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PURSUING A NATIONAL HEALTH STRATEGY IN A DECENTRALIZED FISCAL REGIME

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Drawing from the public finance literature on expenditure assignment, this paper analyzes how devolution in the health sector is being operationalized in the Philippines. A central issue is how the central government can ensure that national and local objectives coincide. The pattern of health spending after devolution is described, and the financing of national health priorities at the local level through the Comprehensive Health Care Agreements is examined. The paper concludes by suggesting some guidelines for a financing mechanism for locally implemented health projects.

1. Introduction

Republic Act No. 7160, otherwise known as the Local Government Code of 1991 (LGC), introduces new opportunities as well as risks in connection with the efficient and equitable delivery of public services. The LGC grants to local government units (LGUs) various powers, authorities, responsibilities and resources which redefine national-local government fiscal relations. Specifically, the LGC mandates the transfer from the national government to LGUs of the primary responsibility for the provision and delivery of basic services and the performance of certain regulatory functions. Concomitant with this transfer of functions is the transfer to LGUs of personnel, records, facilities and other assets corresponding to the devolved functions. The law also guarantees local governments a larger share of national internal revenues, and broadens LGUs' taxing and other revenue-raising powers. In addition, the LGC allows LGUs to tap both government financial institutions and private financial markets in order to finance their development projects. These new arrangements place the burden of planning, financing and management of local projects on local governments while national government agencies (NGAs) are expected to concentrate on policymaking, research and monitoring, and technical assistance for LGUs. The new situation thus invites an examination of the emerging intergovernmental interactions and their implications on economic efficiency and redistributional objectives. An important policy issue, in particular, pertains to the financing of local government projects whose expected benefits transcend local jurisdictions.

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The health sector provides an illustrative example of the problem of pursuing a national objective in a decentralized fiscal regime. In the health sector, devolution has entailed the transfer to local governments of certain responsibilities heretofore exercised mainly by the national government through the Department of Health (DOH). Even before the LGC, however, the Philippine government had already embarked in the early 1980s on a community-based primary health care program to improve the access of the poor to health services. While this early attempt to decentralize operations had mixed results (World Bank, 1993), the wider outreach and greater community involvement gained in the process became the basis for partnerships between the DOH and communities, health workers and non-governmental organizations (NGOs) upon which a broader health sector strategy subsequently installed under the Aquino Government could be operationalized.

The move towards greater local autonomy, therefore, is not incompatible with the public health sector's commitment to a health care strategy that emphasizes the delivery of priority public health services to communities. These services include maternal and child care services, control of preventable diseases (e.g., malaria, schistosomiasis, tuberculosis), nutrition and family planning, safe water and household sanitation, and primary prevention programs for chronic and infectious diseases. The Medium-Term Philippine Development Plan (MTPDP, 1993-1998) in fact specifies the provision of health services as one of the strategies for poverty alleviation, equity promotion and human resource development. Devolution can reinforce this strategy, but it can also derail it depending upon how it affects the capabilities and incentives of the agents tasked with health services delivery at the local levels. A central issue, therefore, is how the central government can ensure that national and local health objectives coincide.

This paper discusses the rationale for central government intervention in the financing of local health projects. It draws from the public finance literature on expenditure assignment to analyze how devolution in the health sector is being operationalized in the Philippines. In particular, the financing of locally implemented health programs with national impact is examined with a view to formulate guidelines for the financing of local government projects supportive of national objectives.

The rest of the paper is organized as follows: Section 2 presents the arguments for devolution. Section 3 discusses why devolution in the health sector may lead to sub-optimal outcomes and why national government intervention may be warranted. Section 4 provides an overview of what the literature on fiscal federalism has to say about expenditure assignment and the role of intergovernmental transfers. Section 5 describes the extent of devolution in the Philippines' health

ctor and the main features of devolution in this sector. In Section 6, the pattern f health spending after devolution is analyzed. Section 7 describes how health rograms at the local level are financed, and examines the Comprehensive Health are Agreement (CHCA) as a mechanism for effecting national transfers to LGUs. ection 8 concludes the paper with a proposed financing mechanism for locally nplemented health projects.

2. Arguments for Devolution

The devolution of various powers and functions to LGUs may be justified in rms of the general principle that, in a democracy, the participation of the governed is essential for government choices to be informed and for the rights of arious social groups to be safeguarded. In a devolved system, the planning of ublic programs and their execution can benefit from better information possessed y the local chief executive about local needs, resources, attitudes and biases. rom the standpoint of the primary health care strategy mentioned above, the remise that locals know best what is best for them can potentially lead to better rgeting of health interventions. To that extent, devolution lowers the costs of ealth care delivery by ensuring greater consistency between the supply of public ealth services and the local population's preferences.

Devolution also allows for greater accountability on the part of elected offiials for policy decisions taken. The prospect of submitting oneself to the judgment f the electorate every three years can create a powerful incentive to build a good eputation for public service. In local communities, this incentive is further reinrced by the relatively high degree of social interaction which functions as an ffective mechanism for monitoring the performance of elected officials and enforcng their contract with the electorate.

Devolution implies the "freedom to fail" on the part of local governments, as ell as the freedom of the central government from any responsibility to bail out GUs that fail. This freedom is concomitant with the LGUs' discretionary auhority which, according to Silverman (1992), is the essence of devolution. Withut this freedom, there can be no accountability for local executives. It is this reedom that distinguishes a devolution-type decentralization from mere econcentration or delegation of powers and functions from national to subnational overnments.

Devolution, moreover, reduces the time lag between project planning and nplementation by dispensing with the unnecessary layers of bureaucracy. Prox-

imity of the project planner to the intended beneficiary facilitates feedback and permits a shorter time within which programs found to be ill-suited to the needs of local populations may be revised.

From a public finance perspective, devolution promotes allocative efficiency in that it vests the responsibility for public service provision in that jurisdiction which has control over the geographic area that will internalize the benefits and costs of such provision.[1] Whenever the financing of services is decentralized, there is an induced incentive for fiscal responsibility and efficiency in public provision. This is expected to result in greater local initiatives in the adoption of efficiency-enhancing innovations and in local resource mobilization, thus closing the gap between resources and needs over time.

3. Limits of Devolution in the Health Sector and the Role of the National Government

The rationale for national government involvement in local health spending decisions springs from both equity and efficiency considerations. The equity consideration is based on the view that health services provision is a form of in-kind redistribution. In the Philippines, this view particularly finds support in the low proportion of medically attended deaths and in the large number of deaths from preventable causes, which indicate that poverty is both cause and consequence of the lack of access to health services.[2] The efficiency consideration, on the other hand, derives from the nature of health services which produces strong incentives for lower level governments to underprovide them. These considerations are discussed below.

Health outcomes depend upon the quantity and quality of health services received. While the consumption of health services is a matter of individual or household choice, income and education significantly circumscribe health choices. This often leaves the poor with little or no access to affordable health care. Given redistribution as a national policy objective, some *minimum level of provision* of health care is thus implied.

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[1] This is the "decentralization theorem" as advanced by Oates (1972). In practice, however, requiring a separate jurisdiction for each public service implies a large number of overlapping jurisdictions.

[2] In depriving the poor access to health services, poverty contributes to low productivity and early disability which limit income opportunities and cause poverty to become self-reproducing.

According to the public finance literature, the redistributive function of the
›lic sector is best performed by the central government. Factor mobility across
isdictions restricts the redistributive role of LGUs. For instance, an LGU sub-
izing social services may find itself swamped by residents of neighboring LGUs.
reover, weak fiscal capacity may prevent some LGUs from attaining the mini-
ım levels of health services desired from an equity standpoint. This would be
e in the case of municipalities which have unfavorable revenue bases to start
:h.[3] In this case, some amount of national government assistance is necessary
l may be beneficial.

Furthermore, since the quality of health services is an important determi-
nt of health outcomes, ensuring the minimum level of provision should be inter-
eted as accounting for *both* quality and quantity. The success of the various
)H immunization programs, for instance, demands a concerted effort from LGUs
the proper handling and distribution of vaccines. However, if LGUs are un-
lling or unable to invest in the required cold chain facilities, these programs
ıy be severely jeopardized. If health care delivery workers are not adequately
ined, health programs may fail to achieve their intended effects. As the DOH
perience prior to devolution has already shown (World Bank, 1993), a decentral-
ed set-up may pose problems to the extent that there are no structures or mecha-
sms in place to ensure coordination, logistical support, and the technical super-
sion of health programs and health care workers at the local levels. For this
ason, some degree of central control from a higher level government may be
arranted.

In a decentralized set-up, the basic problem of the national government is
w to ensure that national health policies and programs will be uniformly imple-
ented by LGUs. Because of differences in preferences or spending capacities, an
GU may depart from the national government's spending priorities—not only
ith respect to the amounts spent on health, but also with respect to the desired
ix of curative and preventive, tertiary and primary health care—and create
oblems in the attainment of redistributive goals.

This need not be a cause for concern, however, to the extent that LGUs are
ee to fail. If the health condition of the residents in a jurisdiction deteriorates
cause the local officials allowed it so, then the residents will simply vote these
ficials out of office at the next chance. However, certain types of illnesses can

[3] Various estimates of the financial impact of devolution point to the likelihood of some
unicipalities experiencing shortfalls due to the inadequacy of the higher IRA mandated by the
GC to cover the cost of both devolved functions and pre-devolution expenditures (Diokno,
994).

spread beyond political boundaries so that the level of health services provision in one jurisdiction can impact on the health situation in another. In practice, there is tremendous social pressure for central governments to intervene even in local health matters. In the Philippines, the national government is often blamed when an epidemic breaks out.

