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Inter-LGU Cooperation:

The Key to the Issues of a Devolved Health Care System

Devolution became a byword in 1991 when the Local Government Code passed legislation. The Code mandated, among others, that the administration of social services be decentralized or "devolved" from the national government to the local government units or LGUs. It was considered a big step in ensuring that social services reach the grassroots level where the LGUs are most effective.

Seven years later, certain problems and concerns have emerged in the devolved system of health care delivery that some opponents of the approach have cast doubt on its viability and have even insinuated that a return to the old system may be a wiser move.

But is this the answer?

In a roundtable discussion sponsored by the Health Policy Development Staff of the Department of Health (DOH), the Philippine Institute for Development Studies (PIDS) and the DOH Region VII office in Cebu last month, the participants were one in saying that renationalization is *not* the answer. Instead, the emanating concerns should be seen as an opportunity to finetune the devolved system in order to realize its full potential and purpose. What is needed is a mechanism that will strengthen the LGUs' capability and authority to deliver health care services to the people.

Devolution: identifying the problems

To begin with, however, what are the problems that confront the devolved health care system? In a paper presented during the above-mentioned roundtable discussion, Dr. Orville Solon, associate professor at the University of the Philippines School of Economics and director of the completed DOH-PIDS project on Baseline Reasearch on Health Care Financing Reforms, enumerated and expounded on some of these problems.

Renationalization of some hospitals

Even as devolution should have put all public hospitals under the control of their respective LGUs, the DOH continues to "retain" 48 hospitals, 35 of which are classified as *tertiary*: hospitals that are fully departmentalized and equipped to treat most ailments (Table

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What's Inside

Editor's Notes

The health care system in the country needs to be continually refined to remain responsive to the needs of the people especially in the face of the devolution of health service delivery to the local government units (LGUs). Financing is certainly a big part of the issue. Equally important, too, is the combined leadership and motivation of the local government officials, the support of the national government, and participation of the people in the community. Only through the cooperation of every sector in society can the vision of "Health in the Hands of the People" be achieved.

The roundtable discussion sponsored last month by the Department of Health

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Bukidnon Health Insurance Program

Meeting Health Needs Through Cost-Sharing

Sharing the costs of health care is necessary to achieve the goals of the devolved health care delivery system in the country. This reality is best seen in the experiences and programs of the Bukidnon provincial government as presented by Dr. Antonio Sumbalan, Provincial Planning and Development Coordinator and Project Director of the Bukidnon Health Insurance Program (BHIP).

Faced with greater responsibility as a result of the devolution of national government functions, the provincial government of Bukidnon committed to strengthen its delivery of social services, especially health care, by formulating and supporting programs that promote cost-sharing among its communities. Dr. Sumbalan said that this was imperative because although the share of the province from the Internal Revenue Allotment (IRA) increased by 88 percent, the corresponding budgetary requirements also multiplied. For example, he noted that to address the requirements of the devolved hospital services alone in Bukidnon, the province needed roughly P60 million.

Dr. Antonio Sumbalan

One of the programs envisioned was the Partnership in Community Health Development project sponsored by the Department of Health (DOH). The DOH provided P1.165 million while the provincial and municipal governments provided technical support to project beneficiaries.

Another key program fully supported by the Bukidnon provincial government was the LGU Performance Program (LPP), a DOH-USAID assisted program which evaluates and rewards the achievements of LGUs. Said program, according to Sumbalan, has influenced municipal governments to "rethink their budgetary support to health programs especially on maternal and child health." This program aims to strengthen the ability of LGUs to plan, monitor and implement population, family planning and children's programs in order to reduce child mortality and have effective family planning services. The DOH committed P7.59 million to the program from 1996-1999 while the province allocated a counterpart fund of P1.47 million.

Another cost-sharing program of the province is the development of health facilities. Bukidnon is now bidding for a ten-bed capacity health center and ten barangay health stations. Under this program, barangays will provide the lots for the barangay health stations while the municipalities will provide the personnel to manage these facilities and take care of operating budgets. For the main health center, the municipality will provide the lot and operating cost while the province will do the construction and provide the personnel.

