as well as in university and government research facilities worldwide, it is curious that no research to date has assessed the actual outcomes of implementing health-care integration on local populations and local health-care systems. With an estimated 80 per cent of populations in low-income countries using, and often dependent upon, heterodox health-care practices, it can be argued that such assessments are long overdue (Bodeker and Burford, 2007).

Therefore, this article will examine the intended and unintended outcomes of health-care integration, as well as assess the assumptions of beneficence embedded in the health-care

integration discourse. This analysis will be supported by the author's research, assessing health-care integration at the local level in communities of the Republic of the Philippines and utilising the specific case example of the integration and reintegration of traditional birth attendants (TBAs).

Assessing the Assumptions of Health-care Integration

Methodology

A qualitative study was conducted over a period of 16 months to determine the effects of, and test the assumptions of, health-care integration on local health-care systems and communities of two municipalities in the Philippines. Bagabag (a municipality of 32 787 residents and 17 communities in the Province of Neuva Vizcaya) has been implementing the policy of integration (top-down through the Municipal Health Office) for the past 3 years and offers training and practice (mainly acupuncture and Chinese orthopaedic massage or Tui na) for physicians and nurses through the Veteran's Regional Hospital, and through the municipal health office (National Statistics Office, 2008).

Murcia (in the province of Negros Occidental) with a population of 59 358 in 23 communities, conducted bottom-up implementation of the imported heterodox health-care practices of acupressure and Tui na; the local heterodox health-care practice of local herbal use; and the biomedical practice of hygienic education via training (conducted by physicians of the NGO INAM) of lay volunteer community health workers (CHWs), working in their own communities at the same time (3 years ago) that Bagabag instituted top-down integration (ibid.).

Four randomly selected communities in each of these municipalities were contrasted with four communities each of two socio-economically similar municipalities that did not implement integration. Bontoc (in Mountain Province), with a population of 24 798 and 16 communities, served as a non-integrating control municipality along with Siquijor (on the Island of Siquior), which has been previously studied for the variety of local heterodox health-care practices found in this municipality of 21 150 with 42 communities (ibid.).

Semi-structured interviews were employed individually and in focus groups of convenience and snowball samples ($n = 500$) of community members, community heterodox practitioners, community biomedical practitioners, community council members and key policy actors at all administrative levels. The interviews were devised to determine if integration actually reduced health-care disparity in terms of: physical and financial access to health care; increased use of heterodox health practices; and increased referral of patients between biomedical practitioners and local heterodox practitioners. As health-care integration in Bagabag and Murcia commenced in 2006, interview questions concerned changes that may have occurred for informants from before the time integration started (or 2005) to 2010, in order to determine if any changes occurred during this 5-year period that could be correlated with integration. Data were analysed with NVivo and simple proportional analysis of qualitative data was conducted (Table 1).

Results

The assumptions of integration policy are challenged in the Philippine context. First, improvements to physical and financial access to health care have not been demonstrated in

Table 1: Summary of research results

Indicator (% of informants)	*Average* (%)	*Bagabag* (%)	*Bontoc* (%)	*Murcia* (%)	*Siquijor* (%)
General population report using heterodox practices	70	61	63	85	88
< 30 years old report using heterodox practices	77	50	55	87	86
Prefer to use biomedicine	80	89	95	65	69
Report increased cost of biomedicine	68	37	60	85	87
Report no change in distance to primary practitioner	92	94	94	87	89
Heterodox practitioners who would participate in standardised training	70	80	50	90	44
Heterodox practitioners who refer to biomedical practitioners	89	90	86	91	89
Biomedical practitioners who refer to heterodox practitioners	54	50	67	96	0

these communities within the period since integration. In fact, formal top-down integration demonstrated the least improvement in physical access to health care, measured as the change in distance to one's primary practitioner (6 per cent of Bagabag informants). The cost of a primary care visit either remained the same or was markedly increased, relative to informants' weekly incomes in 2005 and 2010. Although it could be argued that top-down integrated Bagabag demonstrated the lowest percentage of increase of practitioner consultation fees, it needs to be clarified that Bagabag also contained a higher percentage of informants who were covered by the national health insurance (Philhealth) and therefore informants paid few consultation fees in either 2005 or 2010. It should also be noted that the majority of increases in consultation fees are for informants who went to private physicians, as it is usually free to consult municipal or community health centres. Health-care costs would not have been reduced unless informants were covered by Philhealth in 2010, but this was not the case in 2005.

In general, there was no reported change over the 5-year period in the cost of a visit to a local heterodox practitioner, the majority of whom only accept donations. However, some TBAs who had received training in sterile birthing techniques from the Department of Health and UNICEF began to charge fees for service after training. Therefore, in this particular instance, health-care integration has resulted in an increase in the cost of health care.

