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Health Devolution in the Philippines: Lessons and Insights

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Abstract

The study attempts to document the Philippine's experience in health devolution with focus on the Department of Health's efforts to make it work. It also aims to draw lessons and insights that are critical in assessing the country's decentralization policies and also, in informing future policymaking. In particular, it highlights the importance of (i) a well-planned and well-designed government policy to minimize, if not avert, unintended consequences; and (ii) mainstreaming of health policy reforms to ensure sustainability. It suggests the need to (i) take a closer look at the experience of local government units (LGUs) that were able to reap the benefits of health devolution and find out how the good practices can be replicated in other LGUs; and (ii) review and assess the various health reforms and mechanisms that have been in place to draw lessons and insights that are useful for crafting future health policies.

Keywords*:* Health devolution, health decentralization, devolution, decentralization, health policies

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Health devolution in the Philippines: Lessons and insights

Janet S. Cuenca*

1. Introduction

The 1987 Philippine Constitution mandated the Congress to "enact a local government code which shall provide for a more responsive and accountable local government structure instituted through a system of decentralization with effective mechanisms of recall, initiative and referendum, allocate among the different local government units their powers, responsibilities, and resources, and provide for the qualifications, election, appointment and removal, term, salaries, powers and functions and duties of local officials, and all other matters relating to the organization and operation of the local units (Section 3, Article X)." In response to this Constitutional directive, the Congress legislated the Republic Act No. 7160, otherwise known as the Local Government Code of 1991 (hereafter Code), which was signed into law on October 10, 1991 and took effect on January 1, 1992.

The Code's Book I, Section 2 (i.e., Declaration of Policy) states that the Code aims to grant local autonomy to territorial and political subdivisions of the State. In particular, DILG-LGA (2003, p. 4) specifies the objectives of the Code which include:

- to provide local government units the opportunity to tap their fullest potentials as self-reliant communities and as active partners of the national government in the attainment of national goals
- to facilitate faster decision-making at the local level
- to enhance the participation of ordinary citizens, organized groups, and the poorer sectors in the conduct of public affairs and the business of government
- to deliver basic services more efficiently

The enactment of the Code has changed the way basic government health services are delivered at the local level. From a highly centralized system of health service delivery with the Department of Health (DOH) as the sole provider, the Code mandated the devolution[1] (i.e., involving all dimensions of decentralization of expenditure competencies such as regulation, financing, and delivery of public services (Martinez-Vazquez and Timofeev (2009)) to local government units (LGUs)[2] of many of the functions previously discharged by DOH. Health devolution or decentralization of health services was

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[1] The Code defines devolution as the act by which the national government vests power and authority upon local government units to perform specific functions and responsibilities.

[2] Also referred to as subnational governments

initially geared towards efficiency and effectiveness of health service delivery by reallocating decision-making capability and resources to LGUs (Grundy et al. 2003; Galvez-Tan et al. 2010).
It is noteworthy that decentralization is a core element of the implementation of the Primary Health Care (PHC), which is a strategy adopted by DOH in the late 1970s (DOH 1997; Perez 1998a; Grundy et al. 2003; DOH-BLHD 2013; NCPAG-CPED 2014) in compliance with the Declaration of Alma Ata on PHC[3] to ensure that essential health care[4] is "made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford … (Alma-Ata Declaration 1978)."

Perez (1998a) mentions that the Philippine's local health systems were established on PHC principles, which is basically "Health in the Hands of the People," thus signifying empowerment of the people in managing their health and health service delivery (Galvez-Tan 2013). In the same vein, DOH-LGAMS (1993) explains that the Code ushered in participatory local governance and placed health care in the hands of the people. In this sense, health devolution has not empowered LGUs alone but also the people by allowing them to participate in policy and decision-making that concerns delivery and quality of health care (DOH-BLHD nd).

As a result of health devolution, LGUs have taken on the great responsibility in the delivery of basic services and in the operation of facilities in areas that include primary health care and hospital care/services. On the other hand, the DOH[5] has become the leader, enabler, standard-setter (or regulator-enforcer of standards/regulation) for health services planning and service provision and delivery, policy maker, health advocate, resource center, mobilizer, and technical adviser as well as administrator of regional and special hospitals (DOH-BLHD nd; Mercado et al. 1996; Romualdez et al. 2011; DOH-BLHD 2013). In other words, it has assumed the role of the "national technical authority on health," which implies that it is expected to "ensure the highest achievable standards of quality health care, health promotion and health protection" that LGUs, non-government organizations (NGOs), private organizations (POs), and civil society should uphold (DOH-BLHD 2013, p.7).

In this light, this study attempts to document the Philippine's experience in health devolution with focus on DOH's efforts to make it work. It also aims to draw lessons and insights from existing literature that

[3] A commitment to Primary Health Care (PHC) made by more than 100 heads of state and Ministers of Health during the International Conference on Primary Health Care held in Alma-Ata, U.S.S.R., present-day Almaty, Kazakhstan, on September 12, 1978; a call for "Health for All" that was aimed at ensuring accessibility to essential health care services for the poorest and marginalized through PHC strategy (Alma-Ata Declaration 1978; Perez 1998a; Galvez-Tan 2013)
[4] Based on Alma-Ata Declaration of 1978, it includes education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.
[5] DOH's vision: "A global leader for attaining better health outcomes, competitive and responsive health care systems, and equitable health care financing." DOH's mission statement: "To guarantee equitable, sustainable and quality health for all Filipinos, especially the poor, and to lead the quest for excellence in health (DOH-BLHD 2013, p.7)."

are critical in assessing the country's decentralization policies and also, in informing future policymaking. The rest of the chapter is organized as follows. Section II discusses in detail the health devolution in the Philippine context. Section III reviews the implications of health devolution with highlight on the issues and challenges. Section IV reviews the DOH responses to health devolution through the years to make it work. Section V ends with a discussion on lessons learned and insights which are critical in assessing the health decentralization policies and also, in crafting future policies in the country.

2. Health Devolution in the Philippine Context

The Code's Section 17 identifies the basic health services and facilities devolved to the LGUs. **Table 1** summarizes the devolved functions by level of government. Nevertheless, Section 17.c. excludes "public works and infrastructure projects and other facilities funded by the national government under the annual General Appropriations Act, other special laws, pertinent executive orders, and those wholly or partially funded from foreign sources" unless the LGU is the designated implementing agency. Also, Section 17.f. states that "the national government or the next higher level of local government unit may provide or augment the basic services and facilities assigned to a lower level of local government unit when such services or facilities are not made available or, if made available, are inadequate to meet the requirements of its inhabitants."

Table 1. Devolved Functions by Level of Government

LGU	Devolved Health Services	Reference
Barangay	Maintenance of barangay health center	Section 17.b.1.ii.
Municipality	Implementation of programs and projects on primary health care, maternal and child care, and communicable and non-communicable disease control services;	Section 17.b.2.iii.
	Access to secondary and tertiary health services	
	Purchase of medicines, medical supplies, and equipment needed to carry out the said services	
Province	Hospitals and other tertiary health services	Section 17.b.3.iv.
City	All the services and facilities of the municipality and province	Section 17.b.4.

Source: Local Governmnet Code of 1991

Based on the Department of Health (DOH) Rules and Regulations Implementing the Local Government Code of 1991 (DOH Task Force on Decentralization 1992), primary health services are otherwise known as basic health services, which are delivered at health centers or rural health units (RHUs) and

barangay[6] health stations (BHS). These services include health education; control of locally endemic diseases such as malaria, dengue, schistosomiasis; expanded program of immunization (against tuberculosis, polio, measles, diphtheria, whooping cough, and tetanus); maternal and child health and family planning; environmental sanitation and provision of safe water supply; nutrition; treatment of common diseases; and supply of essential drugs (DOH-LGAMS 1993).