> "...The key selling point of the province's health programs, in particular the BHIP, is social marketing aimed at encouraging various players in the health system to participate."

Bukidnon's flagship health care program, however, is the award-winning ***BHIP Cost-Sharing Scheme*** which started in 1994. The Bukidnon Health Insurance Program (BHIP) is a health insurance program where an annual premium payment of P720 per member can provide members and their beneficiaries with free consultation, medicine, laboratory and diagnostic tests, dental services, doctors' fees, and hospitalization expenses. A family can avail of medicines amounting to P1,500 per year, laboratory and diagnostic services of up to P500 per family annually, hospital expenses of up to P5,000, and dental services amounting to P500 per family per year. Patients are also al-

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Guihulngan's Peso for Health Program

Community Project Pursues Health Agenda

Health programs and services should not be determined solely by policymakers in the national or local governments. People in the communities should also be consulted and empowered to participate in identifying their health needs and developing their own health programs.

This was the principle behind the ***Peso for Health Program*** that originated in Guihulngan, Negros Oriental and was implemented in 1995 by the Guihulngan District Hospital. The Peso for Health Program in Guihulngan refers to a 75-bed secondary public hospital serving Guihulngan and the neighboring towns of Vallehermoso, La Liberta and Canlaon City. The total population of the catchment area is 195,780. According to Dr. Fidencio Aurelia, chief of the hospital, "Peso for Health is a community-funded integrated hospital and health services scheme."

Households can become members by paying a membership fee of only P10 and contributing one peso per family member each month thereafter. After six months or when the equivalent amount has been paid, members are eligible for the "Bracket A" benefit package which includes up to P200 worth of drugs and medicines and a percentage discount in laboratory and diagnostic services during hospitalization. The program does not include outpatient services as yet.

Aside from these benefits, other services include immunization and nutrition for young children, blood pressure check-up, blood typing, temperature readings, health education for adults, and environmental sanitation and other preventive measures for households.

The program is planning to add Brackets B and C packages which call for higher monthly premiums but bigger benefit packages. However, to be able to have these additional packages, the program has to reach a membership base of 20,000. As of October 1998, its membership stood at 15,464.

A "Bracket B" benefit package will require a monthly contribution of P5. In return, members can avail of up to P1,000 worth of drugs and medicines and a percentage discount on hospital services. Outpatient services will be included with up to P100 in drugs and medicines as benefits. "Bracket C" will increase the monthly contribution further to P10 with a corresponding P2,000 worth of drugs and medicines for in-patients and up to P200 for outpatients as benefits.

Dr. Fidencio Aurelia

In pursuit of the vision of a community-based health project, the Peso for Health program's operations will soon be transferred to the rural health units. Dr. Aurelia said that cost-sharing programs such as the Peso for Health should be encouraged by government. Their success owes to the fact that several sectors are involved. The program is a government/inter-LGU/NGO/hospital/health sector undertaking and is basically a community effort. While the government as well as foreign donors give subsidy, the LGUs share resources and strengthen the program, and the hospital and health sector provide technical support, the community itself is the one that maintains the program.

One of the most significant benefits of the program is that the people have learned to put value on their health. The financial contribution the members are required to make have instilled in them the reality that maintaining one's health has a price and as such, they have given it priority. He said that the vision of "Health in the Hands of the People" can be achieved if the people are empowered and not hindered by a sense of mendicancy, helplessness or a total dependency on government. The Peso for Health program provides the members a sense of ownership and belongingness in that they have a say as to how the program is run. As members, they are not mere recipients of benefits but participants who make a difference. DRN

Valencia Medical and Hospitalization Care Plan

Sharing the Responsibility of Health Care Delivery

With most of the social services including health care devolved in the hands of local government units (LGUs) as a result of the 1991 Local Government Code, local government officials have become virtual health secretaries in their respective areas. As such, they are expected to draw up various programs that will uplift the health status of their constituencies.

The added responsibility may have daunted a few but a number of local government officials like Vice-Governor Edgardo Teves of Negros Oriental have risen to the challenge and found innovative ways to address the health needs of their constituents.