Integration in these communities does not appear to foster the use of local heterodox practices. In fact, any increased use of local heterodox practitioners was not correlated with integration, as much as with financial necessity. This is demonstrated via the high correlation between the use (defined as more than three visits from 2005 to 2010) of local heterodox practitioners in Murcia and Siquijor (85 per cent and 88 per cent, respectively), the high

percentage of under 30-year-olds (usually in the lowest income brackets) using local heterodox practices in Murcia and Siquijor (87 per cent and 86 per cent, respectively), and the largest relative increase in biomedical fees reported from informants in Murcia and Siquijor (85 per cent and 87 per cent, respectively).

According to Birn (2005), to whom practitioners refer their patients can indicate the overall extent of integration. Heterodox practitioners demonstrated a consistently high level of patient referrals to biomedical practitioners, irrespective of health-care integration. However, patient referral from physicians to heterodox practitioners appears to be more a function of community accessibility to biomedicine, than a result of integration; for a majority of biomedical practitioners were opposed to health-care integration 'regardless of integration being implemented' in their municipality. Although the patient referral from physicians to local heterodox practitioners was higher in Murcia and Bontoc, than in Bagabag, none of these municipalities demonstrated the zero per cent of reported referral found in non-integrated Siquijor. This extreme lack of referral may be a result of the pervasive reported belief that the local heterodox practitioners of Siquijor were especially associated with black magic and thereby considered dangerous and viewed unfavourably by both the biomedical and lay local communities.

An often sanctimonious assumption of the centrality of safety and efficacy was shared among almost all of the literature reviewed. Markedly lacking in this discourse, however, was the awareness that safety and efficacy may be socially constructed concepts and thereby change from one local context to another. Safety and efficacy, though a primary concern identified in almost every WHO health-care integration document, were concepts that were so foreign to those community members queried that many did not understand the concepts and less than 5 per cent of all community member informants reported any concern about the safety and efficacy of local heterodox practices and practitioners.

The predominant sentiment was that unless a local practitioner gives one reason for concern, there is no conception of risk with local practices. Hence, safety and efficacy may be concepts that cannot be assumed to be universally conceptualised in the same manner, but rather encompass local meanings as well. Such local meanings inherently problematise the paradigm of global policy, which is structurally designed to accommodate a singular universal interpretation of safety and efficacy.

Results: Integration versus no integration

The one criterion that demonstrated a significant difference between integrated and non-integrated communities was the number of heterodox practitioners who reported they would participate in standardised training, which was significantly higher in both Murcia (90 per cent) and Bagabag (80 per cent), than in Bontoc (50 per cent) and Siquijor (44 per cent). Hence, integration may be correlated with a willingness for standardised training among heterodox practitioners in communities where integration has already occurred. However, it should be clarified that compliance with attendance at standardised training is not to be confused with a willingness to replace one's heterodox practice with standardised practices. In fact, no heterodox practitioner interviewed would agree to replace what they traditionally practised with any standardised training they may learn. But more than 30 per cent would agree to incorporate what they learned with what they did, in a

manner of their own choosing. Hence they would individually integrate what they learned, but they would not ultimately be integrated into the health-care system.

Results: Top-down versus bottom-up integration

Although marked differences between top-down and bottom-up integration are not illustrated along the criteria assessed, important differences were identified in interviews and participant observation, especially in terms of individual health-care choice, control and self-determination. Top-down health-care integration, as implemented in Bagabag, was reported to not engender plurality of health-care choice, but instead maintained a locus of control with the physician. It is important to note that of these municipalities, only one local heterodox practice is being integrated (that is, the ten local herbs approved by the Bureau of Food and Drug of the Philippines, in Murcia) and that no local heterodox practitioners are being integrated in these communities. In fact, local heterodox practitioners in Bagabag reported a reduction in their patients from 2005 to 2010, as well as a feeling of purposely being marginalised via the integration process.

This finding is in direct contrast with the integration discourse, which perceives heterodox health-care practices and practitioners as marginalised until they are formally integrated. For example, Dauskardt warns: 'the absence of a decisive position by governments with regard to traditional medical systems does, however, leave traditional practitioners in an ambivalent and marginal position. This marginalisation can retard attempts by the government itself or other health groups to enhance the utilisation and the joint development of health resources' (1990, p. 354). However, as integration is context dependent, both scenarios of marginalisation are clearly possible depending on how integration is implemented relative to a given social context.

According to community health workers (CHWs) in Murcia, bottom-up health-care integration seeks to encourage plurality and self-determination in both awareness of individual choice of available local health-care practices and in terms of self-managed health-care options. This was particularly evident in the CHW focus on the use of herbs available in one's backyard. However, it is noteworthy that after 3 years of bottom-up integration of CHWs in their communities, neither the Municipal Health Officer nor any of the community midwives administrating community health units were aware of the CHWs or their work. Hence, the CHWs have integrated biomedical, local and imported heterodox practices into their own practice, but, similarly to the integration of local heterodox health-care practitioners in communities studied, they have not been integrated in any capacity into the formal health-care system.