The efficiency reasons for government intervention in health concerns are, in general, well-known. These have to do with the joint consumption and non-exclusion properties of health-related goods and services. These public good properties make private provision costly since the benefits are not appropriable by any single individual or group. Private markets, for example, will undersupply health information and underinvest in the prevention and containment of communicable diseases.

There may also be significant externality or spillover effects associated with the consumption and provision of health-related services. Immunization of one's children against contagious illnesses (e.g., measles, cholera, etc.) reduces the chances of transmitting these sicknesses to other children, but parents purchase only that quantity of preventive care consistent with their calculation of private costs and benefits. Whenever consumption of health services is left solely to individual preferences or abilities to pay, it will be less than socially desired. Some amount of government intervention is thus necessary to elicit the socially optimal response from private markets.

The same reasons that cause private markets to underprovide health care services apply in the case of LGUs making the disruption of national health programs a real possibility under devolution. LGUs may choose to underspend on specific health programs knowing that they are national priorities, or knowing that the national government can ill-afford the political costs of being perceived as doing nothing. In such cases, the national government cannot risk not intervening in local health spending decisions. In addition, where the benefits from local government provision of the service can be realized by non-residents of the political jurisdiction, an incentive exists for LGUs to provide less of the service. In the first case, there is a need for mechanisms to ensure that LGUs will allocate resources for what are considered as national health priorities. In the second case, cost-sharing arrangements may have to be worked out between or among LGUs that are benefited by locally provided services with high benefit-spillovers. Higher level governments can facilitate these, although the transaction costs when many LGUs are involved may make direct involvement by a higher level government less costly. Alternatively, subsidies may be granted to the externality-emitting LGU.

When the service area required by a particular service to be cost-effective is rger than the local jurisdiction, intervention by a higher level government may e necessary to avoid wasteful duplication. For example, it would be more efficient have tertiary hospitals and high-tech hospital equipment at the provincial rather ian municipal level. Devolution may result in excessive spending to the extent iat adjacent LGUs decide to provide their own facilities (e.g., tertiary hospitals, igh-tech hospital services, etc.) either as a genuine response to a perceived nderprovision (as when residents of the LGU are prevented from free riding on ie existing health facilities of a neighboring LGU), or out of the personal whim of ie local chief executive.

4. Expenditure Assignment Principles and the Role of Intergovernmental Transfers

The preceding discussion suggests a conceptual basis for the assignment of ealth expenditure responsibilities consistent with the principles of fiscal federal-m.[4] Health services provision should be left to the subprovincial (municipal) or gional (e.g., metropolitan or provincial) level as appropriate unless the benefits nerated are national in scope. Still, responsibility for policy development, mini-um standards of service and performance, and coordination should belong to the ntral government. The management of intergovernmental interactions arising om benefit spillouts and cross-border use of provincially provided services should so be national responsibility. Provinces have a similar role with respect to exter-alities from the provision of health services by LGUs within their jurisdictions.[5] he government level assigned to provide the service then determines whether oduction of the service should be public or private depending upon the usual ficiency and equity criteria.

Following the above principles, the provision of health services should be centralized to the lowest possible jurisdiction (to the municipalities or barangays the Philippine case) if closeness to the beneficiaries is a critical consideration, d if scale economies, externalities, and equity issues are not so important. This ould be the case for such programs where individual LGUs can fail with negli-ble repercussions on other jurisdictions (e.g., dental health). In contrast, preven-ve health programs such as immunization and control of communicable diseases ould be the responsibility of city, municipal and provincial governments. For ese programs, proximity to the beneficiaries is still a major consideration. How-

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[4] See Shah (1991, 1994).

[5] In certain cases, however, the province may not have the political clout or the struc-res necessary to carry out this function (e.g., Philippines).

ever, benefit spillovers can be significant as to require the sharing of expenditure responsibility between or among jurisdictions. Moreover, the public health aspects of these programs can also have important distributional effects. Hospitals can be assigned to the provincial, city and district levels depending upon how consequential the scale economies are,[6] and the extent of the externalities or cross-border use involved. Hospitals that serve as centers of medical research for the nation, for example, should be placed directly under the central government.

Matching the expenditure functions of LGUs with their revenue means is always a critical issue in decentralization. Devolution can lead to fiscal imbalances for some LGUs, necessitating compensatory transfers from the national government. Shah (1994) observes that the dominant source of revenues for subnational governments in most developing countries is intergovernmental transfers. In general, economic and political considerations provide the underlying rationale for grants to subnational governments. The economic arguments are based on equity (fiscal gap, differential net fiscal benefits, redistribution), efficiency (interjurisdictional spillovers, common market arguments and differential net fiscal benefits), and to some minor extent, stabilization objectives. These arguments have been summarized in Shah (1994) and Shah, Qurishi, et al. (1994). Transfers provide an important mechanism by which national governments may be able to influence the spending behavior of subnational governments towards nationally desired outcomes.

The design of intergovernmental transfers has important implications on the efficiency and equity of local public services, and the fiscal condition of both LGUs and the national government. Grant design will, in general, depend on the economic objectives of the grant. Shah (1994) discusses a number of criteria to which grant design must adhere. In principle, grant design must, as much as possible, preserve LGU independence and flexibility in setting its priorities, insure that LGUs have adequate revenues to carry out their expenditure responsibilities, and balance fiscal need and taxable capacity in determining the level of transfer allocations. Transfers must also be designed in such a way that subnational governments can reasonably predict their shares given funding availability. To prevent LGUs from behaving strategically, objective factors beyond their control should be used as bases in determining allocations. Grants must also ideally result in the promotion of sound fiscal management and avoid distorting LGU choices about resource allocation to different sectors or types of activity. Finally, grants ought to be designed in a way that the grant recipients respect the objectives of the grantor.

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[6] These depend upon the level of care (e.g., primary, secondary, tertiary) dispensed.

Obviously, a number of the above criteria can contradict each other in de-igning specific programs. For instance, in the health sector, where ensuring ninimum standards is a reasonable basis for intervention by the central govern-nent, the grantor's objective has to take precedence over the criteria of autonomy nd neutrality. In addition, because of the potential for free-riding given the na-ional importance attached to health programs, the grant mechanism should pay ttention to the incentive criterion. A system of conditional matching transfers an address the minimum-level-of-provision objective and satisfy the incentive riterion simultaneously. However, there may be a need to combine these trans-ers with revenue sharing mechanisms or modifications in the tax base as a way of esponding to fiscal deficiencies which may limit LGU access to the transfers and hereby reduce the grant's effectiveness in attaining the national objectives. Alter-natively, the possibilities can be improved for LGUs to tap private financial mar-ets to finance their share of the cost of social projects. Where benefit spillovers onstitute the primary reason for transfers, open-ended matching grants can be nplemented with the matching rate determined by the benefit-spillout ratio (Shah, 994).

5. Decentralization in the Philippines' Health Sector

he Extent of Devolution

By international comparison, the devolution of powers and functions to LGUs s provided for under the LGC of 1991 is considered drastic in terms of the func-ions covered, the degree of autonomy accorded LGUs, the governmental levels ffected, and the pace of implementation (World Bank, 1994). (See Table 1.)

For the health sector, devolution has effectively handed over to about 1,600 lifferent LGUs control of most health services within their jurisdictions. Imple-nentation of the LGC has also resulted in the transfer of at least 45,000 health ersonnel and most of the facilities managed by the DOH at the local level to the ocal governments at the barangay, municipal and provincial levels. Likewise, the rocurement of drugs, medicines, medical supplies, materials and equipment has een devolved to provincial, city and municipal governments (Table 2). The De-artment of Budget and Management (DBM) has estimated the cost of devolved ealth services to be 4.2 billion pesos (as of June 30, 1993). This is the largest bsolute amount of devolved expenditure, about 65 percent of the estimated total ost of devolved functions, or approximately 39 percent of the DOH budget in 1992.

Table 1 - Organizational Types of Health Service Decentralization

ORGANIZATIONAL CRITERIA	LOW	MEDIUM		HIGH
Functional Scope	Thailand Not Affected		Malaysia, PNG Indonesia Planning, Budget Preparations, Day-to-day Program Mgmt.	Philippines, India Person. Mgmt., Revenue and Expend. Control, Procurement, Training, IEC, Prog. Mgmt., etc.
Degree of Service Autonomy	Thailand Centralized National Service	Indonesia Lower level service decisions making (Deconcentration)	PNG Service implemented by local governments under National Authority (Agency Principle)	Philippines, India Service under complete authority of local governments (Devolution)

Table 1 (continued)

ORGANIZATIONAL CRITERIA	LOW	MEDIUM		HIGH
Levels Affected	Thailand	Malaysia, Indonesia	India, PNG	Philippines
	National System	Administrative regions or districts	Provinces, States	Cities, towns, villages
Rate of Change	Thailand	India	Indonesia	PNG, Philippines
	None to date	Evolutionary change	Slow change	Accelerated change, Rapid change

Source: World Bank (1994).