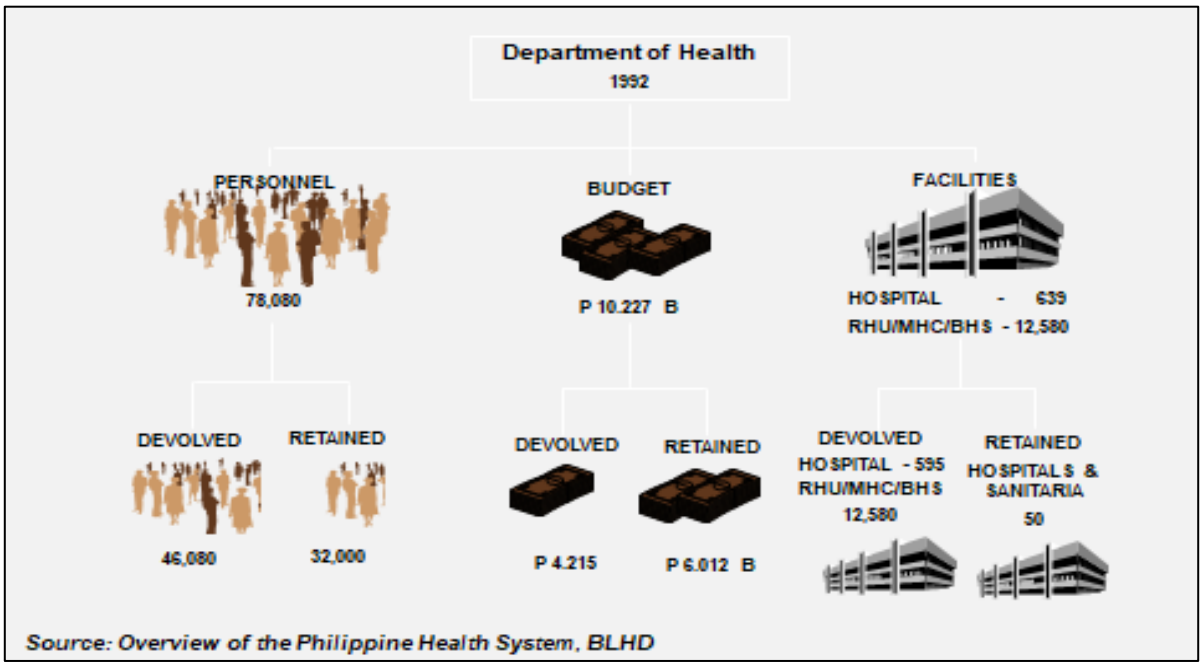
On the one hand, secondary health services are medical services that are accessible in some rural health units, infirmaries, district hospitals, and out-patient departments of provincial hospitals. On the other hand, tertiary health services include medical and surgical diagnostics, treatment, and rehabilitative care that are usually provided by medical specialists in a hospital setting (DOH Task Force on Decentralization 1992). Not all DOH powers, functions, and responsibilities have been devolved. The DOH takes on the residual powers and functions that include oversight or general supervision of the health sector, monitoring and evaluation functions, formulation of standards and regulation, and provision of technical and other forms of assistance (DOH-LGAMS 1993).

As mandated by Executive Order 102 (EO 102) of 1999, the DOH also provides assistance to various entities (e.g., LGUs, NGOs, POs, and civil society) in the implementation of programs, projects, and services that are geared towards (i) promotion of health and well-being of every Filipino; (ii) prevention and control of diseases among populations at risk; (iii) protection of individuals, families, and communities from hazards and risks that could affect their health; and (iv) treatment, management, and rehabilitation of individuals affected by diseases and disability (DOH-BLHD 2013).

The devolution of health services involved the transfer to LGUs[7] of the records, equipment, and other assets and personnel of the DOH, corresponding to the devolved powers, functions, and responsibilities (Section 17.i). **Figure 1** shows in detail the devolved personnel, budget, and facilities from the DOH. More than half, i.e., about 46,080 of the 78,080 health personnel were devolved. In terms of health facilities, about 595 hospitals and 12,580 rural health units/municipal health centers/barangay health stations were devolved. However, the devolved budget was less than the retained budget, i.e., PhP4.215 billion vis-à-vis PhP6.012 billion, which was intended to fund national programs (DOH-BLHD nd). The massive transfer of personnel, health facilities, and budget had an overwhelming effect on the health sector, thus making health devolution the "most dynamic and complex" scheme in the entire decentralization process (Mercado et al. 1996, p.5). As such, the Philippine health devolution experience can be considered as "the most ambitious health decentralization initiatives ever undertaken in Asia (World Bank, 1994, p.i)."

[6] In English, village, i.e., the smallest political unit
[7] Include 76 provinces, 66 cities including Metro Manila, and 1,540 municipalities (Solon and Herrin 2017)

Figure 1. Personnel, Budget and Facilities Devolved from the Department of Health



Nevertheless, Perez (1998a, p.8) notes that there are only limited direct references to health services and its organization in the Code, particularly Section 17 on "Basic Services and Facilities," Title Five in Book 1 on "Local Health Boards", Title Five in Book 3 on "Appointive local officials common to all municipalities, cities, and province, and Article 8 on "The health officer." The said report argues that such treatment for the "largest and most complex" basic government service, which was due for devolution indicates the little regard for technical aspects that are crucial to the delivery of basic health services. ARDI (1998) points out that health service delivery is the toughest technical challenge for LGUs.

To facilitate the implementation of health devolution, the Department of Health Task Force on Decentralization drafted in August 1992 the "DOH Rules and Regulations Implementing the Local Government Code of 1991 (hereafter DOH IRR)," which provides guidance on devolution of health functions, transfer of DOH personnel, assets, and appropriations to local governments, and DOH regulatory functions, among others (Perez 1998b, p. 3).

In addition, the DOH created in December 1992 the Local Government Assistance and Monitoring Service (LGAMS), initially an ad hoc unit but in 1994 got its own line item in the DOH budget, to serve as liaison between the DOH and LGUs (Perez 1998b). The LGAMS was envisioned to respond to issues and concerns arising from the devolution process (ARDI 1998). On the other hand, the Department of Interior and Local Government (DILG) through the Bureau of Local Government Development formulated the Master Plan for Local Government Code of 1991, i.e., to sustain the momentum of

decentralization process (DILG-BLGD nd). In particular, the implementation of health devolution in the country followed three phases, namely:

- Changeover phase (period 1992-1993) – the phase wherein the formal transfer of functions and responsibilities from DOH to LGUs occurred, along with the corresponding personnel and assets and liabilities.

According to Perez (1998b), the transfer of DOH personnel, assets, and appropriations started in September 1992, which involved the formulation and signing of Memoranda of Agreement (MOA) between the DOH and each LGU. However, the actual transfer of health personnel was slated for January 1993. By April 1993, the facilities, personnel, program and services of the DOH were devolved to LGUs (DOH 1997).

- Transition phase (period 1994-1996) – the phase wherein the DOH and LGUs attempted to institutionalize their adjustments to the major innovations introduced by the Code (e.g., DOH restructuring); the phase that was expected to lead/facilitate the LGC implementation to the Stabilization Phase by providing assistance to LGUs and building the capacity of LGUs to manage health services

- Stabilization phase (1997 and onwards) – the phase wherein LGUs were expected to have developed capabilities in managing local affairs (i.e., LGUs were fully autonomous that they manage local health services) and DOH provided constant support and technical assistance to LGUs; the phase wherein LGUs

Moreover, Local Health Boards (LHBs) were created in every province, city, or municipality to operationalize and intensify service delivery at the local level. The local chief executives (i.e., governor in the case of provinces and mayor in the case of cities and municipalities) act as the chairman while the local health officers serve as vice-chairman of the LHBs. Members of the LHBs are the chairman of the committee on health of the LGU councils (i.e., Sanggunian in Filipino), a representative from the private sector or non-governmental organizations involved in health services, and a representative of the DOH in the LGUs.

Based on Book I, Title Five, Section 102 of the Code, the LHBs are expected to propose to the council the annual budget for the operation and maintenance of health facilities and services; to serve as an advisory committee on health matters, particularly on local appropriations for public health; and to create committees that shall guide local health agencies in personnel selection and promotion, bids and

awards, grievances and complaints, personnel discipline, budget review, operations review, and similar functions.

Inspired by the concept of District Health System (DHS)[8], Inter-Local Health Zones (ILHZs) were established for the effective delivery of integrated health care and smooth coordination between and among cities, municipalities, and barangays (Section V of Presidential Executive Order No. 205 of 2000). An Inter-Local Health System (ILHS) is formed by clustering municipalities into ILHZs, which comprise a defined population within a defined geographical area and a central (or core) referral hospital with a number of primary level facilities such as RHUS and BHS, as well as other stakeholders (e.g., community-based NGOs and the private sector) that are concerned about or involved in health service delivery (DOH 2002, p.v).

3. Implications of Health Devolution: Issues and Challenges

Before the health devolution, the DOH recognized that many of the LGUs might be facing resource constraints (e.g., financial, material, and human resource) and thus, it had a policy dilemma on whether or not to devolve health services to LGUs. However, there is wisdom in doing so because of the urgency of local action in providing these services without seeking top-level intervention (DOH 1997). In addition, decentralization of decision-making and administration is a key element in the implementation of the Primary Health Care (PHC), an approach adopted by DOH in late 1970s to achieve health for all (DOH 1997; Perez 1998a; Grundy et al. 2003; DOH-BLHD 2013; NCPAG-CPED 2014).

Nevertheless, the fact remained that many LGUs were not ready for the devolution in terms of both financial and human resource. Fiscal capacity of LGUs and managerial capability of local chief executives (LCEs) were not considered prior to devolution. Grundy et al. (2003) point out that there was no capacity building for local officials and health personnel before the devolution. In general, DOH (1997) recounts that there was no sufficient preparation that would enable all those affected by health devolution to cope with the tremendous changes it brought. Orientations, particularly on Local Health Board (LHB), were conducted in 1994, i.e., a year after actual devolution (Perez 1998a).