It is interesting to note that top-down integration as implemented in Bagabag (based on the medical model) focuses on less sustainable, curative measures, while in bottom-up Murcia, the focus of the CHWs (working within a community health model) was on prevention. However, these findings are neither meant to generalise top-down and bottom-up health-care integration to other contexts, nor to portray these categories as good/bad dichotomies, as there are numerous examples where bottom-up integration may be most similar to what was demonstrated in Bagabag. For example, there is an assumption, especially in the Philippine decentralisation literature, that bottom-up health care will naturally be preferred by communities and be more effective at addressing local health-care disparity (Bautista, 1999). However, this assumption completely ignores the particular resources and capacities available to any

given local level and is challenged by the findings presented here. Furthermore, Walt (1994) notes that decentralisation to the local level may merely mean that power is now in the hands of local landowners and the local power elite. This is particularly germane in the multi-sector decentralised Philippine context, where landowners generally comprise the elite, control politics at even the lowest of administrative levels and have the final say on health-care expenditures (Bello, 2009). Hence, it cannot be assumed that top-down health-care integration is always about control and bottom-up integration always generates autonomy.

Furthermore, it is imperative to consider the type of heterodox practices chosen to be integrated. The Philippine focus on health-care integration of imported heterodox practices that have already been standardised (that is acupuncture, acupressure and Tui na), illustrates the precarious future of local heterodox practices and practitioners. The myriad reasons for the preferential integration of these imported practices include the greater biomedical acceptance of established imported heterodox practices such as acupuncture (especially in the West); China's aggressive globalisation of TCM along with China's health diplomacy, with sales revenue of US$21 billion for TCM products alone (Price Waterhouse Coopers, 2009); and the need for the Philippine Institute for Traditional and Alternative Health Care, the oversight agency for health-care integration, to fulfil its duties as a governmental corporation by focusing on potentially profitable health-care 'products'.

However, the recent re-integration of TBAs in the Philippines, through the prohibition of their ability to deliver, offers a special case example of how specifically local heterodox health-care integration is currently being interpreted and thereby impacting the local level.

The Integration and Re-integration of TBAs in the Philippines

Background: The global context

Traditional birth attendants (TBAs) were the first (and often only) heterodox health-care practitioners to be integrated into formal health-care systems internationally through training directed toward the reduction of maternal and infant mortality, usually sponsored by UNICEF and WHO beginning in the 1950s (Kruske and Barclay, 2004). According to the WHO, although initial assessments of these programmes demonstrated a reduction in maternal and infant mortality, this reduction purportedly 'reached a plateau' in the 1990s; triggering a dramatic shift in TBA policy, with the cessation of training and discouraged or prohibited use of TBAs worldwide (Kruske and Barclay, 2004, p. 307). This was formally announced in a 1992 joint WHO/UNFPA statement declaring that the training and use of TBAs should only be used as an interim measure until all women have access to 'acceptable, professional, modern health services' (WHO, 1992). 'Four years later, WHO policy leaders insisted on "skilled" rather than "trained" birth attendants' (Kruske and Barclay 2004, p. 307). This is a significant policy change as it is believed that globally 'two-thirds of all births occur outside health facilities' (Bergström and Goodburn, 2001, p. 79).

The literature suggests that these purportedly stagnant reductions of infant and maternal mortality rates may not reflect a TBA's innate ability to learn specific birthing techniques, as much as what and how TBAs were taught and particularly how their training was evaluated. According to Bergström and Goodburn, '[o]ne of the reasons for continuing debate over TBA training is the haphazard way the programmes have been evaluated …

there are surprisingly few methodologically sound evaluations, even of programme outputs' (2001, p. 84). A variety of training outcomes between countries reflect this. For example, TBAs were considered to have been successfully integrated and demonstrated marked reduction of maternal and infant mortality in both Malaysia and Samoa (Kruske and Barclay, 2004).

Furthermore, the determination of the success or failure of TBA training is based on infant and maternal mortality data of questionable rigour. Recently there have been myriad issues identified with the unreliable data sets and inappropriate data analysis surrounding these reported stagnant maternal and infant mortality rates. An independent analysis of neonatal mortality from the Institute for Health Metrics and Evaluation (IHME) at the University of Washington, which using 'three times as much data as the previous researchers', demonstrated that neonatal mortality rates fell by 57 per cent from 53/1000 in 1970 to 23/1000 in 2010, with the greatest reduction in neonatal mortality in the period from 1970 to 1980 (a period of intense WHO/UNICEF TBA training globally), and a slight levelling in this reduction from 1990 to 2010, or after the TBA training had ceased (Grady, 2010; Rajaratnam *et al*, 2010).