In Vice-Governor Teves' case, it all started in 1994 when he was still mayor of the town of Valencia, eight kilometers north of Dumaguete City, the capital of Negros Oriental.

Disturbed by the results of a survey conducted by the World Health Organization at that time which showed a very low level of medical-seeking consultations and hospitalization among Valencia townsfolk, Vice-Governor Teves found that factors like financial capability, distance to a health delivery unit, and availability of services and supply were among the major reasons which influenced said finding.

In view of this, he set out to consult with the town people and officials on putting up a cost-sharing health care program. Eventually, the town's Sangguniang Bayan passed Resolution and Ordinance No. 1, Series of 1994 appropriating P240,000 from the calamity fund savings of the municipality to serve as a counterpart to the P10,000 equal sharing of each of the town's barangays from their respective Internal Revenue Allotments (IRAs). This amount constituted the initial program fund of P480,000 for the Valencia Medical and Hospitalization Program. Since then, this cost-sharing scheme has been ongoing, with a standing fund of P23,229.

Negros Oriental Vice-Governor Edgardo Teves

The Barangay Council and the Municipal Social Welfare Officer identify the qualified beneficiaries and give them identification cards which they present for hospital admission. Each beneficiary is entitled to P2,000 medical and hospital care services from the accredited hospital. This includes medicine, subsistence and nursing care, all laboratory procedures and other examinations and treatments needed, except major surgical intervention, maternity admission, eye exams, eyeglasses, dental exams and dentures. Hospital expenses exceeding the P2,000 ceiling are to be shouldered by the patient.

This benefit can also be extended to dependents who are below 18 years old or over 60 years, and physically and mentally disabled. Other services include transportation by ambulance.

A continuing major challenge for the program, though, is how to reach a number of hinterland barangays, given limited funds. Their distance to hospital facilities and poor transportation have lessened the program's intended impact. At the same time, an inequitable cost and benefit-sharing among barangays which have an unequal number of members hospitalized likewise serves as a problem. The question of inequality arises when a barangay fully benefits from its P10,000 share because of a great number of hospitalized patients while another barangay only has a few but must come up with the same share of contribution.

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Local Initiatives in Health Service Delivery Continue to Evolve

One of the visions of the Department of Health (DOH) is to bring health into the hands of the people by year 2020. The devolution of health service delivery to the local government units (LGUs) as a result of the Local Government Code in 1991 was one step meant to bring this vision to reality.

But like any other aspect of change, devolution had its accompanying costs. Whereas before, the health care structure, though not perfect, was nonetheless clear, with the DOH central office having command and control of all health care programs and facilities across the country, devolution brought in a "shock" to the system and fragmented it. With the transfer of control in the hands of cities, municipalities and provinces, the LGUs are now expected to come up with their own health care programs. This added responsibility has taken its toll on LGUs, especially those which did not have clear health programs and priorities.

Dr. Mario B. Lamberte

Still, the situation may not be as bad as it initially seemed to be. In summing up the discussions on local government initiatives as a response to devolution during a recent roundtable gathering in Cebu, Dr. Mario Lamberte, PIDS Acting President, said that in light of the issues and problems surrounding devolution, the LGUs were forced to make their own initiatives, to become more resourceful and to innovate their own programs.

Two approaches, according to Dr. Lamberte, have emerged in addressing the situation, namely, *inter-LGU cooperation* and *community cost-sharing schemes*. A number of LGUs, in fact, adopted such approaches like the Valencia (Negros Oriental) health initiative of Vice-Governor Edgardo Teves, the Bukidnon Health Insurance Project, and the Peso for Health scheme in Guihulngan, Negros Oriental.

In the Valencia case, the initiative began at the municipality level but is now being experimented with at the provincial level. For the Bukidnon project, the provincial government took the lead while in the Guihulngan case, the community residents themselves, together with nongovernment organizations (NGOs) and the district hospitals, became the initiating force.

Evidently, in each scheme, the questions always raised are: is it a sustainable arrangement? is it the least costly in terms of funding?