Grundy et al. (2003) argued that although the DOH drafted an internal implementing rules and regulation (IRR) to guide LGUs in the discharge of their new functions and responsibilities and it held a series of health assemblies to discuss these responsibilities, a strategic plan for the introduction of

[8] Defined by the World Health Organization as a more or less contained segment of the national health system which comprises a well-defined administrative and geographic area either rural or urban and all institutions and sectors whose activities contribute to improve health; subdivided into three levels of referral, namely primary (barangay health stations and rural health units, secondary (district/provincial hospitals), and tertiary (provincial and regional hospitals) that have distinct yet complementary functions (DOH 2002, p. v);

devolution (i.e., prior to health devolution) was lacking. Most of the mechanisms that DOH adopted were put in place after the devolution. Consequently, the national government and LGUs faced (and still face) a number of challenges to make devolution work. The issues and challenges of health devolution can be summarized into three broad topics, namely, financing for health, health personnel, and organization/structural change.

3.1 Financing for health

The issue on financing for health is rooted on the mismatch between the internal revenue allotment (IRA)[9] and the cost of devolved functions (CODEF). This has been an issue since the changeover phase, particularly in the last quarter of 1992, when many LGUs realized that the CODEF was more than the respective IRA share (i.e., inequitable burden of CODEF across LGUs). Consequently, many provinces and smaller municipalities had insufficient funds to pay the salaries of the national workers devolved to them (Perez 1998a and Perez 199b), not to mention the cost of implementing the Magna Carta for public health workers as mandated in Republic Act 7305 of 1992, which was not factored in the estimation of CODEF. Perez mentions in Wibulpolprasert (1999) that tight budgets and high salaries (i.e., due to Magna Carta benefits) of health workers caused a reduction in hiring of health personnel by LGUs, as evidenced by inadequate hospital and rural health unit staff. (DOH 1997) reports that vacant plantilla positions were left unfilled to generate savings and in turn, defray the costs of Magna Carta benefits.

The inequitable IRA distribution vis-à-vis CODEF also caused LGUs to complain about inadequate funding for the operation of health facilities, particularly hospitals (DOH 1997). DOH (1999b) explains that the mismatch between the IRA and cost of devolved hospitals resulted in lower (i.e., vis-à-vis pre-devolution) province-level spending on hospitals. It notes that the number and size of devolved hospitals were greater than what was needed by the LGUs because of the pre-devolution incentive structure that encouraged legislation on the construction of provincial and district facilities at the expense of the national government. Gualvez (1999) mentions that some of these hospitals had bigger staff than what was necessary. NCPAG-CPED (2014) points out that the provinces that received more hospitals got the brunt of devolution because the operation of hospitals entailed huge financial requirement.

Grundy et al. (2003) reiterate the issue on high personal services, limited financial resources for health services, and almost zero budget for capital investment that confronted the LGUs. Underfinancing of

[9] Automatically appropriated and released share of local government units, aggregately corresponding to 40% of the national internal revenue taxes based on the collection of the third fiscal year preceding the current fiscal year, with the share of each local government unit determined pursuant to the provisions of the Local Government Code, by share for each LGU level, and in terms of population/land area/equal sharing (DBM 2015, p. 711).

public health services caused their slow deterioration which manifested "in terms of understaffing, low utilization rates, un-maintained infrastructure and un-repaired or un-replaced equipment." The national government's effort to augment local health budget did not help in preventing the slow decay (Grundy et al. 2003, p.7). However, as caveat to these findings, it is noteworthy that Gualvez (1999) mentions that health facilities were already dilapidated when the LGUs took over because pre-devolution investments meant for local health facilities were never realized. DOH (1999b, p.17) recognizes that health devolution brought to the fore "the years of neglect that provincial, district, and municipal facilities have suffered long before it."

The lack of funding can also be attributed to low priority for health because of the tendency of LGUs to invest in infrastructure projects such as construction of roads and gymnasiums (UP-NIH 1998). Perez (1998a) points out that six years after the Code implementation, the issue on inequitable burden of CODEF across LGUs remained. Inadequate IRA funds resulted in LGUs' failure to implement national mandates, which are usually unfunded, such as salary increases and Magna Carta benefits for health workers. Consequently, hiring of health personnel declined (Wibulpolprasert 1999).[10] Likewise, Bauer (nd) argues that the shortfall in funding for health care made it difficult for less developed fifth and sixth class LGUs to maintain quality of health standards. Consequently, inequity between richer and poorer municipalities as well as between municipalities and cities became even more pronounced and remained a major concern.

Solon and Herrin (2017) mention that almost ten years after the passage of the Code, the DOH, in its effort to draw up the Health Sector Reform Agenda (HSRA), identified major problems relating to the delivery and financing of health services. These problems include (i) the disparity in access and quality of publicly provided health services among LGUs and by type of facility; (ii) LGU's failure to maintain/ upgrade devolved facilities and to provide the mandated benefits to devolved health workers in some areas; (iii) lack of technical coordination across levels of health system; and (iv) slow progress in establishing the Philippine Health Insurance Corporation (otherwise known as PhilHealth) as a social health insurance program, which resulted in huge out-of-pocket spending. Romualdez et al. (2011) argue that the issue on high out-of-pocket payments is the major health financing concern in the country.

On the other hand, the findings of Chakraborty et al. (2011, p.viii) point to the "continuing low levels, fragmentation and inequity in public financing" as one of the structural deficits in the health sector in spite of the important contributions of the Health Sector Reform Agenda 1999-2004 and Fourmula One 2005-2010 in improving health sector performance. The authors identify factors that led to this issue such as (i) constrained revenue-raising capacity of the government which affected its capacity to finance

[10] Based on the contribution of Dr. Juan Antonio Perez, III in Wibulpolprasert (1999)

public expenditures in health, among others; (ii) the challenge of mobilizing health sector resources from a huge informal sector through PhilHealth enrollment; (iii) the fiscal constraint in financing health being faced by LGUs in underserved regions; (iv) lack of incentives on the part of LGUs to enroll indigent families with PhilHealth; and (v) highly fragmented and sometimes overlapping streams of funding (i.e., PhilHealth, DOH, and LGUs). They explain that "these financing 'pools' vary in the way they are funded, in their approach to financing (whether premiums for health insurance or budget financing for health facilities), in their eligibility, in the services they cover and use."

3.2 Health personnel

The changeover phase was distraught with issues relating to health personnel. Some LGUs refused to accept the devolved health workers for varying reasons. In response, the Oversight Committee created for the Code held hearings in all regions to address the misunderstanding among local governments, devolved workers, and concerned national government agencies. This strategy helped solved most of the problems by the second half of 1993 except for the case of the National Capital Region and Camarines Norte, which served as a lesson on underlying issues surrounding devolution (Perez 1998b).

In Metro Manila, some municipal mayors were not willing to absorb the cost of devolved health personnel because they believed that it was estimated based on questionable plantilla while some other municipal mayors thought that having too many highly paid workers, particularly doctors, would hinder their plans for cityhood and still some others thought that the salaries of devolved workers would be higher than that of the existing city health officers. In Camarines Norte, a breakdown of trust arose that almost pushed the devolved health workers to resign because they were not paid for months and the governor's response was to replace them. These issues were later resolved through an Executive Order that imposed administrative sanctions on resistant LGUs.[11] Consequently, health devolution was completed in the final quarter of 1993 (Perez 1998b).

Moreover, health devolution spawned geographical displacement, job loss, income and benefit changes, and increased politicization of health. For instance, midwives were forced to resign because they were displaced or moved away from their place of residence and worse, transferred to the mountains, which was partly attributed to political differences between the current LCEs and health staff. Midwives were not also provided travelling expenses during area visits or service delivery (UP-NIH 1998). Further, health devolution caused demoralization among health personnel due to the reduction (i.e., from one-fifth to one-third) in salary and pay scales of devolved national health workers. National-level health

[11] Romualdez et al. (2011) recount that health devolution was opposed with many protests and much criticism but it was finally implemented in 1993.

workers received higher compensation relative to their local counterparts. Also, devolved national health workers thought that the changes in the health system structure would compromise their chances for promotion and vertical improvement (NCPAG-CPED 2014). Health workers complained that opportunities for career advancement and continuing education were limited (DOH 1997).

The enactment of Republic Act 7305 of 1992 or Magna Carta of Public Health Workers was envisioned to promote and improve the social and economic well-being of the health workers, among others. However, it aggravated the issue on inadequacy of local budget because the implementation of the said law has huge impact on the size of the budget for personnel services in the health office. It entails significant cost that is beyond the financial capacity of poorer LGUs. Also, it caused LGU officials to complain because health workers' compensation is higher than that of the elective officials. As a result, the Magna Carta for health workers has perverse impact on the relationship between the LGU health office and other LGU offices.

