

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 and mandated, among others, that the delivery 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 grass roots level where the LGUs can be more effective. Seven years after, certain concerns and problems have emerged and cast doubts on the viability of a devolved health care system. Indeed, opponents to the idea of devolution have entertained notions that perhaps it might be wise to return to the old system.

The roundtable discussion held in Cebu City late last year that was sponsored by the Health Policy Development Staff of the Department of Health (DOH), the Philippine Institute for Development Studies (PIDS), and

the DOH Regional Office in Cebu, however, came up with a resounding consensus that re-nationalization is *not* the answer. Rather, the emanating issues should be seen as an opportunity to continually refine the system in order to realize its full potential and purpose. What is needed is to strengthen the devolved health care system by empowering the LGUs.

Devolution: Identifying the Problems

In his presentation, Dr. Orville Solon, professor at the UP School of Economics and director of the completed joint DOH-PIDS project on Baseline Research on Health Care Financing Reforms, set out to identify some of the problems that confront the devolved health care system. He likewise offered possible answers to address these problems by formulating a comprehensive policy framework that matched each problem with an attendant solution.

To begin with, what are these problems?

Re-nationalization 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 under its control, 35

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This *Notes* was recast and repackaged by Barbara F. Gualvez based on the paper of Dr. Orville Solon of the UP School of Economics entitled “What the DOH Can Do to Promote Inter-LGU Cooperation for Health.” The views expressed are those of the author and do not necessarily reflect those of PIDS or any of the study's sponsors.

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
RHUs		2,856		2,856
BHSs		17,090		17,090
Private clinics			n.a.	n.a.

of which are classified as tertiary: hospitals that are fully departmentalized and equipped to treat most ailments (Table 1). He said that the number might have already risen to 54 because the DOH regularly “brings back into the fold” other hospitals that have been re-nationalized 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. According to Dr. Solon, 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 to. District and provincial hospitals are considered primary and secondary health facilities (those that offer basic or limited treatments). The 1995 *Family Income Expenditure Survey* (FIES) shows that the poorest 30 percent of the population go to primary and secondary public hospitals when they are sick. Thus, the re-nationalization of some tertiary hospitals is deemed unfair because, as Dr. Solon put it, the poor in Quezon City do not go to such high-end hospitals like the Philippine Heart Center or the Philippine Children’s Hospital. Even if they do, the poor people in other parts of the country are disadvantaged since they cannot avail of the services of these said hospitals. Thus, although the subsidy given by the national government is used for the poor, it does not include *all* the poor people in the country. Yet, the funding came from everybody.

Fragmentation of services

According to Dr. Solon, *administrative* fragmentation of services occurs at different levels because of a lack of referral networking among health care providers. In the past, the national government controlled all public health facilities from the central office down to the regional districts. Today, however, the regional health units (RHUs) and barangay health centers are run by the municipalities while the provincial and district hospitals are controlled by the provinces. The RHUs and barangay centers are not connected with the district or provincial hospitals. 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 happens. Increased networking is not necessary if only inter-relationships among the health units will be formally established.

Administrative risks for public hospitals

It was also learned that public hospitals are 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 at both public and private hospitals, primary and secondary public hospitals were shown to be very competitive as their bills were lower. However, it turns out to be more expensive in the public tertiary hospitals when the rates are quality-adjusted.

Dr. Solon stressed that it is not the price of medical services 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 significant 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 of and quality of service in these hospitals whose main clientele happen to be mostly the poor.

Mismatches of fund allocations

First mismatch: curative vs. preventive health services. 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.

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Dr. Solon cited figures cited in a 1994 study (Racelis and Herrin) showing the sources of funds being spent on health services and the patterns of how national health expenditures are spent on *personal* (meaning curative), *public* (meaning preventive) and other health expenses.

In terms of sources, 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 they pay for them directly.

As for the spending distribution, a **total of P71.9** out of every P100 goes to personal health care services

which Dr. Solon further qualified as *hospital-based tertiary care services*. 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, as Dr. Solon pointed out, 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, thereby saving would-be patients and the government from costly treatments. But since only P13 is allotted 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.

Second mismatch: IRA distribution for various LGU health expenditures. Another mismatch in the allocation of funds is that the amount of Internal Revenue Allotment (IRA) received by LGUs from the national government and the amount they allot from their budget as their share in the cost of devolved health function are at times grossly unfair. Data shown in Table 2 indicate that out of every P100 allotted by provinces to health services, P59 already goes to the salaries of the provincial hospitals' medical personnel. Yet, the provinces only receive 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. Meanwhile, there was less mismatch shown in the case of municipalities—P38 per P100 as expenditure allocations vis-à-vis P34 per P100 in terms of the IRA. Still, the fact remains that there is a mismatch.

