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ORIGINAL RESEARCH

Overview of devolution of health services in the Philippines

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ABSTRACT

Introduction: In 1991 the Philippines Government introduced a major devolution of national government services, which included the first wave of health sector reform, through the introduction of the Local Government Code of 1991. The Code devolved basic services for agriculture extension, forest management, health services, barangay (township) roads and social welfare to Local Government Units. In 1992, the Philippines Government devolved the management and delivery of health services from the National Department of Health to locally elected provincial, city and municipal governments.

Aim: The aim of this review is to (i) Provide a background to the introduction of devolution to the health system in the Philippines and to (ii) describe the impact of devolution on the structure and functioning of the health system in defined locations.

Method: International literature was reviewed on the subjects of decentralization. Rapid appraisals of health management systems were conducted in both provinces. Additional data were accessed from the rural health information system and previous consultant reports.

Results: Subsequent to the introduction of devolution, quality and coverage of health services declined in some locations, particularly in rural and remote areas. It was found that in 1992-1997, system effects included a breakdown in management systems between levels of government, declining utilization particularly in the hospital sector, poor staff morale, a decline in maintenance of infrastructure and under financing of operational costs of services.

Conclusions: The aim of decentralization is to widen decision-making space of middle level managers, enhance resource allocations from central to peripheral areas and to improve the efficiency and effectiveness of health services management. The

findings of the historical review of devolution in the Philippines reveals some consistencies with the international literature, which describe some negative effects of decentralization, and provide a rationale for the Philippines in undertaking a second wave of reform in order to 'make devolution work'.

Key words: decentralization, District Health System, health sector reform, Philippines.

List of Acronyms

DHS District Health System
DOH Department of Health
HSRA Health Sector Reform Agenda
ICHSP Integrated Community Health Services Project
ILHZ Inter Local Health Zones
LGAMS Local Government Assistance and Monitoring Services
LGU Local Government Unit

Introduction

The Philippines is a country of 7100 islands. The two largest islands are Luzon in the north and Mindanao in the south. Between the two large islands is a range of small to medium sized islands known as the Visaya. The country is made up of political Local Government Units (LGUs) of provinces, cities, municipalities and barangays or townships. A local chief executive leads each LGU. Additionally, there are 18 administrative regions, which typically comprise 3 to 4 provinces. The population is approximately 78 million, of which over 52% is urbanized. There are high functional literacy rates, and life expectancy at birth is 68 years. Of the total population 37.5% is below a government-defined cut off point for living in poverty.

The Philippines has a health profile that is generally typical of a middle developing country. Although there are persistent high fertility levels, there is evidence of declining mortality. Health profiles now demonstrate rising mortality due to cardiovascular disease and cancer[1]. Tuberculosis is a persistent problem however, and remains the fifth leading cause of reported morbidity and mortality in the Philippines. Equally persistent are the problems of infant and maternal mortality, with particularly high levels in rural and remote regions. The country therefore displays the so-called 'double burden' picture of epidemiological transition (high prevalence of both communicable and non-communicable diseases and remaining high fertility).

It was against this background that the Philippines commenced a program of health sector reform in 1991. This review of devolution in the Philippines was written based on the authors' involvement in a health sector reform project jointly undertaken by the Department of Health (DOH; the Philippines), Provincial Governments of South Cotabato and Surigao Del Norte, Asia Development Bank and Australian Aid (Integrated Community Health Services Project – ICHSP; Figure 1).

Aims

The aims of this paper are to:

1. Provide a background to the introduction of devolution to the health system in the Philippines.

2. Describe the impact of devolution on the health system, services and selected health status in two selected Provinces in the Philippines (Surigao del Norte, South Cotabato; Figure 1).

Figure 1: Map of the Philippines with Integrated Community Health Services Project provinces

Methods

Sources of information and methods of data collection

International literature was reviewed on the subjects of decentralization. Rapid appraisals of health management systems were conducted in both provinces. Additional data were accessed from the field health information system and previous consultant reports. Rapid appraisal information and subsequent field reporting and consultative workshop feedback filled gaps in routine information system data.