3.3 Organization/Structural Change

3.3.1 Local Health Board

The Code requires the creation and composition of a Local Health Board (LHB) in every province, city, or municipality with the local chief executives (i.e., governor in the case of provinces and mayor in the case of cities and municipalities) as chair and the local health officers as vice-chair. The LHB also comprises the chair of the committee on health of the local councils, a representative from the private sector/non-government organizations and a DOH representative. It is tasked to prepare the annual budget for health, act as an advisory committee on health matters, and create committees that shall guide in personnel selection and promotion, bids and awards, and budget review, among others (Book I, Title Five, Section 102).

In sum, the LHB is expected to recommend policies concerning planning and implementation of local health programs (DILG-LGA 2003). It was envisioned to address transition problems because it was regarded as a venue where the DOH would be able to relate to LGUs (Perez 1998a), particularly through the DOH representative. However, Perez (1998a) recounts that six years after the devolution, there were issues (e.g., inequitable burden of CODEF, unfunded mandates such as salary increases and Magna Carta benefits, etc.) beyond the LHB's power.

AYM (1995) enumerates a number of critical issues relating to the functioning of the LHBs approximately three years after they were convened. To wit:

1. There were only few functional LHBs. Some LHBs stopped functioning in 1993.

Section 103 of the Code requires LHBs to meet once a month or as often as necessary. According to UP-NIH (1998), the functionality of LHBs was gauged in terms of regularity of meetings, which all municipalities failed to comply with. Meetings were done quarterly because LHB members thought there was nothing to discuss. On the other hand, ARDI (1998) reveals that most LHBs were not fully functional.

DOH (1997, p.2) cites a number of reasons behind the issue on functionality of LHB such as lack of financial and material support for LHB activities, political differences of LHB members, lack of monitoring and guidance from higher bodies, and lack of representation of hospital personnel in the LHB. AYM (1995) points out that political affiliations and differences affected the functioning of LHBs, particularly in convening meetings and selection of members. In addition, there was no authority or body that monitored the performance of LHBs, which was highly dependent on the local chief executives (LCEs).

UP-NIH (1998) poses a question on who monitors the LHBs considering that it is a local special body ran by the LGUs, particularly the LCEs and that DOH, through a representative, is just a member. The study mentions that the governor has control over the municipal LHBs. For instance, the governor of one province issued a memorandum to all municipal mayors informing them that municipal budgets would not be approved unless they comply with conditions (e.g., submission of monthly LHB meeting reports). In addition, the Department of Interior and Local Government (DILG) requested the Regional Directors to submit reports on LHBs' activities. Moreover, the community can lodge LHB-related complaints with DILG's Local Government Operations Office (LGOO).

2. NGOs were not represented in the LHBs.

UP-NIH (1998) raises a different issue concerning NGO representation in LHBs, particularly the issue on the process of selection (e.g., LCEs handpicking the NGO representatives) adopted in most municipalities, which did not follow the provisions of the Code.

3. LHBs primarily took on supportive role to on-going local and national programs and performed less of their expected functions and responsibilities.

4. Only few committees (e.g., bids and awards and personnel discipline, among others) were created in only one or two LGUs.

5. Only few resolutions were passed.

6. Only few LGUs had accomplishments in terms of assistance to local and national programs, advocacy activities, and implementation of Magna Carta-related activities

7. The status and effectivity of LHBs did not vary according to the income classification of LGUs. There were no marked disparities between high-income and low-income LGUs. LGUs' perceptions of health issues (i.e., relating to financial and administrative concerns) and their recommendations to address these issues were the same for all LGUs.

8. There was a need to re-orient the LHBS on their tasks and responsibilities in health delivery.

ARDI (1998) validates the need for such re-orientation because of lack of clarity on LHB functions and mandates, coupled with limited flexibility in planning and budgeting, particularly at the municipal LHBs because the provincial government or the DOH pre-programmed the funds. This study reveals that instead of acting as provider of technical assistance, the DOH field offices and provincial offices of the Commission on Population (POPCOM) served as primary implementers of nationally- conceived or desirable programs.

9. There was a need for implementing guidelines that would serve as framework for LHB activities. In addition, there was a recommendation for setting up an information system for monitoring of LHBs' status and performance and identify issues concerning health service delivery.

3.3.2 The issue on fragmentation of health services

Prior to health devolution, the local health systems were structured based on the District Health System, which is defined by the World Health Organization (WHO) as "a more or less contained segment of the national health system which comprises a well-defined administrative and geographic area either rural or urban and all institutions and sectors whose activities contribute to improve health." In short, DHS is a generic term developed by the WHO to mean an integrated health management and delivery system that is defined over administrative and geographical area called health districts. The DHS is comprised of three levels of referral, such as primary (barangay health stations and rural/city health units/centers),

secondary (district/provincial hospitals), and tertiary (provincial and regional hospitals). These levels of referral have distinct but complementary functions. The DHS was envisioned to improve efficiency and effectiveness in health service delivery (DOH 2002, p.v).

Before WHO introduced the DHS concept in 1983, the Marcos administration had already issued Executive Order (EO) No. 851 (i.e., Reorganizing the Ministry of Health, Integrating the Components of Health Care Delivery into its Field Operations, and for Other Purposes) on December 2, 1982. The said EO merged the Provincial Health Office and the Provincial Hospital into a new integrated Provincial Health Office (PHO), which was tasked to integrate the promotive, preventive, curative, and rehabilitative components of health care delivery within the province. In particular, the new PHO was expected to supervise and control district hospitals and other field health units of the Ministry of Health (now DOH) in the province, with the exception of regional hospitals and medical centers, among others (Section 14.1, EO No. 851).

As stated in Section 14.2 of EO No. 851, the integrated health care system within the province was constituted as described below:

a. District hospitals (formerly known as emergency hospitals) were tasked to exercise supervision and control over all field health units in their respective areas as the first step in the implementation of the integrated concept of health and medical services in the province.
b. Rural health units (RHUs) and specialized field health units were tasked to provide the outpatient services of the district hospitals in their respective areas.
c. Barangay health stations (BHS) were considered as extensions of RHUs.

In 1987, the Aquino administration reinforced the DHS concept in its EO No. 119 (i.e., Reorganizing the Ministry of Health, its Attached Agencies and for Other Purposes), which retained the integrated PHO as the Ministry (i.e., referring to DOH) agency in the province. The integrated PHO was tasked to supervise and control district health offices (DHOs) and other field units of the Ministry in the province with the exception of those health units under the Ministry proper or directly under the Regional Health Office (Section 17, EO No. 119). DHOs were created to take on the functions of the district hospitals, which was primarily the supervision and control over district hospital, municipal hospital, RHUs, BHS, and all other Ministry units in the health district.

Health devolution affected the DHS to a large extent because it disintegrated the chain of health care delivery system when the administration of health facilities was transferred from the province (i.e., through the integrated Provincial Health Office) to different jurisdictions (DOH 2001, DOH 2002, Grundy et al. 2003; Romualdez et al. 2011; NCPAG-CPED 2014) as follows:

a. Primary – barangay health stations (BHS) are managed by barangay and municipal/city governments while rural health units (RHUs) and city health centers are managed by municipal and city governments, respectively
b. Secondary – municipal or district hospitals/provincial hospitals are managed by provincial government
c. Tertiary – provincial hospitals are managed by provincial hospitals and regional hospitals (also known as retained hospitals) are managed by the DOH

Apparently, there is separation of administrative control between primary health care (i.e., preventive health care/public health provided in RHUs and BHS) and secondary/tertiary health care (i.e., curative health care provided in hospitals). DOH (1999b, p.17) refers to such separation as technical fragmentation of local health systems, wherein "provincial and district facilities are now managed and financed separately from municipal level facilities" while DOH (2001) refers to it as two-tier health care delivery system wherein there is independent administration of hospital and public health services by provincial and municipal governments, respectively. Likewise, there is independent administration of RHUs by respective municipality, which further disintegrated the public health system within the province. Independent administration is guaranteed by LGUs' autonomy[12] over the health facility under their jurisdiction. In this sense, there is no linkage between RHUs/BHS and provincial/district hospitals. In other words, there is no communication between health facilities (NCPAG-CPED 2014).

Grundy et al. (2003) explain that the breakdown in referral system is due to the Local Health Board, which is in place for each LGU, having control over single political/administrative levels, instead of having jurisdictions between the levels of service (e.g., between primary and secondary levels of health care). In sum, the limit of jurisdiction deters the operation of the referral system. It also hinders collaborative health activities such as technical supervision, health referral communications, sharing of health information, joint health planning, and cost sharing.

In the same vein, Dorotan and Mogyorosy (2004) argue that the lack of coordination among rural health units and hospitals resulted in poor collection and management of essential health information. On the other hand, Solon and Herrin (2017) point out that on the part of DOH, providing technical supervision at the various levels of the local health system as well as maintaining a health information system became difficult, not to mention implementing national health policies. DOH (1999a) regards technical and administrative fragmentation, coupled with the absence of cost sharing among LGUs, as a hindrance

[12] Includes autonomy in interpreting central policy directions, and delivery of health services that is often subject to local political influence leading to considerable disparity in quality of health care across the country (Romualdez et al. 2011)

to efficient utilization of resources while DOH (1999b) views technical fragmentation as a barrier to the success of national and local priority health programs.