The search for the most viable, effective and efficient scheme therefore continues, according to Lamberte,

> "...In light of the issues and problems surrounding devolution, the LGUs were forced to make their own initiatives, to become more resourceful and to innovate their own programs."

involving *inter-LGU efforts* and *cost-sharing formulas*. These efforts continue to *evolve* through time as they get perfected and further enhanced. They also continue to *redefine* their objectives and mechanisms depending on which suit the needs of the people more and which proves to be the most efficient. And because there will always be people who get sick, the LGUs continue to *accelerate* their efforts as they race against time in pushing for more and better assistance schemes. The ultimate success of the LGUs' efforts, however, rests with the greater *participation* of the people themselves. DRN

Inter-LGU Cooperation...

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1). Solon said that the number might have already risen to 54 because the DOH regularly "brings back into the fold" other hospitals that have been renationalized by Congress.

The retention of these hospitals under DOH control may not matter much if it were not for the fact that the DOH pours 52 percent of its annual budget to subsidize them. These hospitals were also prioritized in the distribution of the P6.5 billion budget given out by the Department in 1992 instead of frontliners like the district and provincial hospitals where the poor usually go.

The 1995 *Family Income Expenditure Survey* (FIES) shows that the poorest 30 percent of the population go to primary and secondary public hospitals (the district and provincial hospitals) when they are sick. Thus, the renationalization of some tertiary hospitals is seen to be unfair because, as Dr. Solon put it, the poor in Quezon City do not go to such high-end hospitals like the Heart Center or the Children's Hospital. Even if they do, the poor people in other parts of the country are disadvantaged since they cannot avail of these hospitals' services. Thus, although the subsidy given by the national government may be used for the poor, it does not include *all* the poor in the country. Yet the funding came from the public through taxes.

Dr. Charito Awiten, DOH-VII Regional Director, welcomes the speakers and participants to the roundtable discussion on inter-LGU cooperation and cost-sharing in the delivery of health care services held in Cebu City.

Fragmentation of services

Fragmentation of services occurs at different levels due to a lack of referral networking among health care providers. In the past, the national government through the DOH controlled all public health facilities, from the central office down to the district level. Today, however, the regional health units (RHUs) and barangay health centers are run by municipalities and are not connected with the district or provincial hospitals which are in turn run by the provinces. This proves disadvantageous because the less capable health centers have difficulty getting the services of the hospitals that have well-trained doctors and better facilities. In cases where health units are linked, it is only through informal personal contacts and not institutionalized arrangements. Thus, technical fragmentation inevitably occurs. It is therefore important to formally establish interrelationships and linkages among the health units.

Table 1: Distribution of Health Care Facilities by Ownership

	DOH	LGU	Private	Total
Primary hospitals	6	271	643	920
Secondary hospitals	7	281	384	672
Tertiary hospitals	35	44	148	227
Regional health units		2,856		2,856
Barangay health stations		17,090		17,090
Private clinics			na	na

Administrative risks for public hospitals

Public hospitals are likewise at risk of losing their competitive edge over private hospitals due to the higher

costs of operating them, if quality adjustments are to be factored in. Quality adjustments include, for example, necessities like running water and electricity at a standard number of hours. In a comparison of hospital bills between public and private hospitals, public primary and secondary hospitals were shown to be very competitive since their bills were lower. However, it turned out to be more expensive in public tertiary hospitals when the rates were quality-adjusted. It is not the price of medical services per se that led to the higher price but the cost of running the hospital. In effect, public tertiary hospitals need to spend more to have electricity and water supply for them to match the level of quality of services of their private counterparts.

The implication is that public hospitals have become vulnerable to budgetary allocations by LGUs for electricity and water supply. Less funds for these items would certainly affect the efficiency and quality of service in these hospitals whose main clientele happens to be largely the poor.

Dr. Orville Solon

Mismatches of fund allocations:

First mismatch: curative vs. preventive care expenditures

An ounce of prevention is supposed to be worth a pound of cure but in the case of the health care delivery system in the country, the reverse is true. A lot more funds are spent on curative health services than on preventive health care programs and services.