The rapid appraisal of the health situation in the two project provinces had two major objectives. These were to provide: (i) baseline data for project monitoring and evaluation; and (ii) an analysis of the health situation for the Provincial Health Office. This was to ensure that project activities such as systems development, training, civil works, equipment and medical supply and support for non-government organizations would be based on sound health information.

The appraisal was conducted using a range of methods. These included field observation, interviews, group discussions, review of health information data and socio-economic profile and the conducting of survey questionnaires. Participants in interviews and group discussions included health managers and staff, local chief executives (municipal mayors and their staff) and community members. The questionnaires were circulated to all district hospitals and rural health units in both Provinces. The facility response rate was greater than 90%. A team of Provincial Health Managers and project advisers undertook follow up field supervision to collect the questionnaires and undertake direct observation of facilities and services.

Data were analyzed according to health management system themes of health financing, human resource development, health referral systems, and health planning and community participation. Indicators were tabulated and where possible presented in graphic format for ease of presentation to health managers and political leaders.

In addition to the rapid appraisal, public health data were analyzed through the Field Health Information System. This provided information on morbidity rates and heath service utilization data.

Results

International background

Health system reform has been a priority issue for governments and communities in the Asia-Pacific region. Most policies focus on reforms in the area of health services decentralization. Decentralization involves delegation of powers from central towards provincial or district departments of health. It can be defined in general terms as the transfer of power in planning, management and decision-making from the national level to sub-national levels of government. Various functions can be decentralized to

varying degrees, and can be categorized broadly in terms of legislation, policy making, revenue raising, regulation, planning and resource allocation, management, training and interagency coordination[2].

Devolution is one administrative category of decentralization and typically involves legal transfer of administrative powers to political units. In this situation, health providers then come under the management of non-health managers. This is essentially a public administration conceptualization of decentralization. Other analysts have categorized decentralization in terms of a widening of 'decision-making space' across such technical domains as human resource management, financing and planning[3]. The intent of decentralization and devolution is to improve the efficiency and effectiveness of health-service provision through reallocation of decision-making and resources to peripheral areas. This more local transfer of control is viewed as a way of implementing the primary health-care strategy of increased responsiveness of health systems to local needs.

This reallocation of resources and decision-making is usually implemented within the framework of the District Health System (DHS). DHS are divided into primary, secondary and tertiary sectors. Each sector level characteristically has a defined specialized role that is distinctive but complementary to the other levels. The roles are complementary in so far as cases or services that cannot be managed at a particular level are appropriately identified and referred to a higher level for management. In this sense, the referral system is 'integrated' within one comprehensive operating system. This system is rationalized according to specific criteria such as geographical accessibility of services, clearly defined catchment areas and specificity of roles at each service level[1,4].

Some negative effects of health-systems reforms in developing countries have been well documented[5]. These reported negative effects include an under-prepared middle level management, increased local political influence and control over technical management, and declines in quality of infrastructure and service delivery, particularly in rural areas. In China, responsibility for provision of health services has been devolved to provincial and county governments, and has been associated with greater inequity of access to services and less efficient use of resources[6]. In Papua New Guinea in the mid-1990s, responsibility for public health was devolved from provincial to district health offices. This health sector reform has been associated with a sharp decline in the accessibility and availability of rural health services[7].

Implementation of devolution: effects 1992-1997

Background to devolution: Local Government Code of 1991

The national Department of Health managed pre-devolution health services. Management and delivery of primary health services took a vertical program approach. Government hospitals had control of expenditure at the local level. There was little coordination with or involvement of local governments in health services. In 1991 the Philippines Government introduced a major devolution of national government services through the introduction of the Local Government Code of 1991. The Code devolved basic services, giving responsibility for agriculture extension, forest management, health services, barangay roads and social welfare to LGUs. National government staff, equipment and facilities associated with the devolved functions were all transferred to the LGUs. Administrative autonomy was also granted, which enabled the LGUs to raise local revenues, to borrow and to determine types of local expenditure - including expenditures on health care. The following sections describe the impact of devolution on middle level managers, health administration systems, the financing and utilization of health services and the health referral system.