The negative effect of health devolution on referral system is not as expected because the Primary Health Care (PHC) principle, on which the country's local health systems were established (Perez 1998a), includes decentralization and referral systems as its key elements. As an aside, the Declaration of Alma- Ata at the International Conference on PHC in 1978 states, among others, that: (1) The people have the right and duty to participate individually and collectively in the planning and implementation of their health care. (2) PHC should be sustained by integrated, functional, and mutually supportive referral systems… and (3) PHC relies at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers, as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community. In this light, decentralization and referral systems should both support the implementation of PHC. Thus, these two core elements of PHC should not contradict each other.

On the contrary, in the case of the Philippines, health devolution broke down the referral system that was in place during the pre-devolution period. Solon and Herrin (2017) clarify that the way health devolution was implemented fragmented public health service delivery and financing. To address the issue on fragmented health services, the concept of Inter-Local Health System (ILHS) and Inter-Local Health Zones (ILHZ) was introduced (Gualvez 1999; DOH 2002; Grundy et al. 2003; Dorotan and Mogyorosy 2004). It is considered a revitalization of the DHS concept but it is adapted to the devolved setting, wherein "health districts" are referred to as Inter-Local Health Districts, Local Area Health Development Zone, and Area Health Zone. The legitimacy of the ILHS/ILHZ was guaranteed in Article X, Section 13 of the 1987[13], the Local Government Code of 1991[14], the Health Covenant by the League of Provinces in 1999[15], and EO 205 of 2000[16].

The fundamental idea behind ILHS is the clustering of municipalities into ILHZ, which have defined population within a defined geographical area (DOH 2002). Each ILHZ has a core referral hospital and a number of RHUs and BHS that pool resources (e.g., health personnel, medical supplies including medicines and equipment, etc.). DOH (2002) explains that the ILHS, albeit a new name, is the same mechanism for mobilizing the different stakeholders (e.g., community-based non-government

[13] States that "local governments may group themselves, consolidate or coordinate their efforts, services and resources for purposes commonly beneficial to them"

[14] States that "local governments through appropriate ordinances group themselves, consolidate and coordinate their efforts, services and resources for the purpose beneficial to them. In support of such undertaking the local government involved, upon the approval of the Sanggunian concerned after public hearing conducted for the purpose, contribute funds, real estate, equipment and other kinds of property and appoint or assign personnel under the terms and conditions may be agreed upon by the participating local units through a memorandum of agreement."

[15] Signed March 1999 between the Secretary of Health and the Department of Interior and Local Government (DILG) to seal their commitment for the implementation of the District Health System

[16] Mandated the nationwide establishment of Inter-Local Health Zones

organizations/NGOs and the private sector, including both local and foreign) in health service delivery and promotion towards integrated system of health development through inter-LGU cooperation. The linkage among the ILHZs within a province formed part of the province-wide Inter-Local Health System. On the other hand, Dorotan and Mogyorosy (2004) points out that the ILHZ facilitated the gradual integration of hospital care and preventive health care at the lowest levels of the health delivery system.

Nevertheless, fragmentation of health services has been a long-standing issue. Romualdez et al. (2011, p. 119) point out that it is evidenced by the "lack of coordination/integration between primary levels of health care and specialty intervention within government, within the private sector, and between the private and public sector." The authors reiterate the need to re-integrate government services either through a mandate or agreement among various levels of government. They reveal that there were not enough referral mechanisms in place despite the DOH's effort to set the standards for the referral system for all levels of health care and the intention for the system to link health facilities and rationalize their use. They point out the need to establish a referral system between levels of health care as well as between government and private providers. In addition, they raise concern over the people's health-seeking behavior, which includes the issue on bypassing wherein patients bypass primary health care facilities and go directly to secondary/tertiary health facilities for primary health issues.

This is the same concern that Grundy et al. (2003) point out, particularly the lack of distinction between levels of health service because hospitals located near RHUs discharged the basic outpatient health center functions. The study opines that there is no clear definition of referral system. It also suggests two options to address "disintegration" of systems, i.e., reintegration of systems either through re-nationalization or through "making devolution work." It mentions that there was high-level DOH agitation for renationalization during the late part of the Ramos administration but the Estrada administration did not entertain the possibility. Apparently, the second option prevails up to this day. On the other hand, NCPAG-CPED (2014) highlights the need for re-structuring and strengthening of the referral system. The study notes the lack of institutionalized means of linkages among the many LGU health facilities.

4. DOH's Response to Health Devolution: Making Health Devolution Work

DOH's initial response to health devolution is to "manage" devolved health services. Perez (1998b) recounts that on the third quarter of 1993, the DOH announced to donors and partner agencies its devolution policy through a document entitled "Managing Health Services." The said document

explained the various terms (e.g., "servicer of servicers,"[17] integrated technical assistance through comprehensive service agreements,[18] etc.) used in DOH's post-devolution policies. Also, it identified DOH's key concerns on devolution such as the need for (i) improvement of management capacities of both LGUs and local health workers, (ii) training of new local health personnel; (iii) management of hospitals by LGUs.

In addition, the DOH attempted to establish partnership with the LGUs through the first round of Comprehensive Health Care Agreement (CHCA), which is an agreement entered into by the DOH and LGUs to establish the relationship between them as regards the implementation of health programs (Eleria et al. nd). The CHCAs basically set in stone the core programs that would be managed by both the DOH and the LGUs (Perez 1998b). In general, the CHCAs primarily (i) set the basis (i.e., legal, policy, and mutual benefit) for agreement, (ii) determined the health programs to be covered; (iii) ensured DOH's commitment to provide support to LGU in implementing the programs; (iv) ensured LGUs' commitment to satisfy the necessary conditions for implementing the programs; and (v) set the duration, remedies, and evaluation of the agreement (Taguiwalo 1993). Failure to comply with the terms and details of the agreement would result in partial or full suspension of the CHCA (Perez 1994).

In other words, the CHCAs specified the roles and responsibilities of the concerned parties [i.e., DOH, provincial governments (PLGU), city governments (CLGU), and municipal governments (MLGU)]. In particular, the PLGUs and CLGUs were expected to be program coordinators. PLGUs were tasked to ensure compliance of their municipalities with the CHCAs. The CHCAs also included an agreement on the level of DOH assistance and LGU counterpart funding, which partly explains why signing of CHCAs required Sanggunian (LGU council) resolutions. Aside from the Sanggunian resolutions, CHCAs also required concurrence of the League of Municipalities provincial chapters.

The drafting of the CHCAs required negotiations between DOH and LGUs based on an indicative CHCA package and LGUs' local area-based health plan. The DOH and LGUs were expected to reconcile plans at the start of the fiscal year (Perez 1994). In this regard, senior officials from DOH and regional offices were given training on negotiation skills so as to be able to negotiate with LGUs regarding the details of the CHCAs. North Cotabato, Negros Oriental, and Cavite were the pilot sites for the negotiation process and experiences from these three provinces became the basis for drafting the set of guidelines that were used in DOH regional offices' negotiations. DOH senior officials'

[17] Since 1992, DOH took on the role of "servicer of servicers" to achieve the vision of being the leader in health development initiatives by assisting LGUs and providing health policy direction, among others (PMO-ICHSP nd). Romualdez et al. (2011, p.20) specify the role of "servicer of servicers" such as: (i) develop health policies and programs; (ii) enhance partners' capacity through technical assistance; (iii) leverage performance for priority health programmes among these partners; (iv) develop and enforce regulatory policies and standards; (v) provide specific programmes that affect large segments of the population; and (vi) provide specialized and tertiary level care.

[18] Later called comprehensive health care agreements or CHCAs, which is pronounced as Chicas

intervention was only required in case of difficult LGUs. The LGAMS was tasked to coordinate major program components of provincial and city CHCAs (Perez 1998b).

Perez (1998b) estimates that on the first quarter of 1994, there were about 70 provincial and 60 city packages that had to be prepared based on DOH's "educated guesses" (e.g., combination of disease patterns, field reports, and population projections) on the needs of local health offices. The packages were completed in April 1994. The DOH regional offices had three months to negotiate with LGUs the detailed agreements with validity of until the end of the term of the local chief executive (LCE) in 1995. Eleria et al. (nd) recount that all negotiations done in 1994 were successful in launching CHCA nationwide.

Taguiwalo (1993) argues that LGU cooperation is crucial in DOH's effort to promote public health goals. The study points out that CHCAs were intended to (i) ensure coherent and effective nationwide implementation of health programs and projects; (ii) achieve fair and equitable opportunity for LGUs to participate in national health programs and benefit from increased resource flows to health services; and (iii) build sustainable DOH-LGU partnership in health based on respective responsibilities and authorities under devolution. Based on DOH (1997), CHCA was effective in institutionalizing the DOH-LGU partnership. However, various management problems affected the full implementation of CHCA.