Table 2 - Devolved DOH Assets and Personnel

	DESTINATION OF DEVOLVED ASSETS AND PERSONNEL		
DOH FUNCTIONS	CITIES	PROVINCES	MUNICIPALITIES (BARANGAY)
Basic Health Care (Primary Health Care, EPI, Maternal & Child Health, Dental Health, Nutrition, Family Planning, Comm. Disease Control, etc.)			2,299 Rural Health Units 10,683 Barangay Health Stations 210 Purieculture Centers Municipal Maternity Clinics Municipal and Barangay DOH Staff
Hospital Services (Curative and Preventive Services in Primary, Secondary, and Tertiary Facilities		596 Provincial, District and Municipal Hospitals & Infirmaries District & Provincial DOH Hospital Staff	
Administrative Service	60 City Health Officers Assistant City Health Officers		
Equipment & Supplies	Current Inventories	Current Inventories	Current Inventories

Source: DOH as cited in World Bank (1994).

Table 2 further shows that cities absorbed the least additional expenditure responsibility for health under devolution compared with provinces and municipalities. This is because cities, in general, have managed and financed their own health systems long before devolution. In contrast, provinces took over hospital services (comprising of 596 provincial, district and municipal hospitals and infirmaries), 70 integrated provincial health offices (IPHOs), the staffs of DOH provincial and district hospitals and of IPHOs and District HOs, and all current inventories of equipment and supplies. Municipalities, on the other hand, inherited the DOH infrastructure for basic health care delivery (2,299 rural health units, 10,683 barangay health stations, 210 puericulture centers, municipal maternity clinics), all municipal and barangay DOH staff and current inventories. In effect, the LGC has turned over to LGUs the fiscal responsibility for recurrent expenditures on health services.

The personnel as well as assets retained by the DOH under the LGC are clustered in the DOH central office in Manila, in the specialized hospitals, and in the regional field offices. As of the end of 1994, the DOH-retained personnel totalled some 26,200 out of the previous 75,000. About 14,600 of these retained staff are assigned to the regional health offices.

Despite the decentralization of responsibility for health services delivery, the DOH retains certain key functions considered crucial to carrying out its general mandate to "promote, protect, preserve or restore the health of the people" (DOH, 1994). These include the formulation of a national health policy, regulation and accreditation, information and education, disease surveillance and research, and emergency response. The DOH continues to directly control all foreign-assisted projects, including the disease control programs (e.g., malaria, TB, and schistosomiasis). The DOH is also expected to perform "augmentation and assistance" activities by way of providing technical and financial assistance to LGUs. This function is critical not only during the transition phase of devolution when the uneven distribution of incremental spending for health may destabilize some LGUs, but over the long-term, too, so as to ensure a minimum level of provision of public health goods throughout the nation.

National Health Programs, Devolved Delivery Structures

One feature of devolution in the health sector is that, while the service delivery structures have been devolved, the ownership of existing health programs has remained largely "national". Despite devolution, the DOH continues to maintain responsibility for some 24 programs referred to as "DOH Programs". Annex Table 1 enumerates these national programs showing the de facto assignment of responsibility by jurisdiction for the various activities under each program.

Without inquiring into the bases for determining when a specific health program should be a "national" program, the current situation clearly presents the DOH with the problem of ensuring the continuity of national health programs. This is due in part to the lack of experience in health services management at the municipal level, and the personnel problems that have attended the reorganization of the bureaucracy as a result of devolution (Bustamante, 1994). Such difficulties are not insurmountable, however, given time and a national willingness to invest in the development of local capacities.

A more serious drawback under the devolved health service delivery system is the lack of a structure of coordination between the national center (DOH) and the municipalities and barangays through which the NG can exercise the necessary supervision and oversight in the planning and execution of health programs with national impact. For instance, provincial governments do not formally exercise any oversight function with respect to the health programs of municipalities in their jurisdictions. Provincial and district health officers (PHOs and DHOs) also have no supervisory powers over the RHUs. Since the health offices of component cities and municipalities are under their respective local chief executives who are not accountable to the province, supervision over these health offices by the PHOs is virtually non-existent. This presents a problem for the DOH to the extent that LGUs may have different priorities or no incentive to spend for national priorities knowing that the national government cannot afford not to intervene. This implies that the DOH itself must closely supervise, monitor, and evaluate the implementation of national programs at the local level. The problem is that the DOH has lost most of that capability after its transfer to the LGUs as a result of the LGC.

An attempt to restore the DOH coordinative structure and ensure the alignment of LGU programs with national priorities can be found in the Comprehensive Health Care Agreement (CHCA). The CHCA is a contract voluntarily entered into by an LGU with the DOH, under which the LGU binds itself to implement a set of health programs and the DOH to share in the cost of financing these programs. Through the CHCA, LGUs are able to augment their own finances with contributions from the national government even as local resources are committed to specific health expenditures. In this way, the DOH is able to exercise control over the allocation of LGU resources for what are considered *core health programs*. The nature of the CHCA as an intergovernmental selective matching transfer is discussed in Section 7.

Going to the DOH Programs in Annex Table 1, the basis for considering some of these programs as "national" is rather tenuous. A reading of the activities

volved under each of the programs (cf. Herrin, et al., 1995) suggests that respon-
ility for a number of them can in fact be turned over to subnational govern-
nts consistent with expenditure assignment principles.

A useful rule-of-thumb in determining which programs the NG ought not to
, or to be least, involved in is the extent to which an LGU is free to fail with
spect to a program. Obviously, programs with national impact are excluded
m this set. These would be (a) programs that address health problems of a
tional scope, where LGU capacity is weak, and where LGU failure can have
astrous consequences (e.g., epidemic); (b) programs with clear redistributional
social amelioration objectives; and (c) programs strongly supportive of national
velopment goals.

If these criteria are applied to the 24 DOH Programs enumerated in Annex
ble 1, only a few would qualify as national programs. Under category (a) would
AIDS prevention and control, malaria control, TB control, quarantine services,
d control of filariasis, dengue, and schistosomiasis. Under category (b) would be
ntrol of acute and respiratory infection, expanded program for immunization
d TB control. Category (c) would include family planning. The rest should be
nsidered as non-national programs; the primary responsibility for delivering
ese properly belongs to subnational governments, even if there is a role for the
G/DOH in standard-setting, training, information dissemination and, in certain
ses, financing.

An obvious candidate for higher-government intervention is a program deal-
g with communicable diseases. However, communicability may not be sufficient
a criterion for national intervention because communicability may be geographi-
lly circumscribed, or may depend upon certain features of the physical environ-
ent that are region- or province-specific and, therefore, not nationally shared.
us, health programs whose benefits extend beyond one political jurisdiction
ay be approached on a provincial (i.e., non-national) basis.

To the extent that scale and scope economies can be realized by undertaking
me programs or component activities in a coordinated fashion, an argument for
ntral provision can be made (e.g., control of smoking, cancer and cardiovascular
sease). However, even in some of these cases, the appropriate central authority
uld be other than the national government.

A popular argument in favor of centralized programs is economies of scale
procurement. Indeed, about 60 percent of national program funds in 1993 went
MOOE, the bulk of which were for the purchase of drugs and medicine, and

various commodities. However, unless the program is already deemed a national program, the savings from centralized procurement should be compared with the benefits from timely local deliveries and meeting the specifications set by the recipient LGUs. In fact, procurement is a devolved function.

6. Health Spending After Devolution

This section examines how devolution has affected the pattern of health expenditures in the Philippines. Since the Philippine experience with devolution is relatively recent, the present analysis is limited to a before-after approach, using 1991 and 1993 data for the pre-devolution and devolution regimes, respectively.

The data show that aggregate public health expenditures increased in real terms following devolution. While the share of local governments in health expenditures has increased, LGUs are spending less than what the national government used to spend for local health services before devolution. There is no reason to presume, however, that pre-devolution health expenditure levels were necessarily optimal.

National vs. Local Health Expenditure Shares After 1991

In real terms, overall public expenditures for health increased by 0.4 percent between 1991 and 1993 (Table 3). In 1993, however, LGU health expenditures increased substantially from P6.5 million to P24.7 million, while the national government reduced similar expenditures by 31 percent from P59 million to P41 million. As a result, the share of subnational governments in public spending on health rose from 10 percent in 1991 to 38 percent under devolution.

While information about the allocation of the higher LGU health expenditures in 1993 is not readily available, there is reason to believe that devolution can bring about a more rational allocation of public resources between personal and public health care services. Based on the 1991 National Health Accounts (NHA) data, 73 percent of local government spending went to public health care, whereas about 61 percent of national government health spending went to personal health care. In absolute terms, of course, national government contribution for public health care was still larger. Nevertheless, these figures suggest sufficient scope for greater private provision of personal health services to enable the public sector to direct more of its scarce resources to public health concerns.

Table 3 - Health Expenditures, 1991 and 1993 (in real terms*)

Level of Government	PERSONAL SERVICES			MAINTENANCE & OTHER OPERATING EXPENSES		
	1991	1993	%Change	1991	1993	%Change
National		15.81			21.65	1617.82
Province	1.09	7.60	600.65	0.21	3.53	111.89
City	3.27	3.48	6.34	0.73	1.55	894.96
Municipality	0.68	5.27	668.85	0.27	2.70	

Level of Government	CAPITAL OUTLAY			TOTAL		
	1991	1993	%Change	1991	1993	%Change
National		3.19		58.58	40.65	–30.60
Province	0.02	0.08	282.05	1.31	11.22	755.03
City	0.12	0.26	109.36	4.13	5.29	28.17
Municipality	0.12	0.23	92.64	1.09	8.19	648.26
TOTAL				65.11	65.35	0.37

*using 1988 prices
Source: COA Annual Financial Reports.