Human resources impacts

The devolution reforms were wide sweeping and fundamental in changing relationships among health providers and their managers and funders. During 1 year,

throughout the country health staff and health infrastructure were signed over to the management of non-health locally elected politicians and their bureaucracies. Although the DOHdeveloped Im plementing Rules and Regulations to govern responsibilities of LGUs for health, and a series of health assemblies were held with political representatives to outline these responsibilities, there was no strategic plan for the introduction of devolution.

Additionally, there was no prior development of health staff (including those retained by the DOH) or local government executives and officials for their new roles in a devolved environment. While the DOH created the Local Government Assistance and Monitoring Service (LGAMS) to assist and support DOH representatives located at provincial level this was an ad hoc body with limited resources and adequately prepared staff. LGAMS also had a role in representing the DOH in legislative activities and inter-agency concerns related to devolution, including drafting of proposed amendments to the Local Government Code (LGC) in response to concerns over the model of devolution of health services. (At the time of writing, attempts by the DOH to obtain Congressional approval to amend the LGC in relation to health services had proved unsuccessful.) All concerned and affected by devolution in respect of health services were insufficiently prepared to cope with the wide sweeping changes it brought.

The Technical Assistant team of consultants who helped define ICHSP found that in the first year post-devolution there was[8]:

- Decreased hospital occupancy and health center utilization rates
- Untimely or decreased procurement of drugs, medicines and supplies by LGU officials
- Decreased maintenance and operating expenses for health facilities
- Loss of managerial and fiscal control of hospitals by hospital administration
- Resignation of key personnel
- Low staff morale

There was a perceived loss of regulatory control by the DOH. A perceived political recruitment and retention of health staff at the LGU level exacerbated this sense of lack of regulatory control. The vacuum of regulations, management systems and administrative culture that resulted from the loss of a national bureaucracy was rapidly filled by local government political power. This was to have at times a devastating effect on the morale of health professionals, who were often torn between the conflicting health and political objectives of LGUs. There was a general perception by rural health staff in many areas of the country that devolution was not working, particularly for the poor and rural and remote populations. In 1998 many rural health staff and DOHofficials began to actively lobby for a 're - nationalization' of health services.

Health administration impacts

There are six 'facility levels' in the immediate post-devolution health system managed by different political/administrative units. (According to the DHS model of WHO, facility levels 1-3 correspond to the primary level of care, facility level 4 to the secondary level of care, and facility levels 5-6 to the tertiary level of care.) These are the:

1. Barangay health unit (managed by barangay and municipal governments)
2. Rural health unit (managed by municipal government)
3. City health offices (managed by city governments)
4. Municipal or 'district' hospitals (managed by the Provincial government)
5. Provincial hospitals (managed by Provincial government)
6. Regional hospital and medical center levels (managed by the DOH)

Figure 2: District hospital occupancy rate Surigao Del Norte 1993-1998

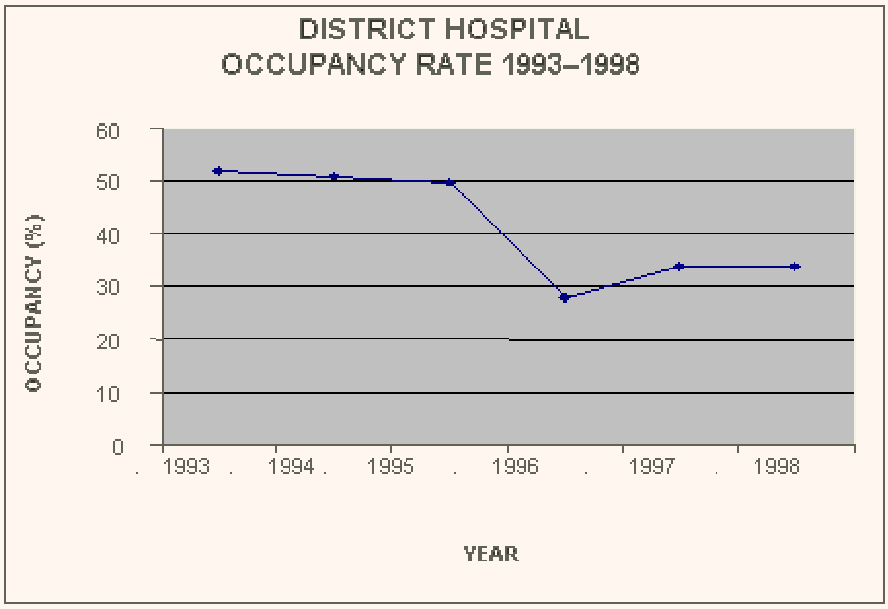

Table 1: Indicators of Provincial expenditure on health, Surigao del Norte and South Cotabato, the Philippines, 1998†