Similarly, IHME identified '342 900 maternal deaths worldwide in 2008, down from 526 300 in 1980' or a 35 per cent decrease in maternal mortality in 28 years (Hogan *et al* 2010, p. 1609). If maternal deaths are statistically controlled for global HIV sero-prevalence, the maternal mortality would drop from 526 300 in 1980 to 281 500 in 2008; or a 47 per cent decrease (ibid, p. 1613). Hence, 12 per cent of maternal mortality in this period may have been related to HIV/AIDS management in pregnant women. Therefore, a significant proportion of maternal mortality may, in actuality, be more a result of access to anti-retrovirals, than of access to emergency obstetric care (Grady, 2010).

These findings are in sharp contrast to a jointly sponsored WHO, UNICEF, UNFPA and World Bank assessment reporting 576 300 maternal deaths globally in 1990, and 535 900 maternal deaths in 2005; or a mere 7 per cent decrease in maternal mortality in 15 years (Hogan *et al* 2010, p. 1609). Although causality cannot be determined from these data – as numerous factors (including malnutrition; infectious environment; and poor pre-natal and post-natal care) can contribute to maternal, as well as neonatal mortality – some correlations are illustrated.

For example, although the research by the IHME does not consider TBA training as a variable in these rates, both their findings and WHO's identify the most marked declines in maternal mortality rate from 1990 to 1995 (again, during the final years when TBA training was still provided by WHO/UNICEF) and the highest increase in maternal mortality rates from 1995 to 2000 (or during the years after global WHO/UNICEF TBA training had ceased) (ibid, p. 1612). The IHME authors conclude that 'variation in the assessments of rates of decline indicates the availability and use of different data sets, different analytical methods, and different decisions about data quality by the analysts' (Rajaratnam *et al*, 2010, p. 1989).

At the time this maternal mortality study was released online by *The Lancet*, a report published by a global alliance hosted by the WHO, the Partnership for Maternal, Newborn and Child Health, claimed progress in maternal health as having 'lagged' (Cheng, 2010). 'According to their detailed analysis, from 350 000 to 500 000 women still die in childbirth every year. The authors did not explain from where their data came or what kind of analysis was used to obtain this wide range of figures, however, in the same report, U.N. officials also claim needing $20 billion every year between 2011 and 2015 to save women and children in

developing countries' (ibid.). The editor of *The Lancet*, Dr Richard Horton, was said to be 'disappointed when maternal health advocates pressured him to delay publishing the report until September, after several of their critical [Maternal and child health-care] fund raising meetings' (ibid.). Hence, it is questionable if the data collection and analysis substantiating TBA policies may, in actuality, be more of a reflection of global and multi-lateral politics, than of any statistical accuracy.

Integrating local heterodox practitioners by prohibiting their practices

The change in global health policy for TBAs may have influenced a recent change in TBA policy in the Philippines. Beginning in 1952, UNICEF and the Department of Health of the Philippines conducted training for TBAs throughout the country. The training sessions focused on sterile and hygienic techniques; pre-natal and post-natal education; and the warning signs of complications requiring referrals to hospital. TBAs were especially discouraged from the practice of cutting the umbilical cord with bamboo and were given sterile birthing kits, which some informants revealed they have kept since their initial training in the 1950s. TBAs interviewed found the training useful, reported having practised what they were taught and were eager for more training.

From 2004 to 2008, the World Bank, USAID, the European Commission and the Asian Development Bank issued reports concerning the funding of a project to reduce infant and maternal mortality in the Philippines via 'skilled' deliveries within in-birthing facilities (USAID, 2004; ADB, 2007; European Commission, 2008). The Asian Development Bank's independent evaluation was the only report to recommend against funding the project, finding it both infeasible and unsustainable and noting the seriously flawed data sets and statistical analyses provided by the Department of Health of the Philippines (ADB, 2007). Unlike the other evaluations, the Asian Development Bank suggested that the development of in-birthing facilities, especially in rural areas, was a project that, even if implementable, could only be implemented in small stages over time and that TBAs attending to at-home births were essential for this process to occur (ADB, 2007).

The concern of the Asian Development Bank was that the cessation of training of, and the lack of a provision of sterile birthing kits for, TBAs would not dissuade women from seeking their help, nor would it encourage TBA's compliance with the policy, by virtue of their priorities to community women as dictated by their cultural role. For, although several TBAs reported to be relieved to be able to give up their roles, all stated that they would not be able to refuse a woman requesting their help.

Furthermore, contrary to the other reports' correlation of infant and maternal mortality rate with TBA deliveries, the independent evaluators of the Asian Development Bank reported that when they disaggregated the Department of Health data (purportedly serving as the main data set for all of the above-mentioned reports), they found that the training of TBAs substantially reduced maternal and infant mortality in the Philippines and that the far lower number of in-facility deliveries actually resulted in a higher relative proportion of infant and maternal mortality (ADB, 2007).