Public health care services (as distinguished from personal health care) include health services whose benefits are not exclusive to those receiving the service or treatment (e.g., safety and standards regulation, disease control programs, health information and education), as well as those which generate positive externalities or benefit spillovers (e.g., immunization). Included also as public health services under the NHA are programs which provide personal care services (e.g., primary health care, maternal and child health care, control of diarrheal diseases and of acute respiratory infections) but which are administered through rural health units (RHUs), puericulture centers (PCs), barangay health stations (BHS), and chest/floating clinics. The reason is that such personal health care services, when dispensed through these sources, incorporate an informational or educational aspect via their demonstration effects on local communities.

Figure 1 shows that health services with greater public benefits are delivered mainly through RHUs and BHSs rather than through hospitals. In general, because local government expenditure decisions tend to be more oriented towards the provision of social services (Klugman, 1994), the larger LGU share in health spending may be seen as an opening to increase the "public good" content of publicly provided health services. Based on past trends, this is superior to a situation where health expenditures are centrally determined.

Local Health Expenditures by LGU Type

Aside from the greater LGU share in public spending for health under the decentralized regime, another striking observation is the dramatic rise in the health expenditures of provinces (755 percent) and municipalities (648 percent) compared with that of cities (which rose only by 28 percent).[7] Table 3 shows the distribution of government health expenditures by level of government pre- and post-devolution.

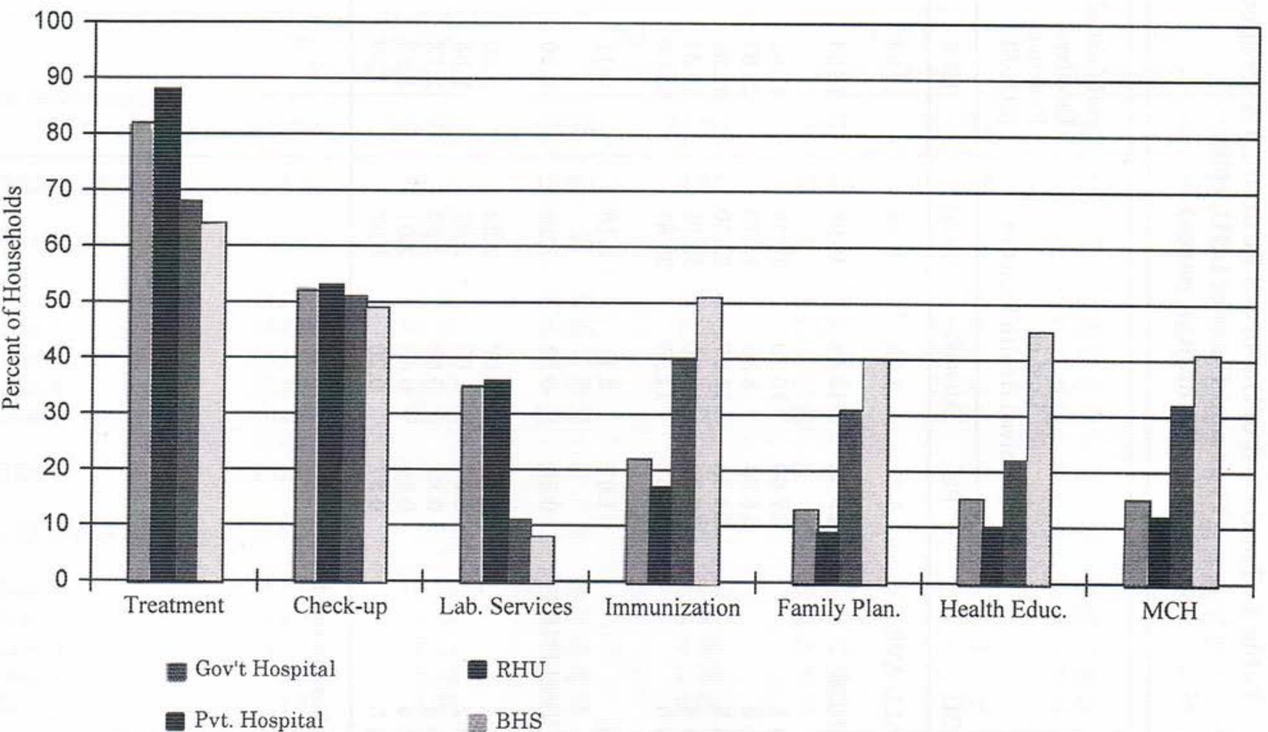
The changes noted above reflect the new expenditure responsibilities mandated by the LGC. According to one estimate (Capuno and Solon, 1995), the average cost of devolved health functions (measured by PS and MOOE)[8] accounted for 56 percent of the total cost of devolved functions per LGU in 1993. When broken down by LGU type, however, the data (Table 4) show that devolved health functions accounted for a substantial portion of the new expenditure responsibilities absorbed by the provincial governments under the LGC (81 percent). For cities and municipalities, the ratios average 52 and 49 percent, respectively. The assignment of the bulk of DOH personnel to municipalities and provinces explains the more than 600 percent real rise in their PS expenditures. In contrast, cities which absorbed fewer health personnel experienced a mere 6 percent increase in PS spending.

The differential impact of devolution on provinces, cities and municipalities is also borne out by the relative changes in their MOOE figures. Largely on account of the transfer of hospitals and various health care facilities to their jurisdictions, provinces' MOOE for health rose by 1,618 percent in real terms from 0.2 to 3.5 million pesos and that for municipalities rose by 895 percent from 0.3 to 2.7 million pesos. In comparison, the increase for cities has been much lower at 111 percent, from 0.7 to 1.5 million pesos. The comparatively lower figure for cities

[7] These large percent changes could be due to the inclusion in the data base of LGUs which reported zero health expenditures in 1991.

[8] The cost of devolved health functions (CDHF) is measured by the reduction in the DOH budget as a result of the assignment.

Figure 1.
Services Received in Health Facilities



Source: DOH, National Health Survey, 1987 as reported in Herrin, Russo and Pons (1992)

Table 4 - Total Cost of Devolved Functions Averaged by Type and Class of LGU, 1993 (in million pesos)

LGU	Cost of Devolved Health Function			Total Cost of Devolved Function (CODEF)	Share of CODEF to Total CODEF
	PS	MOOE	Total	1993	1993
OVERALL AVE.	4.75	3.39	8.14	10.83	56.18
PROVINCE	20.32	13.59	33.90	41.64	81.49
Class 1	22.66	15.79	38.45	47.68	80.64
Class 2	15.34	8.36	23.70	29.83	79.18
Class 3	24.33	13.97	35.30	42.96	82.17
Class 4	19.36	13.60	32.96	39.31	83.85
Class 5	17.32	11.55	28.87	33.89	85.19
CITIES	1.07	2.11	3.18	6.11	52.05
MUNICIPALITIES	0.66	0.52	1.18	2.30	49.21
Class 1	1.13	0.09	2.22	3.36	66.07
Class 2	1.07	1.00	2.07	5.53	58.64
Class 3	0.82	0.68	1.50	2.78	53.96
Class 4	0.58	0.43	1.01	2.13	47.42
Class 5	0.37	0.20	0.57	1.39	41.01

Source: Capuno and Solon (1995).

Table 5 - Internal Revenue Allotment, Tax Revenues, Total Expenditure and Health Expenditures Averaged by Type and Class of LGU: 1991 and 1993 (in million pesos)

Local Government Unit	Internal Revenue Allotment		Tax Revenue		Total Expenditures		Health Expenditures	
	1993	'93-'91	1993	'93-'91	1993	'93-'91	1993	'93-'91
OVERALL AVE.	43.81	29.70	10.60	4.53	43.14	9.33	6.91	5.15
PROVINCE	103.47	68.55	11.25	6.15	103.15	26.98	25.55	23.51
Class 1	142.64	94.62	10.76	5.70	93.26	-2.61	25.67	23.07
Class 2	87.95	58.15	15.06	9.26	103.80	50.21	27.04	25.98
Class 3	61.45	40.72	11.52	5.41	136.65	83.89	25.36	23.25
Class 4	64.86	40.97	3.36	-0.56	93.17	22.36	18.73	17.05
Class 5	52.94	42.68	15.09	11.25	103.95	52.16	29.88	28.55
CITIES	142.62	100.58	57.86	23.90	123.83	3.90	8.64	-2.53
MUNICIPALITIES	8.70	5.74	2.27	0.71	11.05	4.91	0.95	0.90
Class 1	17.09	10.13	10.29	3.05	36.32	11.34	2.95	2.53
Class 2	13.80	8.46	5.79	1.44	19.43	7.44	1.59	1.48
Class 3	11.13	7.11	2.26	0.98	13.71	6.08	1.21	1.12
Class 4	7.57	5.22	1.48	0.58	8.58	4.15	0.80	0.79
Class 5	4.62	3.32	0.36	0.06	5.13	2.93	0.42	0.41

Source: Capuno and Solon (1995).

compared with that for provinces may be traced to the fewer facilities absorbed by cities. In fact, the presence of provincial hospitals or DOH-retained facilities in some cities confers a subsidy to cities which results in lower health budgets.

LGU Health Expenditures vs. Cost of Devolved Health Functions

In spite of the noted increase in LGU health expenditures, they have fallen short of the CDHF. If the CDHF is taken as a benchmark of what LGUs must spend in order to maintain local health services provision at the pre-devolution level, then a case for underspending in health under the devolved set-up can be made.