In addition, DOH initiated the Health Development fund (HDF), which was an anti-poverty investment package for health (i.e., community-based health programs) to provide support to LGUs, NGOs, POs, and the basic sector. HDF was implemented through a memorandum of agreement (MOA) with LHB resolution and it was created as LGU trust fund. The Provincial Health Board was tasked to integrate all HDF-related projects (Perez 1994). HDF was also used to support CHCA (Taguiwalo 1993). Based on Perez (1998a), in 1995, HDF amounted to PhP35 million of the DOH budget that was used to address the gaps identified in the CHCAs. Also, the HDF was one of the most useful and effective DOH programs.

The Regional Field Offices (RFOs) served as centers for technical resource management, which directed the flow and utilization of DOH's assistance to LGUs (Perez 1994; Taguiwalo 1993). In addition, the RFOs performed the following responsibilities: (i) assessment of LGU area-based plans; (ii) negotiation for and monitoring of CHCAs with LGUs; (iii) HDF allocations; (iv) mobilization of technical and administrative assistance; and (v) preparation of monitoring reports (Perez 1994).

Moreover, DOH put in place the Quick Health Response System (QHRS) in RFOs and Central Office. The QHRS had two components, namely preventive element (i.e., Disaster Management Units) and a

ready health team (STOP Death).[19] The DOH representatives in LHBs were tasked to provide the link to QHRS and make initial assessment. In this system, DOH was expected to (i) declare an epidemic or public health emergency in consultation with LGUs; (ii) to provide assistance even without formal LGU request; and (iii) to provide continuing assistance through joint management by the higher LGU or DOH per se.

Further, DOH responded to the challenges of devolution through the Integrated Community Health Services Project (ICHSP), i.e., a collaborative six-year project among DOH, Asian Development Bank (ADB), Australian Agency for International Development (AusAID), and the provincial government of Kalinga, Apayao, Guimaras, Surigao del Norte, South Cotabato, and Palawan. The ICHSP was geared towards strengthening of primary health system through upgrade of basic health facilities, development and implementation of key health subsystems, provision of quality essential drugs, training of health personnel, and mobilization of community participation and support for health (PMO-ICHSP nd). It was piloted in the aforementioned six provinces with the end in view of improving the health services in these provinces and replicating successful models in other provinces.

Assessment of how these DOH mechanisms fared is lacking. Nevertheless, the fact that the DOH launched the 1999-2004 Health Sector Reform Agenda (HSRA) in 1999 suggests that there was a need for a new strategy in addressing the longstanding issues and challenges faced by the health sector. NCPAG-CPED (2014) mentions that the HSRA, particularly the local health systems reforms, was formulated to address the issues that emerged from health devolution. On the other hand, Romualdez et al. (2011) point out that the HSRA was initiated as a major policy framework and strategy in improving health financing, health care delivery, and health regulation. The HSRA focused on five broad areas of reform geared towards identified objectives (DOH 1999b), as follows:

i. Hospital system reforms were primarily aimed at providing fiscal autonomy to government hospitals by allowing them to collect, retain, and allocate revenue from socialized user fees to lessen their dependence on direct subsidies, which in turn would free up resources for other priorities. These reforms involved upgrading of their critical capacities (e.g., diagnostic equipment, laboratory facilities, and medical staff) to enable them to adopt fiscal autonomy, which among others, empowers them to convert hospitals into government corporations but cognizant of their social responsibilities. The expected result was more competitive and responsive government hospitals.

ii. Public health program reforms were intended to secure funding for priority public health programs by providing multi-year budgets with focus on reducing the burden of infectious

[19] A line item in DOH General Appropriations Act since 1995 to quickly respond to health emergencies and disasters that could overwhelm local capacities in terms of funds, staff, supplies, and equipment (Perez 1998b)

diseases. Investments were crucial to address emerging health concerns and enhance health promotion and prevention programs. Effective utilization of these investments necessitated upgrading of management capacity and infrastructure of public health programs.

iii. Local health system reforms were meant to promote the development of local health systems and ensure its effective performance. These reforms required the development and institutionalization of appropriate mechanisms to ensure sustainable delivery of quality care. In particular, cooperative and cost-sharing arrangements among LGUs were deemed important to improve local health services. Secure funding was critical for the development of local health systems, particularly upgrade of local health facilities and capacity building of human resources. The participation of the private sector and volunteer groups cannot be underestimated in ensuring effective performance of the local health systems and so, it must be encouraged.

iv. Health regulatory reforms were geared towards strengthening of the capacities of health regulatory agencies for safe, quality, accessible and affordable health services and products. These reforms focused on the need to address weaknesses in regulatory mandates and enforcement mechanisms and also, appropriate legislation to fill regulatory gaps.

v. Health financing reforms mainly involved the expansion of coverage of National Health Insurance Program (NHIP), which aimed not only to extend protection to a wider population, particularly the poor but also, to improve health insurance benefits, thus hoping to increase enrollment. These reforms required (i) secure funding of premium subsidies for indigent enrollees; (ii) effective mechanisms to provide service to individually paying members, (iii) appropriate mechanisms for quality and cost effective services; and (iv) capacities and new administrative structures to enable the Philippine Health Insurance Corporation (PHIC) to effectively provide service to more members and manage increased benefits spending.

The five reform areas were regarded as "highly interdependent, complementary and therefore expected to be implemented as a package (DOH 1999b, iv)." To elucidate, there is a link between health financing reforms and hospital system reforms as NHIP expansion was expected to make hospital autonomy sustainable. In addition, hospital reforms were envisioned to free up resources for public health investments, health systems development, and health regulation, both at the national and local levels. Effective health programs and local health systems were meant to prevent hospitalizations, which could otherwise put a strain on NHIP funds.

Due to budget constraints and forthcoming change in administration, these reforms were first implemented in selected sites called implementation or convergence sites, with the objective of generating improvements in health care delivery and financing in provinces and cities that would in turn provide momentum for HSRA implementation in other parts of the country. However, the target number of convergence sites was not hit because of the change in government, scarce resources for site development activities, lack of convergence site development units that were expected to facilitate activities at the field level, and underestimated level of effort for carrying out site development activities. In addition, the target activities and outcomes were not fully achieved even in eight advanced convergence sites.[20] Factors for the successful HSRA implementation were identified, such as "(i) reform-minded local executives, (ii) elements of convergence that were already in place or ongoing; (iii) collaborative effort between DOH, PHIC, and LGU staff; and (iv) the presence of technical assistance provided by MSH-HSRTAP" (Solon et al. 2003, p.8).

Cognizant of the challenges in implementing HSRA, DOH adopted "Fourmula One for Health (2005-2010)" (otherwise known as F1) as its implementing framework applicable to the entire health sector and thus, all health interventions (Paulino 2008; NCPAG-CPED 2014). The implementation of F1 was geared towards achieving better health outcomes, more responsive health system, and more equitable health care financing, in support to the Millennium Development Goals (MDGs) and Medium Term Philippine Development Plan (MTPDP) (DOH AO 2005-0023; DOH-HPDPB 2006). The F1 consisted of four components such as (i) health financing – to secure more, better, and sustained investments in health that will ensure equity and improved health outcomes; (ii) health regulation – to assure access to quality and affordable health products, devices, facilities and services, especially for the poor; (iii) health service delivery – to improve the accessibility and availability of basic and essential health care for all, particularly for the poor; and (iv) good governance in health – to improve health system performance at the national and local levels (DOH 2005).

DOH (2005) enumerates the various strategies involved in these four components. First, the strategies for health financing include (1) mobilizing resources from extra budgetary sources; (2) coordinating local and national health spending; (3) focusing direct subsidies to priority health programs; (4) adopting a performance-based and need-based financing system; and (5) expanding the national health insurance program (DOH 2005, p.43). Second, the strategies for health regulation include (1) harmonizing the licensing, accreditation and certification systems among health agencies; (2) issuance of quality seals for health goods and services; and (3) assuring the availability of low-priced quality essential medicines (DOH 2005, p.44).

[20] Include Capiz, Pangasinan, Bulacan, Negros Oriental, Misamis Occidental, Nueva Vizcaya, Pasay City, and South Cotabato (See Solon et al. 2003 for the other convergence sites and more findings of the review on HSRA implementation progress)

Third, the strategies for health service delivery include (1) ensuring the availability of providers of basic and essential health services in all localities; (2) designating providers of specific and specialized services in strategic locations; and (3) intensifying the implementation of public health programs in targeted localities (DOH 2005, p.45). Fourth, the strategies for good governance in health include (1) establishing inter-LGU coordination mechanisms like inter-local health zones *(or convergence sites that will undertake integrated implementation of health reforms)* and other models of appropriate local health systems in the context of devolution; (2) developing performance assessment systems that cover local, regional and central health offices, (3) institutionalizing a professional career track mechanisms for human resources for health, and (4) improving management support systems to enhance the delivery of health goods and services (DOH 2005, p.46). It should be noted that the LGU Scorecard was developed in this regard to track the performance of LGUs and inter-local health zones.