Although these conclusions may seem counterintuitive, Penwell (2009) identified poor hygiene, lack of medical equipment, lack of sterile technique, and lack of appropriate care in labour and delivery and neonatal intensive care units of selected Philippine hospitals as possible factors. Furthermore, it has been determined that 'there is no conclusive evidence

that trained TBAs can prevent maternal deaths unless they are closely linked with existing health services, and are supported to refer women to functioning hospitals providing essential obstetric care' (Bergström and Goodburn, 2001, p. 79).

Akin to the issues concerning scientific rigour identified in the global WHO/UNICEF data, in assessing the Philippine Department of Health data, the independent evaluators at the Asian Development Bank found that essentially all at-home deliveries that resulted in maternal and infant mortality (regardless of who assisted delivery, very often being a family member or the mother by herself), along with purposeful abortions by the mother, were statistically attributed to the TBAs (ADB, 2007).

However, even at a basic level of data collection and analysis, the Department of Health data may significantly underestimate the reductions in infant and maternal mortality since the inception of TBA training. The Asian Development Bank's findings are corroborated by the data of the IHME. In their analysis of under-five mortality in the Philippines, a 67 per cent reduction in the under-five mortality rate from 1970 to 2010 was identified, with a 10 per cent reduction from 1970 to 1980, a 31 per cent reduction from 1980 to 1990, a 29 per cent reduction from 1990 to 2000 and a 25 per cent reduction from 2000 to 2010 (Rajaratnam *et al,* 2010, p. 1989). Although causality cannot be attributed, it is interesting to note that the periods of the largest reduction in child mortality rates (1980–2000) were, again, also the periods in which informants reported the highest number of TBA trainings.

The research team from IHME also identified a decrease in the maternal mortality rate for the Philippines from 443 to 174 per 1000 (or a 61 per cent decrease) from 1980 to 1990; 174 to 103 per 1000 (41 per cent decrease) from 1990 to 2000; and 103 to 84 per 1000 (18 per cent decrease) from 2000 to 2008 (Hogan *et al,* 2010, p. 1614). Again, it is noteworthy that the periods with the largest decreases in the maternal mortality rate in the Philippines (from 1980 to 1990) were also identified as the periods with the highest number of TBA trainings.

However, with substantial loans from the remaining lenders, the Department of Health of the Philippines issued an Administrative Order in September 2008 (AO 2008-0029) stating that all women in the Philippines are to be considered at-risk during pregnancy and must only deliver in-facility by skilled professionals (that is physicians and biomedical midwives). TBAs are to be integrated into the maternal child health team only if they agree not to perform deliveries again. However, the definition of the new role for these re-integrated TBAs and the specific activities they would be allowed to perform as part of the maternal child team is quite vague, primarily identified as assistance to the biomedical midwife without further elaboration (DOH, 2008).

Results: The feasibility of mandatory in-facility deliveries with skilled birth attendants for all women in the Philippines

As part of my research assessing the assumptions of beneficence of health-care integration in the Philippines, and thereby using the same methodology, feasibility and sustainability of implementing this Department of Health policy were found to be challenged along numerous criteria. First, 80 per cent of Filipino women in rural or isolated areas prefer to deliver at home, predominantly with the assistance of TBAs (ADB, 2007). Furthermore, less than 25 per cent of the women interviewed, who preferred to deliver at home with TBAs, would change their preference because of the DOH administrative order.

When questioned how communities would handle the situation of women who desired at-home deliveries with TBAs, and who did not comply with Department of Health policy, some community members and community administrators reported tactics from persuasion and coercion to outright threats and apparent harassment. Currently, infants who are delivered by a TBA are not issued a birth certificate, as only a skilled professional is authorised to sign the certificate. That a woman's choice of how, where and by whom she would prefer delivery should be removed and dictated to her by a devolved Department of Health, and that this policy may be considered an infringement of women's rights, does not appear to be introduced into the consciousness of this discourse except by a few women interviewed (less than 10 per cent).

In order to replace at-home delivery by TBAs, it is planned that in-facility delivery costs for indigent women will be covered by the national health insurance, Philhealth, for up to $130 per delivery, for a maximum of four deliveries. However, this amount does not fully cover the cost of in-hospital delivery, and women still must pay for medications (before reimbursement by Philhealth); transportation to the facility; and any costs beyond the allocated coverage; all of which may be well beyond a family's budget. Furthermore, if there are complications resulting in costs beyond Philhealth coverage, women and their families would be responsible for the difference.

The locations of in-birthing facilities are chosen by a Municipal Health Officer with possible input from a provincial governor. However, facilities were not always planned for those communities furthest from hospitals, where women were least likely able to access emergent care. When queried how locations for birthing clinics were determined, one municipal health officer stated simply, 'I just chose it'. Another stated that the criteria included were: according to which community was most likely to sustain and utilise the clinic, which physicians could staff the clinic and where greatest need was determined. From other interviews, the choice of which community would receive an in-birthing facility appeared to be determined by a combination of political and feasibility criteria.