Third mismatch: big budget vs. nonexistent expenditures. Furthermore, Dr. Solon bared 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 did not have hospitals to run. Indeed, the cities received a lot more money than they should have. 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 cities get a higher amount of IRA but have much less to spend it on.

Aside from the obvious problem of discrepancy, it is likewise unsure whether local governments actually used their IRA for health care for said purpose or whether they used it for other priorities. Thus, the problem of fund mismatch on health care services poses an urgent call for government to resolve since 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 situation, **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.

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. Dr. Solon pointed out that a province-wide or city-wide pool of health insurance members can cross-subsidize poor communities and thus help the local health financing scheme 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 make it easier for LGUs to simultaneously manage 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

Table 2. IRA Distribution vis-à-vis LGU Health Expenditures

LGU	IRA	CODEF	CDHF
Total	100.0	100.0	100.0
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

CODEF: Cost of devolved functions
CDHF: Cost of devolved health function

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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. First, 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. Second, 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. Third, shared financing between LGUs can bolster their health care programs. Fourth, 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.

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

Dr. Solon pointed out, though, that there are, unfortunately, barriers that keep inter-LGU cooperation from being fully realized. These barriers should be eliminated

in order that cooperation among LGUs will be fully accepted and adopted by local government units all over the country as a means to advance their respective health care services and programs. In this regard, the DOH can do much to break the barriers.

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 (during the discussion, though, it was revealed that the current Secretary of Health, Hon. Alberto Romualdez, has stressed that as long as he is at the helm of DOH, there will be no re-nationalization). It is still at the stage of debating the merits of these two policies. The result is that the "creeping re-nationalization", as Dr. Solon terms it, of health services 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 what he calls a **strategic behavior**: they wait and see what policy will win out.

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Make the DOH organization more effective

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, for the devolved health care system to fully succeed, there is a need for the DOH to reinvent itself through the adoption of changes in its structure and organization so as to be more efficient.

Put more emphasis on local hospitals

Another matter that should be addressed involves the role of hospitals retained by the DOH vis-à-vis local hospitals. Instead of complementing local hospitals, these retained hospitals which are usually more capable and better equipped than the locals virtually become the latter's substitutes and serve as the primary facilities. Because of this and because more people use their facilities, these retained hospitals then ask for bigger subsidies. As a result, local leaders see the futility of upgrading their local hospitals and are content to just have their local citizens use the services of the retained hospitals.

Resolve pre-devolution backlog

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

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Politics also added to the backlog. In the past, it was the practice to put up a hospital through legislation since 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 even nonexistent. Furthermore, the plantilla of positions for such hospitals was

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usually too big, resulting into an overstaffing of some of these public hospitals.

Work with differences in political affiliations

Being in different political parties is obviously a problem because after all, local government leaders are also politicians. Cooperation may not be easy to reach when the leaders are of different political parties. Local leaders may also have different priorities and thus may not be too keen on joining forces with other LGUs for health. Certainly, the politization of health care services is a reality. But there is also a good side to it since health programs can be a showcase of the candidates' priorities. They can be used to show the people whose candidate has a better program.

When the right leader gets elected, however, another problem arises: the planning timeframe for a good health program is limited by the official's term of office. Three years is the minimum term of a mayor or governor and if the constituents believe in his/her programs, the incumbent may serve for a maximum of nine years. But the program of establishing inter-LGU cooperation requires long-term planning and outlook. Changes in leadership therefore also serves as a barrier at times.

Institutionalize legal instruments

There is clearly a need to establish legal instruments and make them available to local government leaders to strengthen cooperation among their units. As it stands, 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 and from thereon, 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 devolution*. 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, *block grants should be provided 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

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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.

The DOH has three policy instruments that can be used to solve the four kinds of general problems identified, namely: IRA mismatches, pre-devolution backlog, fragmentation of services and "strategic behavior." Table 3 is a matrix presentation of the framework providing these policy instruments.

Conclusion

In breaking the impassé towards a better devolved health care delivery system, it is clear that the Depart-

Table 3. Proposed Policy Framework

	IRA Mismatch	Pre-devolution Backlog	Administrative & Technical Fragmentation	Strategic Behavior
<i>Money</i>	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.
<i>Regulations</i>		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.
<i>Laws</i>	Amend Local Government Code: take out the 1991 cost of devolved health function from IRA and allocate to LGUs with devolved functions.	Introduce a multi-year DOH budget item to secure the upgrading of devolved facilities.	Amend LGC to introduce legal basis for inter-LGU cooperation for health.	

ment 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 but the process needs to be institutionalized in order to foster stronger inter-relationships 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 going back 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. 📄

References

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