The F1 components (also referred to as four pillars of health sector reforms) were operationalized as flagship programs, projects, and activities (PPAs) for implementation both at the national and local levels (DOH-HPDPB 2006). The F1 was first implemented in 16 F1 provinces (or convergence sites), which involved the preparation of Local F1 investment plans (later referred to as Province-wide Investment Plan for Health or PIPH) that contain the initiatives of the F1 pillars. The PIPH is the key instrument in forging DOH-LGU partnership to achieve better health outcomes, more responsive health system, and more equitable health care financing (DOH AO 2007-0034). As of 2009, the nationwide rollout of the F1 implementation covered 81 F1 sites (DOH AO 2009-0008).

However, Romualdez et al. (2011, p.xvii) argue that the implementation of the various health reforms has been "challenged by the decentralized environment and the presence of a large private sector." In particular, Solon and Herrin (2017) mention that the transaction costs associated with F1 implementation were enormous. As a result, Chakraborty et al. (2011, p.viii), in their review of the health sector performance in the context of the Health Sector Reform Agenda (1999-2004) and the Fourmula One (2005-2010), identify structural deficits in the health sector as follows: (i) the continuing low levels, fragmentation, and inequity in public financing; (ii) limitations in PhilHealth's performance in implementing universal social health insurance and using health financing as a lever to drive health sector development; (iii) large gaps in service delivery capacity, particularly in some regions, particularly the poor and underserved regions; and (iv) gaps in the stewardship of the sector in the sense, for instance, that DOH cannot require LGUs and the private sector to submit health sector data, which challenges DOH ability to exercise its stewardship function. Nonetheless, the authors do not discount the important contributions made by the HSRA and Fourmula One to the health sector.

DOH AO 2010-0036 recognizes these contributions that include improvement in the following aspects: (i) social health insurance coverage and benefits; (ii) execution of DOH budgets and its use to leverage

LGU performance; (iii) LGU spending in health; (iv) systematic health investment planning through the Province-wide Investment Plan for Health (PIPH)/Citywide Investment Plan for Health (CIPH)/Annual Operational Plan (AOP) process; (v) capacities of government health facilities; and (vi) implementation and monitoring of public health programs. Nevertheless, it also admits that despite all these achievements, equity and access to critical health services are far from the reach of poor Filipino families.

In this light, the DOH initiated the Aquino Health Agenda (AHA) to improve, streamline and scale up reform interventions adopted in the HSRA and Fourmula One. Under the AHA, there is deliberate focus on the poor to ensure that nobody will be left behind. AHA's implementation framework is referred to as the Universal Health Care (UHC) (Filipino translation: Kalusugan Pangkalahatan). It was designed in such a way that transaction costs of engaging with LGUs would not be huge through use of goods and services that were centrally procured using proceeds of "sin taxes" (Solon and Herrin 2017). The implementation of AHA/UHC is aimed at achieving the health system goals of better health outcomes, sustained health financing, and responsive health system by ensuring that all Filipinos, particularly the disadvantaged/ marginalized, have equitable access to affordable health care.

It involves pursuing three strategic thrusts such as (i) financial risk protection through expansion in NHIP enrollment and benefit delivery; (ii) improved access to quality hospitals and health care facilities; and (iii) attainment of the health-related MDGs. These strategic thrusts require six strategic instruments that include (i) health financing - financing that lessens the impact of expenditures especially among the poorest and the marginalized sector, (ii) service delivery - appropriately delivered essential services, (iii) policy, standards, and regulation - accessible and effective medical products and technologies; (iv) governance for health - enlightened leadership and good governance practices; (v) human resources for health - competent workforce; and (vi) health information - accurate and timely information and feedback on performance. All these instruments are essential in the successful AHA/UHC implementation (DOH AO 2010-0036).

Galvez-Tan (2012) commends the DOH and PhilHealth's efforts to achieve the AHA and the MDGs[21]. In his aptly titled article, the author points out that there is much work to be done in realizing the goal of Kalusugan Pangkalahatan (Universal Health Care). Galvez-Tan (2012, p.7) recommends three important factors in this regard: (i) public-private partnerships in health – cooperation and involvement of all sectors is critical for the attainment of UHC and the MDGs; (ii) political will in the passage of the legislations on the Reproductive Health Bill and the Sin Taxes;[22] and (iii) health is wealth – which

[21] Based on Asuncion (2016), the Philippines did not meet the 2015 target for health-related MDGs such as maternal mortality, access to reproductive health, and HIV-AIDS.
[22] Enacted as Republic Act No. 10354, also known as Responsible Parenthood and Reproductive Health Act of 2012; Republic Act No. 10351, otherwise known as the Sin Tax Reform 2012

requires good use of increased budgetary allocation for health, i.e., quick, effective, and efficient use of health budget to improve the health of all Filipinos.

On the other hand, Solon and Herrin (2017, p.87-88) argue that the health sector reform initiatives are constrained by three major structural weaknesses, which challenge the realization of their full impact on health sector performance. The structural weaknesses include: (i) a highly fragmented health delivery and financing system dominated by a fee-for-service private market, and a highly decentralized public delivery system brought about by the devolution of health services; (ii) a scientific community in short supply but which is needed to understand the many aspects of major health problems – including disease burdens, risk of epidemics, and effective interventions; and (iii) a lack of capable managers who understand the relatively complex and sophisticated regulatory and policy instruments and contracts needed to implement reforms.

Solon and Herrin (2017) recommend strategies to address these weaknesses. On fragmentation of financing and delivery of health services, a legislation that would amend the Code to consolidate service delivery networks at the province level as well as a province-level approach to address public health concerns that cut across municipalities (e.g., vector-borne diseases) would help address this weakness. On the other two structural weaknesses, the authors highlight the importance of expanding and strengthening scientific community as well as expanding the capacity to manage health sector reform.

5. Lessons from the Health Devolution Experience

With the full implementation of health devolution in 1993, the Philippines undeniably has long and rich experience with it. Certainly, lessons and insights can be drawn from its 27 years of experience with health devolution. First, DOH (1999a, p.i) recognizes that "In retrospect, the present reality in the health sector is brought by several factors affecting the delivery of health services. One of these is the devolution of health services to the local government units (LGUs). Passing on the big responsibility of health care to LGUs was done with noble intentions, but unfortunately, with inadequate preparation resulting in inappropriate and ineffective health service implementation." This statement highlights the importance of a well-planned and well-designed government policy to minimize, if not avert, unintended consequences.

Atienza (2004) reveals that the adoption of decentralization policies was not only due to traditional public administration arguments but more so, political considerations. To elucidate, political leaders, particularly legislators, had personal reasons (motivations) for carrying out decentralization, such as (i) the desire to assume local government positions in the future, cognizant of the new constitution's provision on term limits, and the devolved powers and finances to LGUs; and (ii) the desire to get re-

elected/elected to higher posts in the 1992 elections (held on May 11, 1992), considering the timing of the Code's approval (i.e., October 1991). Atienza (2004, p.29) opines that "hasty approval of the decentralization law without careful deliberation was seen as a way of gaining significant support and votes." [23] World Bank (1993, p.12) argues that: "Hasty and unplanned decentralization, sometimes purely in response to political pressures, can create new problems." This lesson (insight) is deemed useful in crafting any public policy in the future.

Azfar et al. (2001, p.1) enumerate the three key institutional disciplines, namely, civic disciplines, intergovernmental disciplines, and public sector management disciplines that determine the actual outcome of decentralization. Civic disciplines refer to the capacity of citizens, media, and non-governmental organizations to voice out their views so that the government will know and also, to switch to/transfer to other localities or service providers. Intergovernmental disciplines basically refer to inter-governmental relations such as national government oversight of local government operations or budgetary constraints imposed by the national government on lower levels of government. Public sector management disciplines refer to mechanisms (e.g., anti-corruption provisions, performance-based recruitment and promotion, and provision for periodic audits) by which each government body practices control over behavior of respective officials. These factors are critical for successful decentralized governance and thus, these should be taken into account in the implementation of devolution.

On the other hand, Bahl and Linn (1992, p.389) identify the conditions for decentralization, which on hindsight should have also been considered in the formulation and implementation of health devolution in the country. These conditions allow developing countries to reap the full benefits (gains) from a more decentralized local government structure: (i) enough skilled labor, access to materials, and plant capital to expand public service delivery when desired, (ii) an efficient tax administration, (iii) a taxing power able to capture significant portions of community income increments, (iv) an income-elastic demand for public services, (v) popularly elected local officials, and (f) some local discretion in shaping the budget and setting the tax rate. The authors note that these conditions are more likely to be present in large cities in developing countries and less so in small municipalities and rural local governments.