Regardless of placement, several municipal health officers reported subsequent under-utilisation of in-birthing facilities. For example, one rural community that opened the only birthing facility in a municipality in 2009 reported that in that year 31 women delivered at home and only one delivered in the in-birthing facility. When the women were queried why they did not use the new in-birthing facility, they stated that the table was too uncomfortable. And the one woman delivering in-facility agreed, stating that in the future she would not use the facility again.

These choices were made by women despite referrals to the facilities from their TBAs. According to Bergström and Goodburn, '[w]hen TBAs do refer, a significant proportion of their patients do not comply with the referral advice. Reasons for non-compliance with referral by TBAs included financial constraints, lack of transportation and fear of disrespectful or painful treatment from medical staff' (2001, p. 85).

The feasibility of the capacity for increased hospital deliveries is also challenged. Several chiefs of hospitals reported that their number one admission of normal spontaneous deliveries was overtaxing an already crowded hospital system and that hospital obstetric staff have had to encourage women deemed not at-risk to deliver at home. For example, in one regional hospital normal spontaneous deliveries increased from 1858 deliveries in 2006 to 2116 deliveries in 2009 (or a 12 per cent increase in 4 years), while the number of medical staff has remained constant or decreased.

Furthermore, though this policy has slashed the health-care workforce by prohibiting TBAs from delivering, it is of particular concern that no provisions have been offered for increasing the number of 'skilled' birthing professionals. Nor does the policy address the issue of physicians who refuse to work in rural areas. A representative from the Department of Health stated that TBAs under 40 years of age were being offered full-paid scholarships to two-year midwifery schools. However, this is assuming that TBAs are both interested in attending a midwifery programme and literate. This professional human resource imbalance may prove particularly difficult to overcome in a country with a well-documented mass migration of medical professionals.

In general, feasibility and sustainability for a given local context has been neither assessed nor fully accounted for in this policy, so much as assumed. A majority (83 per cent) of biomedical midwife community health unit administrators interviewed believed the Department of Health policy was neither feasible nor sustainable. Furthermore, many midwife administrators reported good collaborative working relationships with the TBAs who were formerly trained in their communities, and reported few if any TBA delivery complications, with appropriate referral to the biomedical midwife or hospital when complications did arise. Considering that some midwife administrators are currently responsible for as many as three to four different community health units, additionally having to be available around-the-clock for deliveries in several communities may stretch them beyond a functioning capacity. According to Walraven and Weeks (1999), 'Not training TBAs who are willing and capable to learn skills of prevention, early recognition, and management of life-threatening obstetric complications will cause more harm than good'.

Hence, if the outcome of this situation is that Filipino women will continue to have at-home births with TBAs – who are now no longer being trained or supplied with a sterile birthing kit – then there is a clear *potential* for increased maternal and infant morbidity and mortality, especially in remote, poor and inaccessible areas where the implementation of this policy is least feasible. Thereby, the primary objective behind health-care integration, to decrease health inequity and improve health-care access, is being severely compromised by this particular form of integration.

Discussion

In discussing how health-care integration is being implemented in the Philippines, one municipal health official noted that 'the goal is to completely retrain them to our standard of safety'. The official then outlined an explicit plan to render all local heterodox practitioners 'safe' by retraining chosen practitioners in those practices that have been approved as safe and effective by the Philippine Institute for Traditional and Alternative Health Care, the Bureau of Food and Drug, and the Department of Health of the Philippines. Thereby, *albularyos* that would normally use an abundance of local herbs for treatment will be retrained to only treat with the ten herbs approved by the Bureau of Food and Drug of the Philippines; *hilots* employing 'spiritually guided' massage will be retrained in forms of massage approved by the Department of Health, and TBAs will assist midwives but no longer deliver. If the practitioner was unwilling to be retrained or was found to not comply with training, they would not be allowed to continue practising. Hence, in this context,

standardisation and integration are being utilised to narrow the practices that local health-care practitioners can use or even to completely eradicate them.

Clearly, the assumptions of the beneficence of health-care integration have been challenged in these local contexts of the Philippines. Although improved access to health care was one of the primary reasons health-care integration was originally sought in the Declaration of Alma Ata, integration has neither improved physical nor financial access to health care in the communities assessed. In fact, health-care integration as demonstrated in these communities has decreased access to health care. For in addition to the demand for fees from trained TBAs who formerly only accepted donations, physicians and nurses trained in acupuncture reported that they would only accept fees for service. In this manner, the formal health-care economy could potentially replace the informal health-care economy of monetary and in-kind donations, rendering both formal and informal health care inaccessible to the majority of the Philippines's poor.