One factor potentially operating against increases in locally-provided social services in a decentralized regime is the differential impact of increased expenditure responsibilities on the budgets of LGUs. Data indicate that the new LGU responsibilities may have created fiscal problems for some LGUs.

A recent study (Capuno and Solon, 1995) analyzed the impact of devolution on the health expenditures of 180 LGUs (which include 37 provinces, 21 cities and 122 municipalities) for 1991 and 1993 using LGU survey data collected in 1994. The study observed that decentralization in the health sector had a "heavy fiscal bias" against provinces. A comparison of the relevant columns in Tables 4 and 5 reveals that, on average, provinces experienced the largest shortfall in health spending relative to CDHF.

The following observations underscore the vertical fiscal imbalance resulting from devolution: First, while both provinces and cities received higher IRAs between 1991 and 1993, the increase obtained by cities was, on average, considerably more than was received by the provinces. Yet the average increase in total provincial expenditures over the same period was almost eight times that of the cities'; Second, cities also have, on average, about four times the tax revenues of provinces and about 20 times that of municipalities. Yet cities got more of the central government transfers thru the IRA; Finally, with respect to health, cities had the least additional expenditures following devolution on account of operating their own health systems even prior to the LGC of 1991, while provinces and municipalities inherited most of the devolved DOH personnel and assets. The lower city expenditures on health may also be due in part to the tendency on the part of the NG before devolution to locate provincial or regional hospitals in cities which effectively subsidized health services for city residents. In fact, the 21 cities in the 1994 sample of LGUs decreased health spending, on average, with devolution.

The fiscal bias notwithstanding, LGUs enjoy a positive fiscal gap, on average, once tax revenues are augmented by their IRAs.[9] This indicates that capacity to finance local health services provision, everything else remaining the same, is less of a problem. Thus, the fiscal bias against provinces does not fully explain the shortfall in health expenditures vis-à-vis the CDHF.

Capuno and Solon (1995) explore free-riding as a reason for the observed "underspending". Their econometric results yield only weak evidence regarding the disincentive effect of DOH-retained hospitals on the health spending of provinces. The presence of devolved hospitals in other provinces was found to have a negative effect on local spending for provinces which have absorbed many hospitals. As for municipalities, the tendency to free-ride on the hospital facilities of neighboring localities arises only if the other municipalities belong to a higher class province.

It is, of course, possible that the lower health expenditures are the result of LGUs' decisions to get rid of excess capacity.[10] In this case, the shortfall in health expenditures relative to the CDHF is an adjustment to a presumably more efficient level of spending for local health services. To the extent that devolution has made the real costs of operating public hospitals more apparent, as well as consequential, to provincial governments, an incentive has been created to either operate the provincial hospitals efficiently, or privatize those that can be privatized. Either way, resources that can be utilized more productively will be freed. Provincial governments may then focus on the greater provision of public health services and in strengthening coordination of health programs among subprovincial LGUs. This is consistent with the higher quality of health services envisioned under devolution.

Based on the limited Philippine experience with devolution, any judgment regarding the direction of health expenditures is likely to be premature. Policy recommendations have to be tempered by the consideration that the period of transition is not over yet. On balance, the situation is not one that calls for drastic NG (DOH) measures to centralize spending decisions, especially if without the benefit of better information about the factors underlying LGU expenditure trends in health. A reduction in local health spending (relative to NG pre-devolution spending for local health) for reasons of excess capacity is an efficiency.enhancing move and should not be cause for concern. If, on the other hand, local health

[9] See Diokno (1994), however, for alternative methods of estimating the fiscal gap.

[10] As the study cited above suggests, this is easier to do when similar facilities are present in neighboring jurisdictions. In other words, LGUs' perceptions of the appropriate size of facility to provide are not independent of what neighboring LGUs provide.

spending is declining because of fiscal deficiencies or incentive effects due to spillovers and cross-border use, intergovernmental arrangements (e.g., transfers, cost-sharing schemes) may be called for to correct the situation.

7. Financing Health Programs at the Local Level

Local Revenues and General Transfers

To finance their health and other expenditures, LGUs depend largely upon two sources: locally generated revenues and their share of national internal revenues or the internal revenue allotment (IRA). With the enactment of the LGC of 1991, the LGU share of national internal revenue taxes was increased to a maximum of 40 percent based on collections of the third fiscal year prior to the current year. Using data from the Commission on Audit (COA) for a sample of 28 provinces, Quitazol (1995) observed a more than 200 percent average increase in the IRA from 1991 to 1993. Moreover, the growth in LGU receipts from the IRA was higher for poor provinces.

The IRA constitutes an important source of LGU finances. As a proportion of total provincial revenues, the IRA increased from an average of 60 percent in 1991 to 83 percent in 1993. Third and fourth class provinces registered the greatest dependence on the IRA with their ratios of IRA to total revenues at 91 and 93 percent, respectively.

While their higher IRAs allow the LGUs to meet their increased health expenditures under devolution, complaints by local chief executives gathered from the field betray some dissatisfaction at the local levels regarding the adequacy of the IRA. Local chief executives have decried the mismatch between the additional responsibilities and resources.[11] The mismatch seems to have arisen from the fact that the IRA formula was determined independently of the devolution of functions to LGUs. More specifically, the requirement that LGUs must first allocate funds for devolved services before any other expenditure (Executive Order 507) means that provinces and municipalities, which absorbed the bulk of devolved DOH personnel and facilities, must spend their additional funds from the higher IRAs on financing higher outlays on PS and MOOE under the LGC of 1991. Thus, LGUs

[11] The LGC of 1991 mandates the following IRA shares after 1993: provinces, 23 percent; municipalities, 34 percent; cities, 23 percent; and barangays, 20 percent. Before devolution, barangays received 10 percent of the available IRA and the remaining 90 percent was divided among provinces (30 percent), cities (24 percent), and municipalities (45 percent).

el that they have very limited discretion over the additional resources resulting om the higher IRA. On top of this, the NG instituted a Magna Carta for Health /orkers providing for an increase in the pay of devolved health personnel.

For 1996, the IRA was estimated at P56.6 billion (or 40 percent of the 1993 ational internal revenue tax collection). Relative to total LGU resources, this epresented 53 percent. By LGU type, the share of IRA to total resources based on he 1996 appropriations was as follows: provinces, 60 percent; cities, 37 percent; ıunicipalities, 58 percent; and barangays, 72 percent.

An adjustment in the 1996 budget was the direct allocation of P3.3 billion of he P 56.6 billion IRA (or 50 percent of the 1992 cost of devolved functions and city-unded hospitals) to LGUs according to the actual financing burden they absorbed ıs a consequence of devolution. The remaining P53.3 was then allocated according o the formula prescribed in the LGC. Figures from the DBM (1995)[12] show, as a esult, a slight deviation from the IRA allocation by LGU type as prescribed by the .GC: provincial share rose to 24 percent while the city share was reduced to 22 percent; municipalities' share increased to 35 percent while barangays' share de-clined to 19 percent. This adjustment increased the amount of discretionary re-sources available to an LGU type depending upon its actual share of the total cost of devolved functions. Provinces and municipalities, as a group, were expected to benefit from this budgetary adjustment. Nevertheless, such adjustment left unad-dressed the potential issue of inter-provincial and inter-municipal burden shar-ing.

In its current design, the IRA allocation may be contributing to horizontal inter-LGU inequities. The IRA is allocated among LGUs of the same type based on the following formula: population (50 percent), land area (25 percent), and equal share (25 percent). This formula favors high-income LGUs in that it is these LGUs which are larger and well-populated. While these characteristics imply greater expenditures for infrastructure and public services, higher-class LGUs also have well-developed tax bases and hence, more favorable revenue potentials than lower-class LGUs. Thus, even with the recent change noted above, the IRA allocation formula continues to reward high-income LGUs, muting the equalizing intent of general purpose transfers.

A possible innovation in the sharing formula would be to consider the de-gree to which an LGU has satisfied a set of minimum basic needs, as practiced in Colombia. The amount of central transfers to an LGU would then be negatively

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[12] Cf. Republic of the Philippines, 1995. *Budget and Expenditures and Sources of Financ-ing: Fiscal Year 1996.* Manila.

related to the degree to which it has met the minimum basic needs. Such a system, however, is very data-intensive and requires regular updating of minimum basic needs information. Where these are not easily available, data on poverty incidence per LGU can be used as a proxy for the basic needs information. However, it is also important to weigh this concern against the potential adverse effect of the IRA on local fiscal effort (Quitazol, 1995).

To relate the foregoing discussion to health spending, modifying the existing formula for general transfers to correct for both vertical and horizontal fiscal imbalances may not necessarily lead to greater local spending on health. However, in combination with other mechanisms (e.g., categorical matching transfers, improving access to credit markets, greater LGU participation in program planning), putting more discretionary resources in the hands of LGUs may eventually lead to a level of health spending that is more responsive to both national and local concerns.

Specific Purpose Transfers: The CHCA

Nature and Objectives of the CHCA

Another source of finance for nationally important but locally implemented health programs is the Comprehensive Health Care Agreement (CHCA). The CHCA was conceived in 1993 in response to the need for a mechanism to ensure that national health programs would not be disrupted by the devolution to LGUs of the responsibility for health services delivery.