Indicator	Surigao del Norte	South Cotabato
Total provincial health budget (Peso [AUD])	9 922 788 (475 514)	42 445 491 (1 768 562)
Total provincial budget spent on health (%)	34	20
No. provincial funded government hospitals	12	4
Provincial per capita expenditure (Peso [AUD])	137 / 5.51	65 / 2.71
Provincial budget (%) spent on: • Personnel • Maintenance, operating and other expenses • Capital outlay	 82 18 0	 66 33 1

† It should be noted that expenditure data presented in Table 1 represent expenditure by provincial governments and does not include expenditure by municipal governments. Figures above therefore only indicate expenditure on provincial-level managed health services and hospital services under provincial governments, not rural health services. However, a similar picture is evident at municipal level although budgets allocated by municipal governments for health are significantly less and the ratio between personnel and operating expenses is even greater.
Data source: Philippines Department of Health; Hassall & Associates; Provincial Baselines for Surigao del Norte (2000) and South Cotabato (1999).

Local Health Boards have jurisdiction over single political/administrative levels, rather than having jurisdiction between the levels of service. There is difficulty in managing referral systems that have catchment areas that cut across these political/administrative units. Therefore province wide health-referral systems were unable to take account of the administrative reality of five political units managing two technical levels of the health system (primary and secondary levels).

The 'district' hospital sector illustrates this the most clearly. Provincial health boards administer the 'district' hospital sector, but municipal health boards administer the catchment areas of the hospitals. Operations of the referral system are therefore hindered by limits of jurisdiction, which acts to restrain cooperative health activities such as technical supervision, health referral communications, sharing health information, joint health planning and cost sharing.

Financing and utilization of health services impacts

Rapid appraisals of health services in two Mindanao ICHSP project provinces confirmed the findings of the earlier Asia Development Bank consultants. Since the advent of devolution, the under financing of public health services had resulted in their slow decay. The decay was measured in terms of under staffing, low utilization rates, un-maintained infrastructure and un-repaired or un-replaced equipment.

This was despite some national government effort to augment LGU budgets to address inadequate financial capacity of LGUs in terms of absorbing staff and operations following devolution. Provincial health expenditure statistics indicate very high expenditure on personnel, but contrastingly very low expenditures on resources to deliver services and virtually no funding for capital investment. This lack of investment in public infrastructure and operational costs is further evidenced by under utilization of services (Figure 2) and the high out-of-pocket expenses borne by those who access services (eg to buy their own drugs, medicines and supplies). Although additional funds are available through LGU Annual Investment Program budgets, the state of repair of government health facilities and equipment is evidence that this is inadequate.

An example of provincial health expenditure shows a very high proportion of budgets allocated to personnel costs, in contrast to expenditures on operating costs (Table 1); there was almost no finance budgeted for capital outlay (which includes maintenance and repairs).

Health referral system impacts

Due to understaffing (despite high expenditure on personnel), a critical lack of operating expenses and decaying infrastructure, the distinction between levels of service was being lost. In many cases, primary and secondary hospitals were sited next to rural health units, but were largely performing the same basic outpatient health center functions. Referral systems lacked clear definition. Under-financing and under-resourcing had resulted in the primary and secondary hospitals no longer having the capability of providing referral services to the health centers in the catchment areas.