Furthermore, local heterodox practitioners under top-down integration complained of marginalisation. Municipal Health Officers seeking to markedly restrict what local practitioners would be allowed to practise could further compromise available human resources for health care in the Philippines, as exemplified in the integration trajectory for TBAs (from trained-to-deliver to prohibited-from-delivery). Integration was not correlated with an increased use of heterodox practices and practitioners. Again, the eradication of TBA practices and the decrease in patients reported by local heterodox practitioners in top-down integration demonstrates that integration can, potentially reduce population use of heterodox practices and practitioners.

Referrals to patients between heterodox and biomedical practitioners do not appear to be correlated with integration in these communities. Furthermore, if health-care integration emphasises acupuncture practised by physicians or nurses more than the use of local practices and practitioners, then physician referrals may be directed predominantly toward these imported practices. Or referrals to local heterodox practitioners may be altogether discouraged, as currently evidenced in the case of TBAs. Although integration and training may result in more local practitioners willing to engage in training, this training is of questionable utility if no heterodox practitioner interviewed would agree to replace what they traditionally practised with the practice taught in standardised training.

This last issue highlights inherent problems in the normative concept of standardisation in health-care integration. The concept of standardisation assumes bounded health-care practices or practices that can be systematised. If, as in the Philippines, the majority of local heterodox practitioners are, in essence, self-taught via dreams and visions, then possibly no member of a given labelled practitioner category will practise in the same manner, nor then, could a standard of this practitioner category be identified. Although, local health-care practices may conform with a dominant Filipino cosmology, it is doubtful that such a cultural standard could be translated into an acceptable biomedical application of standardisation.

In addition, there is no single universal system of classification of local heterodox health-care practices in the Philippines (Tan, 1987). Attempts to organise local practices and practitioners have been incomplete, containing only certain practice and practitioner labels specific to the particular community studied. Furthermore, overlapping categories of local health-care practices and practitioners are commonly identified (Tan, 1987; Jocano, 2004; Kadetz, 2009). For, even when practice categories are representative of a given local level,

practitioners rarely strictly practise as per their given practitioner title. Hence, 'herbalists' may primarily perform massage and 'bone setters' may only prescribe herbs (Kadetz, 2009). These challenges to a conceptualisation of basic practice/practitioner categories would present insurmountable problems for a biomedical understanding of standardisation dependent upon such discrete categories.

Lastly and possibly most problematic for the standardisation of local heterodox practitioners is the fact that many local practitioner informants found the concept of standardisation inherently ignorant, for they believed that what was given to them as a gift from God could neither be taught nor standardised, nor should it be shared. However, the normative conceptualisation of standardisation leaves little room for such cultural and belief system variations.

This research suggests that there are as many ways 'to do' health-care integration as there are interpretations. But beneficent outcomes cannot be assumed merely by virtue of engaging in any given form of health-care integration. Theory and intention are markedly different from practise and outcomes. A brief comparison of the historical formation of TCM and the modern integration of ayurveda is illustrative.

Even without acknowledging that health-care integration in Mao's China was actually integration of an already integrated heterodox system of TCM, basing all health-care integration on the integration of TCM and biomedicine, as the WHO has done, poses several pertinent challenges when applied to other countries or even to China today. First, it is imperative to acknowledge that health care functions within a given political economy. The formation of TCM was conceived and implemented within an egalitarian-authoritarian economic and social system, which may not be compatible, and thereby transferable, into liberal-democratic and other economic/social systems (Walt, 1994).

Second, although Mao believed that the integration of Chinese medicine could provide an opportunity to redress rural health inequities with the practitioner resources already available, he had to overcome opposition from biomedical physicians, the Ministry of Health and the modernisation movement of the early Chinese Communist Party, which originally sought to extinguish Chinese medicine (Lucas, 1982).

Therefore, as health-care integration in China could not be achieved by complete consensus, force and coercion were employed (Rosenthal, 1981). This particular means of integration, in which the governmental reduction of control and power granted to physicians and heterodox practitioners, rendered them politically impotent, offers a stark contrast to the political agency of ayurvedic practitioners in India, who were able to achieve parity between ayurveda and biomedicine at approximately the same historical moment (Leslie, 1992).

Yet the WHO chose to base their conceptualisation of integration on Mao's model of the enforced integration of TCM and biomedicine. Although it is beyond the scope of this article, it is imperative to consider the effects of WHO's choice to define and champion integration in terms of a model that is historically tied to the top-down assertion of governmental force and control (TCM in China), rather than a model of integration achieved by more equitable political power and agency, as demonstrated by the powerful political lobby of independent ayurvedic practitioners in India (Leslie, 1992; Bala, 2007).