Thus, the readiness in terms of capacity (i.e., fiscal and managerial), of LGUs to take on the devolved functions, especially in the absence of adequate intergovernmental transfers (e.g., higher share in national taxes such as the internal revenue allotment/IRA or equalization fund) to defray the cost of devolved functions, is an important consideration. Having said this, it is imperative to put in place a well-designed system of intergovernmental transfers to address vertical imbalance (i.e., the imbalance

[23] There was no careful discussion on health devolution and other areas of the proposed decentralization law. The Department of Health (DOH) was not consulted during the deliberations in Congress (Atienza 2004).

between the expenditure assignment and fiscal capacity of LGUs to raise revenues) and horizontal imbalance (i.e., the disparity in fiscal capacity across LGUs).

Recently, Solon and Herrin (2017, p.87) regard "a highly decentralized public delivery system brought about by the devolution of health services" as a structural weakness. On the other hand, Romualdez et al. (2011, p.xvii) argue that the implementation of the various health reforms has been "challenged by the decentralized environment..." In this light, one cannot help but wonder whether health devolution was the right thing to do. Nevertheless, Solon and Herrin (2017) clarify that it is the way health devolution was implemented that fragmented public health service delivery and financing. This leads to the second lesson (insight), which is related to the design of health devolution.

It is noteworthy that Regmi (2014, p.4-5) emphasizes that "the most appropriate level of decentralization in the health system is an important unresolved policy debate." Such debate dates back to as early as 1992 which focuses on the following questions (Bahl and Linn 1992, p.385): "Which level of government should provide which services? How much managerial and fiscal autonomy the local governments should have? How much fragmentation in the structure of local government within urban areas should be allowed?" In addition, Bahl and Linn (1992, p.387) pose the question "What does the theory of public finance suggest about the optimal assignment of functions among levels of government?" Similarly, Bahl (nd, p.1) raises an interesting question, i.e., "What is the best arrangement of fiscal powers and responsibilities between the different levels of government?"

Bahl and Linn (1992, p.387) point out that economic theory does not have "firm conclusions on the best division of fiscal responsibilities between central, state, and local governments, that is, about optimal fiscal decentralization.[24] Nonetheless, it can suggest important considerations in making the best (albeit varying across countries) fiscal assignments based on Musgrave's principles of public finance, particularly on the purposes of government budgets, such as macroeconomic stabilization, income redistribution, and fiscal resource allocation that has been the basis for the division of taxing powers and expenditure assignment. Based on Musgrave's principles, the first two roles are appropriate functions of the central government while the last one is the main role of local governments.

On the other hand, Shah and Shah (2006) summarize the concepts and theories relating to central-local relations and local governance. These concepts and theories provide strong justification for decentralized decision-making and major role for local governments particularly in fostering efficiency, accountability, manageability, and autonomy. As discussed in Shah and Shah (2006, p.3-4), the theories are as follows:

[24] The authors recognize the importance of influence of politics on the choice of structure for local government.

- Stigler's menu – refers to Stigler's principles of jurisdictional design:

  - The closer a representative government is to the people, the better it works.
  - People should have the right to vote for the kind and amount of public services they want.

In pursuit of allocative efficiency, Stigler's principles indicate the importance of decision-making at the lowest level government. Economies of scale and benefit-cost spillovers determine the optimal size of jurisdiction.

- Fiscal equivalency principle – refers to Olson's argument that provided there is overlap between political jurisdiction and benefit area, the free-rider problem is addressed and that the marginal benefit and marginal cost of production will be equal or the same. Consequently, optimal provision of public services is ensured. This principle is referred to as fiscal equivalency principle because political jurisdiction is equated with the benefit area. However, it requires separate jurisdiction for every public service.

- The correspondence principle – related to Oates' concept, i.e., "the jurisdiction that determines the level of provision of each public good should include precisely the set of individuals who consume the good." Such principle highlights the importance of having large number of overlapping jurisdictions.

- The subsidiarity principle – argues that lower levels of government should exercise the taxing, spending and regulatory functions except for cases wherein assigning these functions to higher levels of government is justified.

- The decentralization theorem – developed by Oates; The principle points out that "each public service should be provided by the jurisdiction having control over the minimum geographic area that would internalize benefits and costs of such provision" due to the following reasons as enumerated by Shah et al. (2006):

  - Local governments have understanding of the concerns of local residents;
  - Local decision making is responsive to the people for whom the services are intended, thus encouraging fiscal responsibility and efficiency, especially if financing of services is also decentralized;

- Unnecessary layers of jurisdiction are eliminated;
- Interjurisdictional competition and innovation are enhanced.

Oates' decentralization theorem points out that central planners have information asymmetry problem while local planners have perfect information on local preferences and cost conditions because of their proximity to their respective constituents, thus enabling them to provide the right goods and services. Consequently, there is increased economic welfare because the provision of goods and services are adapted to local preferences (Oates 1999).

Azfar et al. (2001, p.1) opine that the benefits from decentralization "depend on placing responsibility for different types of public goods at appropriate levels – e.g., goods where local features dominate at the local level, and those with strong spillovers at higher levels." Public health issues (e.g., epidemics like dengue, communicable diseases such as tuberculosis, pneumonia, malaria, and the like) certainly have spillover effects and so the question that comes to mind is "why did the Philippine government devolve public health?"

DOH (1997) argues that health devolution is justified on the grounds of urgency of local action in providing health services without the need for higher-level government intervention. Locally identified and managed health programs and services are expected to be more responsive and apt to local health needs and preferences. Nevertheless, Manasan and Cuenca (2006) point out the public good nature of public health services and so the national government cannot fully abdicate its role in this sub-sector despite health devolution.

In view of this, there is wisdom in differentiating expenditure assignments (i.e., either retained at the national government, devolved to LGUs, or shared by both the national or local governments) by sub-sector (i.e., public health care vis-à-vis hospital/personal care). For example, public health can be a shared responsibility of both national and local government. According to Manasan and Cuenca (2006), the *de facto* assignment of expenditure responsibilities between the national government and local governments with respect to the Expanded Program on Immunization (EPI) is that the former provides the vaccines while the latter take care of the logistics part (e.g., administration of the vaccines which include the provision of syringes, cotton, and safety boxes). In addition, hospital/personal care can be the responsibility of the provinces considering the catchment area of hospitals.

Gonzales (2013, p.49) argues that "the appropriate *balance between central direction and local autonomy* is likely to vary over time and circumstances, perhaps even within the same setting. This equilibrium is not necessarily dependent on laws and institutions, but on a *negotiated arrangement* on where authority and responsibility for specific activities between principal at the center and local agents

should lie." In the final analysis, it is the design of health devolution, particularly "(1) the appropriate assignment of expenditure responsibilities across levels of government, and (2) unambiguous and clear assignment of functions" that determines the success in bringing about the benefits or efficiency gains expected from fiscal decentralization (Manasan 2009, p.337). McLure and Martinez-Vazquez (nd) argue that the latter is the primary step in designing a system of intergovernmental fiscal relations. In this regard, there is a need to revisit/review the Code's Section 17(c) and 17(f), which encourage the existence of two-track delivery[25] of system (Manasan 2005, WB and ADB 2005, Manasan 2009), which brings about confusion and weak accountability between levels of government as well as inefficiencies in health service delivery.

Third, some LGUs are better able to fully reap the benefits of health devolution. Existing literature points to success stories or good practices (e.g., Galing Pook awards, Fourmula One for Health exemplary health practices in 2005-2009, Compendium of Good Practices Towards Universal Health Care, etc.) in health service delivery. The interesting question to ask is "why is this so?" What are the factors that make health devolution work for these LGUs? Insights/lessons can be drawn from the experience of these successful LGUs and thus, it would be useful to take a closer look at their experience and find out how the good practices can be replicated in other LGUs, with modifications to adapt to specific LGU context, if necessary.

Fourth, a number of health reforms/mechanisms have already been initiated to achieve national objectives for health. However, the effectiveness of these reforms is constrained by the varying priorities/thrusts of political leaders and even DOH secretaries through time. Sustainability of health reforms is not assured in every change (i.e., every six years) of political administration unless they are mainstreamed such as the Reproductive Health Law (albeit not yet fully implemented) and Six Tax Law, among others. By the time that some health reforms take root and reap the expected benefits, they are replaced by new ones due to the change in political administration and/or lack of (political) traction. Mainstreaming of health policy reforms through enactment of national laws can ensure sustainability of these reforms.

Fifth, the literature is wanting of reviews and assessments of these health reforms/mechanisms. Very few studies have attempted to do review and assessment of these reforms/mechanisms, particularly the relatively recent ones such as HSRA/F1 and AHA/UHC. Insights/lessons can be drawn from the country's experience with these reforms/mechanisms that can inform future public policies. In addition, it is noteworthy that while a number of heath reforms/ mechanisms have been launched to make devolution work, it should be noted that health devolution, *per se*, is considered a health reform to

[25] Multi-tracked system of service delivery in every sector as World Bank (2010) puts it

improve health service delivery and thus, it also needs to be assessed, especially that it has been in place for 27 years now.

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