The CHCA is a contract between an LGU and the DOH, under which the two parties agree to implement a set of health programs through a cost-sharing arrangement. Through the CHCA, the DOH commits to augment LGU finances for health and LGUs bind themselves to implement a set of nationally prescribed health programs. In this way, the DOH is able to exercise control over the allocation of LGU resources for what are considered core health programs.

The CHCA is essentially a selective, intergovernmental matching transfer. It provides for both a *Baseline Package* and an *Incremental Health Package*. The *Baseline Package* consists of the total amount that the LGU must set aside from its IRA to cover the cost of devolved health personnel and services. As a result of devolution, LGUs are expected to shoulder the cost of personnel services and maintenance, and operating expenses incurred by the DOH prior to devolution. The *Baseline Package* basically sees to it that this is accomplished. In so doing, the CHCA is able to ensure the smooth transfer from the NG to the LGU of the responsibility for maintaining both health personnel and facilities (e.g., hospitals,

unicipal health centers, barangay health stations). From the national view-
)int, the absorption of these devolved expenditure items by LGUs is crucial in
ıat this assures the minimum conditions for the local delivery of health services.
'ithout agreeing to fund the *Baseline Package* from its IRA, an LGU cannot have
:cess to the resources under the *Incremental Health Package*.

The *Incremental Health Package* consists of the resources, both cash and
nd, contributed by the DOH and the LGU, in support of nine core health pro-
:ams of the DOH and the priority health program(s) of the LGU. The following
ealth programs are included in the CHCA core programs: (1) Child Health Pro-
:am, including Expanded Program of Immunization, Control of Diarrheal Dis-
ises, Control of Acute Respiratory Infections; (2) Comprehensive Nutrition Pro-
:am; (3) Women's Health and Safe Motherhood Program, including Family Plan-
ing, Maternal Care and Under 5 Program, and Breastfeeding; (4) Tuberculosis
ontrol Program; (5) Hospital Management Program; (6) Safe Water and Envi-
)nmental Sanitation Program; (7) Institution Capability Building Programs;
3) a Regional Core Program; and (9) DOH Monthly Events. The core programs
)nstitute a pre-selected combination based on a set of criteria which include the
xtent of the health problem, national development objectives, financial commit-
ıents (both foreign and local), direct service programs, and community prefer-
ıces, among others. The CHCA provides a mechanism for the DOH to implement
ıany of its programs enumerated in Annex Table 1 under the regime of devolu-
on. It also co-finances local health programs.

Brief Assessment of the CHCA

As of 1994, the DOH had concluded CHCAs with 141 provinces, cities and
ICR municipalities (DOH, 1994). The DOH experience in packaging, negotiating,
nd implementing the various CHCAs is discussed in Eleria, et al. (1995), and in
uanzon (1994). Institutional issues regarding the CHCA are discussed by Gonzalez
1995). This subsection focuses on certain features of the CHCA as a mechanism
)r transfers to LGUs.

In so far as national health objectives are concerned, the CHCA seems to be
potentially effective mechanism for enticing LGUs to undertake health pro-
rams considered national priorities. The CHCA also provides a way by which the
)OH is able to move funds under its control (about P 2.1 billion in 1993) for health
rograms at the local levels in a manner that respects incentives. In the initial
ears of devolution, the CHCA was successful in securing (through its Baseline
'ackage) the organizational capacity of the public health system to carry out its
ıandate in a decentralized regime. The CHCA served to cushion the impact of
evolution on the budgets of many LGUs while trying to avoid the adverse incen-

tive effects of transfers. It thus offers not only a strategy for implementing nationally mandated programs at the local levels, but also a funds-flow mechanism for extending national government assistance to local projects deserving of national support. Nevertheless, various institutional adjustments are called for both at the DOH and LGU levels in order to maximize the benefits from CHCAs.

From an LGU's perspective, the value of the CHCA lies in the access it provides to additional NG resources. However, because LGUs must also commit their own resources as counterpart to what the NG provides under the Incremental Health Package, the health programs covered by the CHCA must be deemed important locally for the CHCA to be acceptable.[13] This matching or balancing of nationally determined priorities with local demands is supposed to be accomplished through negotiations between the DOH and the LGUs. The premise in these negotiations is that LGU officials are adequately informed about local health priorities. The local health plans drawn up by the local health boards is the vehicle for making these priorities known.

In the 1994 CHCA negotiations, local inputs were inadequate owing to the lack of local health plans for which LGUs had no experience prior to devolution. Consequently, very little of actual negotiations transpired, and local executives agreed in the main with the proposed CHCA packages which were centrally prepared by the different DOH program offices. Discussions centered largely on the magnitude of LGU shares. For practical reasons, NG-LGU negotiations were conducted only at the provincial/city government level. However, this created problems when subprovincial LGUs were not properly informed about their financial commitments under the CHCAs. In fact, some municipalities were unaware that they had existing CHCAs. These deficiencies have been brought to the attention of the DOH. To ensure better coordination between national priorities and local preferences, a greater presence of the DOH through its representatives in the Local Health Boards is crucial as is some investment in capability building for local health planning.

To ensure that CHCAs are enforced, a system for monitoring NG and LGU commitments is critical. With an effective monitoring system for LGU contributions, LGUs cannot escape the cost associated with having a CHCA. This should create an incentive for local communities to ensure that CHCAs are consistent with local demands for health services. To the extent that the cost of entering into a CHCA is public information, this should also reduce the opportunity for local government executives to misuse the resources obtained under such facility.

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[13] This assumes the absence of significant spillover effects or cross-border use possibilities arising from a neighboring LGU's CHCA. The presence of such may lower the value of a CHCA to an LGU. The CHCA incentive structure needs to anticipate this possibility (See Capuno and Solon, 1995).

The effectiveness of the CHCA as a vehicle for implementing national health priorities at the local level also rests upon the credibility of NG commitments, i.e., on the ability of the DOH to deliver. In principle, once a CHCA has been concluded, NG to LGU flows should be self-enforcing as every LGU has an interest in receiving the share pledged by the NG. In practice, however, several factors make it difficult to determine the NG's performance with respect to its commitments under the CHCA.

The existence of other sources of financing support for LGU health projects lessens the value of the CHCA to LGUs. These other sources include congressional pork barrels as well as parallel health programs with foreign funding. These alternative fund "windows" of the NG, each with its own set of procedures, compete with the CHCA and weaken the incentive for LGUs to monitor NG/DOH contributions under the CHCA. The case of Cebu City illustrates the point: when queried about NG/DOH performance relative to their CHCA commitments, the city health officer replied that they did not bother to monitor this at all since there was a general sense that their health programs were already well-funded. In particular, the health officer mentioned the Urban Health and Nutrition Project (UHNP), a foreign-funded program, as the source of transfers from the NG/DOH. Many components of the UHNP are similar to those of the CHCA. Unless properly coordinated, other mechanisms of resource transfer to LGUs can undermine the effectiveness of the CHCA.

A related problem seems to be the readiness of the DOH itself to use the CHCA as a strategy for moving funds to LGUs to push its programs. Within the DOH, there is a need to improve coordination between the unit overseeing the CHCAs and the various DOH services and programs. The DOH has continued to implement its programs through project management offices (PMOs) which operate quite independently of each other. In part, this may be due to the pre-devolution practice of organizing DOH activities around specific programs or concerns. That this practice continues today indicates that the structures within the DOH have lagged behind in adjusting to the reality of devolution, giving way to a segmented approach to planning the CHCA. A less sympathetic interpretation is that national officials still view LGUs as no more than agents of national policy, instead of governmental units with discretionary authority.[14] As a result, programs under the CHCA were presented to the LGUs with hardly any attempt to integrate similar activities (e.g., training) across programs.[15]

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[14] An essential property of discretionary authority, argues Silverman (1992:1), is "that the oversight role of the central government is limited to ensuring that local governments operate within very broad national policy guidelines."

[15] For an elaboration, see Eleria, et al. (1995).

The "program approach" to organizing DOH efforts may also be due to the fact that DOH programs are funded from various foreign sources, and creditor/donor requirements stipulate maintenance of separate project management offices for accounting purposes. The problem is that there does not exist a central source of information for determining how much resources have flowed from the NG/DOH to the LGUs under the CHCA given the current system where resources are managed by different program offices and possibly disbursed through several windows.[16] Determining if resource commitments by the NG under the CHCA actually reached the LGUs is thus rendered difficult and organizationally cumbersome.

NG resource commitments under the CHCA were initially conceived to flow to LGUs through a proposed Health Development Fund (HDF) whose mechanism was patterned after the Municipal Development Fund (MDF). The HDF was envisioned to be the channel of "all resources in cash or kind coming from the GOP and donors which the DOH makes available to the LGU" (as quoted, Eleria, et al., 1995). The scheme provides that the DOH would "make its resource commitments to support the...(CHCA) available through the HDF" (as quoted, Eleria, et al., 1995) from which LGUs eligible to drawdown may do so in cash or kind. The proposed HDF did not materialize, however. At present, DOH resources issued to LGUs under the CHCA are coursed through the Regional Offices which in turn are expected to monitor the flows to LGUs. The problem is that there are projects, particularly foreign-funded ones, which prefer to release directly their resources to LGUs. This contributes to the difficulty of monitoring the delivery of NG commitments under the CHCA. Clearly, organizational adjustments within the DOH are necessary if the CHCA is to be an effective strategy under devolution. The idea of an HDF should be seriously considered.

Beyond issues of institutional readiness of the DOH to support the CHCA as a strategy for implementing national health programs under devolution, there is a need to consider how the CHCA can lead to a more equitable allocation of national health resources.