In a 1994 study, Racelis and Herrin showed the patterns and sources of national health expenditures. For instance, their data showed that out of every P100 spent on health care, P44 comes from government through taxes on income and services; P38 comes from individual consumers and households as out-of-pocket payments for medical services; P12 from compulsory insurance like Medicare; and P6 from private insurance. Based on these data alone, it shows that the individual consumer bears the biggest burden of health care expenses since he/she pays for them directly.

In terms of spending distribution, Table 2 shows that a total of P72 out of every P100 health expenses goes to personal health care services which are qualified as curative and hospital-based tertiary care sevices. Conversely, a mere P13 out of every P100 goes to public health services that involve preventive measures such as immunization for transmissible diseases, dengue early warning devices, proper nutrition and other programs. This is unfortunate because preventive health care services do a lot more in the long run in protecting the people's health and require less amounts of money than medical treatments. Immunizing people from hepatitis or TB, for example, lessens the risk of transmitting the disease to others. But since only P13 is alloted for public health services, the government's preventive health care programs cannot adequately address the needs of the public. The spread of dengue that killed more than 200 people a few months ago indicates just how important preventive public health care programs are.

Table 2: National Health Expenditure Pattern

Health Item	*Expenditure Distribution per P100*
Personal health care	71.9
Public health care	13.0
Others	15.1
Total	100.0

Second mismatch: IRA distribution for various LGU health expenditures

Another mismatch in the allocation of funds involves the amount of Internal Revenue Allotment (IRA) received by LGUs from the national government vis-à-vis the amount they allot from their budget as their share in the cost of devolved health care.

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"...Since only P13 is alloted for public health services, the government's preventive health care programs cannot adequately address the needs of the public."

Bukidnon Health...

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lowed to have their preferred family physicians.

To date, the BHIP's premium payments total P16.7 million. As its counterpart fund, the province has earmarked P45.8 million. It has the full participation of the public and private medical sectors, hospital owners, government heads and employees, NGOs and farmers associations, religious groups and community residents.

Dr. Sumbalan revealed that the key selling point of the province's health programs, in particular, the BHIP, is *social marketing* aimed at encouraging various players in the health system to participate. Health providers are presented with an opportunity to enlarge their resources for health services; target beneficiaries are educated on the need for health insurance; and the provincial government is encouraged by the cost efficiency of providing health services through pooled resources. The BHIP also promotes the "can-do" spirit of the people and instills in them a sense of pride in the thought that because of their contributions to the program, their families and others can avail of efficient health services.

Equally important was what Dr. Sumbalan termed as the *proactive provincial budget* which allots counterpart funds to secure additional projects from national line agencies. Their budget for 1998 had a 20 percent Development Fund of P5 million used as counterpart funds for the province's various programs. Their proposed budget for 1999 has a P2 million counterpart fund.

In summing up, Dr. Sumbalan said that the DOH should promote constant consultations with local governments because as shown by Bukidnon's experience, consultations with LGUs are crucial to the success of the Department's programs. The purpose of devolution – to enable LGUs to plan, formulate and implement their own social service programs – will be achieved through constant coordination and exchange of information and ideas between the national and local governments. DRN

Valencia Medical...

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Modifications are currently being discussed to reduce this inequality.

These problems and challenges notwithstanding, Vice-Governor Teves said that the overall objective of the Valencia Medical and Hospitalization Program is to ensure hospital care of patients whenever the situation demands. On this matter, it is effective in providing the initial and immediate financial assistance for medical care while giving time for the family to secure more resources to cover all hospital expenses. The subsidy given to beneficiaries enables them to avail of prompt diagnosis and proper treatment. Along these lines, he said that the program has been successful as indicated by a number of outcomes.

For one, there has been a decrease in the morbidity and fatality rates of top-rated diseases. Two, disease transmission was also reduced which is one of the objectives of the program. And three, there has been an increase in the number of distant barangays wanting to participate in the program.