Hence, political and social capital may be one element that effects the type of integration a given heterodox practitioner group seeks and achieves. But one may further question whether WHO's choice of the Chinese model has facilitated an inequity of power between key

health-care actors and stakeholders by virtue of its historical use and structure, as demonstrated in the top-down implementation of integration in Bagabag. Once it is acknowledged in the integration discourse that there is more than one way to accomplish health-care integration, finding the appropriate integration for a given context may then be possible.

Conclusion

In conclusion, there is an unchallenged conception of the inherent beneficence of reducing health-care disparity in the discourse of health-care integration that is not substantiated by the data presented here. The unintended negative consequences of health-care integration presented in this article may be understood as a microcosm of the larger issues embedded in the domains of global health policy and global health governance. Feasibility, sustainability and outcomes for a given local context are often not so much assessed as assumed in global health-care policymaking (Oxman *et al*, 2007). This may be a reflection of the hegemony of the biomedical paradigm in global health policy, or it may also reflect the WHO policymaking process, whose transparency and structure is brought into question.

Oxman *et al*'s (2007) assessment of WHO's systematic and transparent approaches to policymaking identified an over-reliance on experts; lack of attention to Member State adaptation of global recommendations; lack of attention to local needs, conditions, resources, costs and values; lack of attention to effective dissemination and implementation strategies and their rigorous evaluation; and a failure to develop recommendations that address existing health systems.

The mere fact that different local contexts have different needs presents challenges to the entire universalist paradigm of global health policy. However, this is not to denigrate policies and interventions that have most certainly improved population health as a result of global and international coordination. One is immediately reminded of the successes of numerous vertical disease eradication programmes, with global smallpox eradication marking one of the triumphs of global health-care policy and coordination through multilateral institutions. But it is important to note that these programmes address specific health-care issues that best fit within a medical model of intervention.

It is imperative to recognise that local heterodox practitioners serve important social and cultural functions in their communities and that their practices can be altered to the point of being no longer socially meaningful, or specifically able to address culture-bound illnesses and thereby of questionable utility for the local context. Yet these valid concerns are neglected in the current discourse on health-care integration.

Furthermore, that integration should require experts who often know little about local heterodox health-care practices, and that communities are often considered by these experts to be incapable of making the best health-care choices on their own, is another significant unchallenged assumption of this policy domain. This particular assumption is especially contradictory for communities that have been entrusted with the stewardship of their local health care, by virtue of a decentralised health-care system, such as in the Philippines, yet are rendered incapable of making decisions concerning preferred health-care use.

Although the integration of imported heterodox health-care practices to the potential detriment of local heterodox practices is not representative of countries that have been the focal

point of the majority of literature on integration – such as China, India and Tibet – health-care integration in the Philippines may actually be more representative of issues facing local levels in other low-income countries with more informal and unstructured heterodox health-care practices. This is not to imply that these findings are generalisable beyond the communities presented here. Nor is the potential value in the concept of health-care integration being dismissed. Rather, these results question precisely how health-care integration is being implemented, and whether the best practices specific to each local context are being considered in the policymaking process. For although this analysis was neither intended to advocate for or against health-care integration, the research findings do suggest that integration policy that ignores the specific needs of local contexts may negatively impact informal local health-care systems, access to health care and ultimately the health of communities.

The cases presented here pose the question of whether health-care integration is something that really needs to be done to a population, done with a population or whether it is something a population will organically arrive at if left to its own devices. Although the model for integration chosen by the WHO emphasises a normative conception of integration as something that needs to be done to a population, it is suggested here that there is no one way to universally implement health-care integration. Rather, such integration may be best determined by the local context. This is because population preferences, governed by changing sociocultural factors, may be most central in generating the demand for particular local health-care practices and practitioners.

For example, in the Philippine municipality of Sadanga, poor access to biomedical health care has necessitated that local heterodox practitioners be the primary caregivers for the majority of the population. These practitioners have referred to physicians as needed and the integration of biomedicine into a predominantly local heterodox health-care system has reportedly worked well for Sadanga. Hence, I conclude that context ultimately needs to determine policy, regardless of the geographic or administrative designation to which health-care integration is applied.

Clearly, the field of health-care integration demands more research at local levels in order to provide an evidence base for health-care policy that benefits population health in practise, as opposed to doing so only in theory. In their study of the WHO policy process, Oxman *et al* (2007) found that interviewed WHO directors identified the use of evidence more frequently than any other area as needing improvement; 'evidence is generally not retrieved, appraised, synthesised, and interpreted using systematic and transparent methods. Few directors reported using data about potential harms or explicitly considering values – i.e. the relative importance or worth of the consequences (benefits, harms, and costs) of a decision' (pp. 1885–1886). Hence, such important global health policies as health-care integration may only benefit from research if policymakers are, in fact, interested in both the intended and unintended consequences of their policies, and use the derived evidence as a feedback mechanism to establish best practices for the benefit of all local contexts.

About the Author

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