Table 6 shows provincial commitments under the CHCA Incremental Package for a sample of 13 provinces.[17] The data show that in most cases, the national government had financed more than 80 percent of the total cost of the incremental package. A more striking observation is that the cost shares do not vary with the

[16] For example, in determining how much funds were available for DOH programs in 1993, the information had to be gathered from the various PMOs (Schwartz, 1993).

[17] The data are from the DOH-LGAMS (Local Government Assistance Monitoring Services).

Table 6 - Provincial Government Cost Shares Under the CHCA Incremental Package

Province	LGU Class	Cost Share (in %)	Cost of Package (in '000 Pesos)
Davao del Norte	1st	9	38,994.15
Davao del Sur	1st	12	19,744.23
Palawan	1st	11	19,758.89
Negros Oriental	1st	11	23,020.89
Pangasinan	1st	15	36,487.24
Cavite	1st	13	22,740.74
Camarines Sur	1st	21	27,377.41
Quezon	1st	10	32,503.36
Bohol	1st	14	25,958.39
Ilocos Norte	2nd	19	11,307.44
La Union	2nd	13	18,066.19
Northern Samar	3rd	9	13,550.33
Nueva Vizcaya	4th	11	20,271.30

class of province in a way that one would expect to be consistent with equity objectives. For instance, Davao del Norte, a first-class province, has the same cost-share as Northern Samar, a third-class province, and an even lower cost-share than Nueva Vizcaya, a fourth-class province; Ilocos Norte, a second-class province, has a cost-share that exceeds most of the first-class provinces except Camarines Sur. While very limited in coverage, the data suggest immediately that the current design of the CHCA does not discriminate between rich and poor LGUs.

It may be argued, of course, that the cost-shares were determined by negotiations between the DOH and the provincial governments, and that the CHCA packages were approved by the Provincial Councils (Sangguniang Panlalawigan) composed of all the local chief executives (municipal mayors) and presided over by the provincial vice-governors. Relying solely on negotiations to determine the LGU cost-shares is unsatisfactory, however, in that it leaves the outcome to depend mainly on the bargaining strength of the provincial executives. On the other hand, having a more objective basis for allocating national resources among LGUs of varying financial capabilities is more in keeping with the redistributive function of the national government in a decentralized regime. It is also more consistent with the intent of devolution to make LGUs shoulder an increasingly larger share of the responsibility for basic services provision as their resources will allow.

At present, population is the only basis for determining how much resources to allocate to each LGU. No consideration is given to either the initial health conditions in the LGU or its ability to finance its share of the cost of the CHCA package. In order to make the CHCA more responsive to distributional concerns, the cost-sharing between the NG/DOH and the provincial/city governments should be made to depend upon the economic class of the province/city. Higher class LGUs should be made to bear a greater percentage of the financing cost of health programs than poorer LGUs.

Within the CHCA Incremental Health Package, a distinction exists between health programs that are considered national priorities and those considered local priorities. The former are referred to as Core Health Programs while the latter fall under Other Priority Programs. The latter category includes those DOH programs which are optional for the LGUs depending upon the availability of DOH resources and LGU counterpart resources.

Available data show that while the DOH funded a substantial portion of the Core Health Programs, LGUs have been willing to finance a greater share of the category Other Priority Programs. Table 7 shows the total cost of Other Priority Programs and the corresponding provincial commitments. In a number of cases, first-class provinces contributed more than the national government to funding such programs. Davao del Norte and Pangasinan though stand out because of their relatively small contributions. Nueva Vizcaya is also interesting since it is a fourth-class province and yet its share is greater than those of the second- and some first-class provinces included in the sample. This willingness on the part of LGUs to shoulder a greater proportion of the cost of health programs which they are not required to implement suggests that these programs must have a high value from the local standpoint. Thus, a case can be made for generally making LGUs contribute a larger share for programs which are not national priorities. What is not clear from the CHCA experience is the DOH mechanism for rationing national resources for ostensibly local priorities. Nevertheless, this shows that there is scope for refining the cost-sharing formulae under the CHCA in order to reflect the weights given to national objectives and local priorities while giving due consideration to disparities in local financing capabilities.

Table 7 - Provincial Government Cost Shares for "Other Priority" Programs Under the CHCA Incremental Package

Province	LGU Class	Cost Share (in %)	Cost of Program (in '000 Pesos)
Davao del Norte	1st	10	4,417.62
Davao del Sur	1st	43	713.59
Palawan	1st	40	658.61
Negros Oriental	1st	61	1,024.98
Pangasinan	1st	29	2,062.99
Cavite	1st	67	651.79
Camarines Sur	1st	67	2,488.49
Quezon	1st	72	566.40
Bohol	1st	44	796.13
Ilocos Norte	2nd	25	1,032.69
La Union	2nd	14	2,566.41
Northern Samar	3rd	1	733.75
Nueva Vizcaya	4th	30	1,296.31

8. Towards a Financing Mechanism for Locally Implemented Health Programs

This review of devolution in the health sector was motivated by the need to define appropriate financing policies consistent with the intergovernmental relations envisioned under the LGC of 1991. Inasmuch as devolution shifted the responsibility for health services delivery to LGUs along with greater resources, the main question that needed to be addressed was the rationale for NG support in the financing of local health projects and the mechanism(s) for doing so. But while in other sectors similarly affected by devolution (e.g., natural resources and environment) the policy question was prompted by LGUs seeking NG support for ostensibly local projects or programs, in health, the problem appears to be a tendency to "centrally own" programs. Local health programs have been generally nationally initiated.

From one point of view, this seems to solve the problem of NG financing support for local health programs because, in practice, most health programs are still considered national programs,[18] although they could be otherwise. For in-

[18] Table 8 enumerates these programs with their various sources of financing. After 1993, the number of such programs has increased.

stance, the Core Health Programs under the CHCA include a number of those which, based on expenditure assignment principles (Section 4), should not continue to be "national" programs. While this relieves LGUs of the problem of securing financing for these programs,[19] it also limits their flexibility in allocating monies available for health according to their local priorities. It should be mentioned that LGUs already feel that the IRA has not effectively increased their discretionary resources because of various stipulations regarding the IRA and the fiscal imbalances resulting from devolution. The situation also erodes LGU incentives to undertake health programs to the extent that the programs are mainly NG-sponsored and thus considered an imposition from the top. Instead, these earmarked funds can be placed in a fund (e.g., HDF) from which LGUs can draw to finance their local health priorities after satisfying certain requirements (e.g., local counterpart funding, minimum standards).

Moreover, the DOH can reduce the problem of supervision if it limits its involvement mainly to those health programs or activities where a role for the national government is clearly warranted. *A review of current DOH Programs should, therefore, be undertaken with a view to free the NG and its resources where possible and to specify the appropriate governmental level responsible for delivering the various health services.*

After determining which health programs ought to be left to LGUs to undertake and which should be the responsibility of the NG, the next set of questions pertains to the form and level of NG support for local health programs that warrant such support.

Conceivably, health projects with significant social impact may be initiated by either the NG or an LGU. It is important for the financing mechanism to allow for both possibilities. *For NG-initiated health programs to be implemented locally, the CHCA framework provides a workable mechanism.* This needs to be improved, however, in light of the assessment made in the previous section.

For LGU-initiated health projects that request NG support, grant funds will have to be provided to LGUs on a competitive basis. In order to access such grant financing, LGUs must submit proposals and pass the screening criteria of the evaluating agency (DOH). LGUs must be able to justify why the national government must provide financial assistance for their proposed health project(s). This addresses the apparent lack of a rationing mechanism that was observed with the CHCA's Other Priority Programs.

[19] Assuming, that is, that they need the program.

Whether nationally- and LGU-initiated health projects will be funded from the same channel or window depends upon the desirability of letting health projects of the latter type compete with other social projects (e.g., water and sanitation, environment, etc.). An alternative is to maintain an exclusive window for all health projects. If the former option is chosen, then a separate funding mechanism is necessary, such as the Municipal Development Fund (MDF) or some equivalent of a social investment fund which shall make grant funds from various sources available for LGU projects with social objectives on a competitive basis. If the latter option is chosen, then the idea of a Health Development Fund (HDF) as proposed in 1993 may have to be resurrected. The merit in this concept is that it offers a solution to some of the problems currently encountered with the CHCA as a result of having several parallel funding windows. All NG to LGU transfers can then be effected through the CHCA mechanism consistent with the principles of grant design.

Given the economic considerations for grant design, it is proposed that the NG-LGU cost-shares be made contingent on who the initiator ("owner") of the project is. Specifically, *the governmental level that chooses the project should finance a larger proportion of the cost.* Fiscal capacity, proxied by LGU class, should also be an important consideration. *The lower the LGU class, the lower the cost-share.* In no case should the LGU share be zero, however. Where the LGU is the project proponent, the share of the lowest class LGU should be at least 50 percent of the project cost.[20] (See Examples 1 and 2.) As much as possible, NG contribution must also not be in the form of MOOE, or should this be the case, the LGU should plan to increasingly absorb this before the conclusion of the project. This cost-sharing formula may be fine-tuned further depending upon the specifics of a particular project and as more experience is gained in managing intergovernmental fiscal relations.