On the whole, more people are having themselves registered and the increase in hospital admissions may be attributed to a greater utility of the program. Of course, one other reason may be a possible deterioration in the community's health status. As such, the need for an expansion of the program and greater participation of the communities becomes more pronounced. DRN

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Data shown in Table 3 indicate that out of P100 allotted by provinces to health services, P59 already goes to the salaries of the provincial hospitals' medical personnel. Yet, the provinces only receive an equivalent of P23 per P100 in terms of the IRA. This means that the provinces are shortchanged by as much as P36 or 61 percent. On the other hand, only P3 out of every P100 is allotted by cities for health services but they get around P23 per P100 of the IRA. The cities spend very little on health care but get about seven times that amount as their IRA.

Meanwhile, there seems to be little mismatch in the case of municipalities – P38 per P100 as expenditure allocations vis-à-vis P34 per P100 in terms of IRA. Still, the fact remains that there is a mismatch.

Third mismatch: big budget vs.small or nonexistent expenditures

Dr. Solon noted that some of the P6.5 billion budget of the DOH that was distributed to all public hospitals in 1992 may have gone to some recipient cities which actually did not have hospitals to run. Indeed, the cities received a lot more money than what their expenses warranted. An unfortunate result of this is that the mismatch in fund allocation for health between cities and provinces has "encouraged" municipalities to become cities since the latter get a higher amount of IRA but have much less to spend it on.

Moreover, it is unsure whether local governments actually used their IRA for health care for said purpose or whether the amount was spent for other priorities. Thus, the problem of fund mismatch on health care services poses an urgent call for the government to resolve inasmuch as this will determine how effective the devolved health care delivery system could be implemented.

The Value of Inter-LGU Cooperation

In the face of all these problems, are there solutions? Dr. Solon offered that in the case of the devolved health care delivery system, **inter-LGU cooperation** may potentially be the answer. He cited the gains that may be reaped by promoting inter-LGU cooperation in terms of financing and delivering health care services to the people at the local level.

Table 3: IRA Distribution Vis-à-Vis LGU Health Expenditures (In pesos)

LGU	IRA	CODEF	CDHF
Provinces	23.0	45.6	59.0
Cities	23.0	7.0	3.0
Municipalities	34.0	47.4	38.0
Barangays	20.0	0.0	0.0
Total	100.0	100.0	100.0

CODEF: Cost of devolved functions

CDHF: Cost of devolved health function

Scale economies

Buying in bulk is always cheaper. The same is true when applied to inter-cooperation among LGUs. First, catchment areas of hospital facilities are larger than local jurisdiction. For instance, Bulacan has a district hospital at the border of Nueva Ecija where most of the patients come from. If funding is left solely to the province of Bulacan, this situation poses a problem since the local leaders in Bulacan may resent the cross-border utilization. However, if there is cooperation and cost-sharing between the two provinces, the problem can be solved. In fact, the combined funds from the two LGUs would boost the hospital's services.

The second gain from inter-LGU cooperation is related to the fact that health programs tend to have large spillovers since there are health problems that cannot be confined to one local area. The spread of dengue fever is a good example. As such, its solution may likewise be adequately addressed jointly. Another advantage of cooperation concerns health insurance. Health insurance will only work if there is a large pool of members. A province-wide or city-wide pool of health insurance members can cross-subsidize poor comunities and thus help the local health financing scheme to remain viable. Finally, the cost of upgrading dilapidated facilities is too large for a single LGU to shoulder. Thus, additional funds from other local government units are needed. These can be attained through inter-LGU cooperation.

Scope economies

Scope economies makes it easier for LGUs to simultaneously manage

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public health programs through a network of facilities meant to address all kinds of health problems. LGUs can share common inputs like laboratory facilities and skilled services thereby preventing underutilization of facilities and helping bring down costs. Meanwhile, cost-sharing schemes could likewise address the problem of IRA mismatch. Since cities "enjoy" the benefit of receiving a large IRA without a corresponding number of facilities to spend on, LGUs can resolve it by agreeing on an arrangement that will benefit concerned areas without having to violate the law.

Levels and venues for inter-LGU cooperation

Cooperation may be arranged among municipalities, between municipal and provincial levels, among provinces and between regions. Dr. Solon, however, suggests that the most ideal set-up is within the province since there is a complete network of facilities there, from the primary to the tertiary level.

Cooperation may also be applied in four different manners. One, through facilities networking where district hospitals from other local areas can link with RHUs from another area so they can share services and benefit from one another. Two, cost-sharing arrangements or joint investments can help boost the capability of health facilities. Such arrangements, though, must be institutionalized and contracts must be drawn up to formalize arrangements. Three, shared financing between LGUs can bolster their health care programs. Four, a common health program will help to make cost-sharing schemes work well. For instance, mayors may agree to allot certain amounts to finance the province's dengue eradication project. Such arrangements need to be formally established in order that the programs will not be derailed by leadership changes.

"Primarily, the national policy on devolution should be devoid of ambiguities."

Political will is a critical element in making inter-LGU cooperation succeed. It is thus important for LGU leaders to put the interests of the majority of the people above all things rather than simply concentrate on narrow self-interests that will only serve a few.

Clearing the Ambiguities Toward Inter-LGU Cooperation

Unfortunately, there are barriers that keep cooperation among LGUs from being fully realized. These barriers should be eliminated in order that cooperation among LGUs will be fully accepted and adopted all over the country as a means to advance their health care services and programs.

Clear the ambiguous DOH policy

Primarily, the national policy on devolution should be devoid of ambiguities. As it is, the DOH seems neither strongly committed to implement devolution or to return to the policy of a nationalized health care system. It is still at the stage of debating the merits of these two policies. The result is that the "creeping renationalization of health services" issue keeps cropping up and muddles the efforts to enhance the health care delivery system. Such ambiguity confuses the local government leaders and forces them to adopt the so-called **strategic behavior**: they wait and see what policy will win out.

"It is important for LGU leaders to put the interests of the majority of the people above all things rather than simply concentrate on narrow self-interests that will only serve a few."

Make the DOH organization more responsive

The DOH should also exert every effort to enable its organization to cope with the new system of devolution in order to fully realize its optimal purpose. Dr. Solon said that the national public health programs suffer from the medical term "phantom-limb syndrome" which refers to a person who seems to "feel" a body part even if it has already been amputated. Devolution has virtually "amputated" the Department and with the transfer of responsibility (and power) to the local chief executives, made mayors and governors virtual health secretaries in their respective areas. Still, there is a need for the DOH to play a role but it needs to reinvent itself through the adoption of changes in its structure and organization in order to make the devolved system fully succeed.

Strengthen local hospitals

Another matter that should be addressed is the issue of hospitals that have been retained by the DOH. Instead of complementing local hospitals, these retained hospitals, which are usually more capable and better equipped than the locals, become substitutes for local hospitals. They become the primary facilities. Because of this, the retained hospitals begin to ask for bigger subsidies. As a result, local

Table 4: Proposed Policy Framework

	IRA Mismatch	*Pre-devolution Backlog*	*Administrative and Technical Fragmentation*	*Strategic Behavior*
Money	Funding for the formulation of new IRA formula.	Public investments to upgrade devolved health facilities and personnel.	Finance pilot projects in various forms of inter-LGU cooperation.	Leverage DOH spending for better LGU performance.
Regulations		Rationalize licensing and standard-setting and link to DOH investment for public facilities.	Express preference for working with LGU networks in undertaking public health programs.	Send a clear signal of DOH support for the devolved system.
Laws	Amend Local Government Code (LGC): take out the 1991 cost of devolved health function from IRA and allocate to LGUs with devolved functions.	Introduce a multiyear DOH budget item to secure the upgrading of devolved facilities.	Amend LGC to introduce legal basis for inter-LGU cooperation for health.	

leaders see the futility of upgrading their local hospitals and are content to just have their constituents use the services of the retained ones.

Resolve pre-devolution backlog

The DOH can break another barrier to inter-LGU cooperation by resolving the backlog of problems before devolution was implemented. Since investments that have been earmarked for local health facilities were never carried through, the facilities were already dilapidated when the LGUs took over.