Example 1: Proposed Cost-Sharing for NG-Initiated Health Project

LGU Class	NG Share	LGU Share
1st	60	40
2nd	70	30
3rd/4th	80	20
5th/6th	90	10

[20] 50-50 seems to be a reasonably good starting point as this sharing rule accords well with conventional notions of fairness.

ample 2: Proposed Cost-Sharing for LGU-Initiated Health Project

LGU Class	NG Share	LGU Share
1st	20	80
2nd	30	70
3rd/4th	40	60
5th/6th	50	50

Table 8 - Sources of Funds: DOH Programs, 1993 Appropriations (in thousand pesos)

DOH PROGRAMS	GOP	USAID	WHO	UNICEF	WORLD BANK	OTHERS*	TOTAL	% TOTAL
AIDS Prev. & Control	16,500	4,792	7,206			7,568	36,606	1.7
Blindness Prev.	24,263	7,052					31,315	1.5
Cancer Control	54,757	4,465					59,223	2.8
Cardio Vascular Disease Control	83,619	4,714					88,333	4.1
Control of Acute Respiratory Inf.	16,774	30,265	2,514	3,750	8,917		62,220	2.9
CDD & BF Promotion	23,032	10,686	1,216	3,164			38,098	1.8
Community Based Rehabilitation	3,197	2,784					5,980	0.3
Dengue Control	4,230						4,230	0.2
Dental Health	31,672	1,144	1,010				33,826	1.6
Envi'l Health Prog.**	128,028		750	4,000	102,250		235,028	11.0
Expanded Prog. for Immunization	90,327	40,024	1,231	5,596		87,414	224,592	10.5
Family Planning	7,090	253,524				135,075	395,689	18.5
Filariasis Control	3,393						3,393	0.2
Leprosy Control	16,890		1,010			20,375	38,275	1.8
Malaria Control	132,487		920		78,619		212,026	9.9

Table 8 (continued)

DOH PROGRAMS	GOP	USAID	WHO	UNICEF	WORLD BANK	OTHERS*	TOTAL	% TOTAL
Maternal Care/ Under Five	2,672	22,679	2,570	5,154		17,622	50,697	2.4
Nutrition Prog.***	89,495	8,933			20,939		119,367	5.6
Occup'l Health	5,568						5,568	0.3
Quarantine Services	26,305						26,305	1.2
Rabies Control	3,111						3,111	0.1
Schistosomiasis Control	13,247				38,316		51,563	2.4
Smoking Control	2,033						2,033	0.1
STD Control	32,993		13,516				46,509	2.2
TB Control	304,228	650	995		52,486	7,140	365,499	17.1
TOTAL	1,115,910	391,713	32,939	21,664	301,527	275,194	2,138,946	100.0
PERCENT TOTAL	52.2	18.3	1.5	1.0	14.1	12.9	100.0	

* CIDA, Rotary International, AIDAB, UNFPA, Italian Government, Sasakawa Memorial Health Foundation, American Leprosy Mission.

** Water Sanitation, Excreta and Waste Disposal, Food Sanitation, Public Places Programs

*** Malnutrition, Rehabilitation, Vitamin A Deficiency Prevention and Control, Micronutrient Supplementation Programs

Source: Schwartz (1993).

Annex Table 1 - DOH Programs

PROGRAM/ ACTIVITY	NATIONAL	PROVINCE	CITY/ MUNICIPALITY	BARANGAY
Community-based Rehab. Program			(Mun.) - Early detection of disability - Provision of rehab. services within the resources of the community - Training of community health volunteers	
Dengue Control Program	- Provision of supplies and IEC materials		- Epidemiological and Entomological Investigations of cases	
Dental Health Program	- Distribution of IEC materials - Workshops		(Mun.) - Oral examinations, preventive and curative services to children and mothers in selected health centers	- Training of Barangay Dental Aides (BDAs)

Annex Table 1 (continued)

PROGRAM/ ACTIVITY	NATIONAL	PROVINCE	CITY/ MUNICIPALITY	BARANGAY
Environmental Health Program	- IEC campaign on water, food, sanitation and red tide	- Training of health workers	- Training of health workers - Surveillance/Control of existing water supply in the community - Construction/improvement and use of sanitary toilets in households - Evaluation/Control of food establishments and promotion of household food sanitation - Public sanitation - Environmental management of disaster-affected areas - Training of health workers	
Expanded Prog. for Immunization	- Distribution of vaccine nationwide		- Immunization of childrem women of child-bearing age and pregnant women	

Annex Table 1 (continued)

PROGRAM/ ACTIVITY	NATIONAL	PROVINCE	CITY/ MUNICIPALITY	BARANGAY
Family Planning Program	- Upgrading of outlets and provision of supplies		- IEC services directed to married couples - Maintenance of Family Planning service outlets - Training of health personnel in various methods of family planning	
Filariasis Control Program		- Maintenance of Filariasis Control Service Units in regions where endemic for casefinding activities, diagnosis and treatment, health education, vector control and research - Hands-on training on Entomological Techniques for Filariasis Control for health workers - Entomological study - Health education in endemic - Information campaign		

Annex Table 1 (continued)

PROGRAM/ ACTIVITY	NATIONAL	PROVINCE	CITY/ MUNICIPALITY	BARANGAY
Leprosy Control Program	- Supplies of drugs - IEC Campaign		- Training of health workers - Consultation and treatment of patients with skin ailments in health centers	
Malaria Control Program	- Malaria vector distribution - Supply to LGUs		- Early diagnosis and prompt treatment (City) - Disease prevention and vector control (Mun.) - Training on Malario-logy and Microscopy of MHOs	
Maternal Care and Under-Five Care Program		- Workshop for health workers	- IEC Campaign (Mun.) - Distribution of Manuals for Rural Health Mid-wives and Hilot Training Manuals	

Annex Table 1 (continued)

PROGRAM/ ACTIVITY	NATIONAL	PROVINCE	CITY/ MUNICIPALITY	BARANGAY
Comprehensive Nutrition Program	- Conference/Symposia - IEC Campaign - Monitoring	- Advocacy meetings in regions and provinces - Targeted Food Assistance/Fortification of basic foods in regions/provinces where deficiency is endemic	- Vitamin A and Iodine Supplementation - Training courses for health staff	
Occupational Health Program			(Mercury Surveillance Program) - IEC on safe handling and use of mercury - Case finding and proper referral - Lab work-up - Management and Treatment of cases (Industrial Hygiene Prog.) - Training of field health personnel - IEC on rules and regulations	

Annex Table 1 (continued)

PROGRAM/ ACTIVITY	NATIONAL	PROVINCE	CITY/ MUNICIPALITY	BARANGAY
Occupational Health Program (cont.)			(Safety in Geo. Plants) - Training of field health personnel in identifying and managing cases of potential poisonings	
AIDS/STD Prevention and Control Program	- Training - IEC Campaign - Research - Monitoring and evaluation - Conference and Workshops			
Prevention of Blind-ness Program	- IEC Campaign	- Training of Pro-vincial Hospital Physicians - Public Health Nurses/Health Midwives - Service delivery	- Training of Public Health Nurses/Health Midwives (City) - Training of District Hos-pital Physicians - Service delivery (Mun.) - Training of Rural Health Physicians	

Annex Table 1 (continued)

PROGRAM/ ACTIVITY	NATIONAL	PROVINCE	CITY/ MUNICIPALITY	BARANGAY
Cancer Control Program	- Information dissemination and education - Provided drugs and supplies for early detection to hospitals and health centers	- Cancer treatment and management	- Early detection/screening activities in health centers (City) - Cancer treatment and management	
Cardiovascular Disease Prevention and Control Prog.	- IEC Campaign - Workshops/Symposia	- Training - Diagnostic and Therapeutic Services	- Training - Diagnostic and Therapeutic Services	
Control of Acute Respiratory Infection Program	- Nationwide information campaign - Supply to selected hospitals - National consultative workshop	- Training for health workers	(City) - Training for health workers	
Control of Diarrheal Diseases Program	- Nationwide media campaign on ORT - Distribution of IEC materials		- Early case finding - Rehydration and proper case management	

Annex Table 1 (continued)

PROGRAM/ ACTIVITY	NATIONAL	PROVINCE	CITY/ MUNICIPALITY	BARANGAY
Breastfeeding Promotions Program	- IEC campaign - Accreditation of baby-friendly hospitals - Workshops		- Training of health workers on lactation management - IEC Campaign	
Quarantine Program	- Monitoring health and sanitation in vessels, aircraft, ports, airports including catering and eating establishments therein - Examination of foreign nationals for immigration purposes - Examination and clearance of foodstuff for exports - Health education activities			

Annex Table 1 (continued)

PROGRAM/ ACTIVITY	NATIONAL	PROVINCE	CITY/ MUNICIPALITY	BARANGAY
Rabies Control Program	- IEC Campaign	- Trainings at regional and provincial levels	- Immunization of human animal-bite victims - Canine rabies immunization (Mun.) - Training at municipal level	
Schistosomiasis Control Program			(Mun.) - Control Program using Schistosomiasis teams in different affected municipalities - IEC materials distributed to households - Environmental sanitation and snail control - Workshop for program coordinators and health educators	- Examination by health workers and public health nurses in barangays
Smoking Control Program	- Information and health education			

Annex Table 1 (continued)

PROGRAM/ ACTIVITY	NATIONAL	PROVINCE	CITY/ MUNICIPALITY	BARANGAY
Tuberculosis Control Program		- Tuberculosis control, care and treatment - Training	- Diagnosis in health centers (City) - Tuberculosis control, care and treatment	

Source of basic information: DOH Annual Report, 1994.

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