Politics also added to the backlog. In the past, it was the practice to put up a hospital through legislation – politicians could easily muster enough votes to pass a bill that would provide for the establishment of a hospital. The problem, however, was that the sources of funds were unclear or sometimes nonexistent. Furthermore, the plantilla of positions for such hospitals was usually too big, resulting into an overstaffing of some of these public hospitals.

Institutionalize legal instruments

There is clearly a need to establish legal instruments for inter-LGU cooperation. This will help strengthen cooperation among LGUs. At present, local leaders are unsure if there are such instruments provided in the Local Government Code that will lend legality to any move they wish to make to institutionalize agreements. Such uncertainty keeps them from going ahead in forging partnerships.

Certainly, the DOH cannot do everything by itself to resolve the issues and problems regarding the full adoption and success of inter-LGU cooperation. The Department, however, can do much to spearhead the efforts by first coming to terms with its own policy on devolution. From thereon, it can help break the other barriers and advance the cause of a better devolved health care system strengthened by close cooperation among LGUs.

Matching Solutions to Problems: Policy Framework for Inter-LGU Cooperation

To reiterate, for the Department to effectively resolve the issues, it has to, first, *clarify the DOH policy on devolu-*

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tion. The DOH's stance should be made clear because uncertainty only leads to more problems and hinders long-term planning. Second, *the DOH organization must be made responsive to devolution*. The Department must reorganize its structure in order to complement the devolved system and help LGUs implement public health programs and services. Third, *the Department can give block grants to solve pre-devolution backlog*. Block grants can be used by the DOH to leverage for better performance from LGUs. Fourth, the Department may give LGUs a hand by *providing technical support*. Research on how to combat dengue fever, administer immunization and so on are very useful to LGUs. Fifth, *advocacy* is needed in order for the DOH and the LGUs to have an effective partnership in formulating and implementing health programs for the people.

To solve the problems of: (a) IRA mismatch, (b) pre-devolution backlog, (c) fragmentation of services, and (d) "strategic" or wait-and-see-which-policy-wins behavior, the Department can make use of three policy instruments which may be defined in terms of money, regulations and laws. Table 4 outlines this framework.

Conclusion

In breaking the impassé toward a better devolved health care delivery system, it is clear that the Department of Health should not be the only one involved but also other agencies, including all the branches of government. In this regard, Dr. Solon stressed that the DOH has already done a lot towards enabling the adoption of inter-LGU cooperation.

However, it is imperative that the process is institutionalized to foster stronger interrelationships among the LGUs, NGOs and other government and private entities. This will require coordination and cooperation between the executive and legislative branches.

The challenges of devolution may be daunting but the answer does not lie in returning to the old system of nationalization. Instead, the solution should be going forward to empower local government units to join forces so that they can stand on their own and adequately address the health needs of their people. DRN

Editor's Notes
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and its regional office in Cebu, in collaboration with the Philippine Institute for Development Studies (PIDS), put forward the many concerns that need to be addressed if the devolution of responsibility for health care delivery to the local government units is to succeed in making quality, affordable, effective and efficient health care services available and accessible to the majority of the people.

Beginning with a comprehensive exposition by Dr. Orville Solon of the University of the Philippines School of Economics on the problems associated with a devolved health service delivery system and on the mechanisms --cost-sharing between the national and local governments, and inter-LGU cooperation in the delivery of health care services-- that may provide the key to responding to such problems, the discussion also showcased examples of local initiatives in cost-sharing and other forms of cooperation in health care delivery.

This special issue of the DRN focuses on the highlights of this roundtable discussion. The banner story deals with the issues raised by Dr. Solon. It reveals interesting if somewhat disturbing facts about the prevailing system that require major changes in order to be resolved.

The three succeeding articles (pages 2-4) present the case studies which provide insights on what some LGUs are doing in order to meet the enormous responsibility of addressing the health needs of their constituencies. Finally, the synopsis of the discussion as aptly given by PIDS Acting President Dr. Mario Lamberte is contained in the article on page 5. DRN

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