Consequently, access to essential surgical and obstetric services in the primary/secondary hospitals was reduced. In the remote province of Surigao del Norte there were 12 municipal and 'district' hospitals in operation in 1998 but none could conduct emergency Caesarian section. A similar situation existed in South Cotabato for the 3 municipal and 'district' hospitals. Consequently, access to essential obstetric care was dictated less by need and more by the ability to pay for care in more distant towns and cities. Very high death rates from TB also highlighted the disintegration of systems of logistics, technical supervision, health information and drug supply between levels of service. Managers, consumers and providers expressed concern that there was an association between the introduction of devolution and declining quality and coverage of care.

That the governor (or city mayor in the case of city hospitals) managed hospitals and city or municipal mayors managed health centers also called into question the management authority and responsibility of hospital managers within the DHS model. Within an integrated DHS, systems of information, transport, logistics and patient referral are defined by regulations that link facilities from primary to secondary to tertiary level. However, political unit management of health facility levels effects system integration by altering the relationships of authority between health system levels. If a patient is referred from one level to the next, who funds the transport costs – the referring municipal authority or the Provincial Government that funds the district hospital? If a maternal death is recorded, who is the report made to – the local political authority or the district hospital? Within a national health system, the lines of authority and reporting are clear from central to peripheral level. In a devolved system, relationships of power and authority between health managers at different levels are more complex given the fact that their primary accountability is to political authority rather than a Department of Health Management system.

Responding to effects of reform 1998 by making devolution work

If the most obvious feature of early implementation of the policy of devolution in the Philippines was 'disintegration' of systems, two options remained:

1. Reintegration of systems through re-nationalization.
2. Reintegration of systems through 'making devolution work'.

Despite some high level DOH agitation for re-nationalization later in the Ramos administration, it was clear that the new 1998 administration of President Estrada was not willing to entertain the prospect of re-nationalization of health services. (In the case of a number of devolved hospitals legislators, in view of difficulties experienced in sustaining hospital operations, initiated re-nationalization. Although the DOH did not actively support these bills, due to approval by the Congress and Senate, the DOH was required to incorporate these hospitals back into its administration and budget.) 'Making devolution work' through reintegration of health systems then remained the only logical policy alternative (J Perez, unpubl. obs., 1998).

In the Philippines, these early attempts on system reform have focused on system 'rationalization' as the fundamental approach to resolve the conflicts inherent within a rapidly implemented policy of devolution. This rationalization takes the form of systems reintegration within a DHS framework, adapted for the devolved context in the Philippines.

At the Third Philippines National Health Assembly in 1998 a concept for an Inter LGU health system based on Inter Local Health Zones (ILHZ) was proposed as a mechanism to foster greater collaboration and coordination for health between LGUs. The relationship between the autonomous LGUs was to be consensual in nature with LGUs participating as equal partners. Members of the ILHZ would determine the extent of coordination between member LGUs, management structure and implementation of activities to be undertaken in partnership.

In early 1999 the League of Governors of the Philippines, with the DOH and Department of the Interior and Local Government entered into a Health Covenant to achieve a unified integrated health care delivery system based on the Inter LGU approach. Agreement was reached to formulate the requisite plans, policy reforms, and implementing strategies to achieve a meaningful partnership in devolution.

To encourage and facilitate inter-LGU cooperation and innovative strategies and approaches for basic health service delivery, President Estrada issued Presidential Executive Order 205 in January 2000 mandating establishment of ILHZ and Integrated (inter-LGU) Health Planning.

In mid-2000, the then Hon. Secretary of Health, Alberto Romualdez launched the Health Sector Reform Agenda (HSRA) to guide the DOH in its support of LGUs in their efforts to 'make devolution work'. The intention of the

HSRA is to provide mechanisms and directions for reforming the health system. The HSRA outlines reforms in three key areas:

1. Health services delivery reforms for local health systems, government hospitals and public health programs.
2. Health regulatory reform to fill gaps post-devolution and since the advent of the ILHS.
3. Health financing reforms for the National Health Insurance Program and creation of mechanisms for complementation with community health insurance schemes.

Discussion and Conclusions

A primary aim of decentralization is to increase the resource base for primary care, by shifting as many resources as possible from central to peripheral locations. The experience in the Philippines is that LGUs often lacked sufficient financial commitment or capability to fund a DHS post-introduction of devolution. This is particularly relevant to the funding of the district hospital sector.

A second aim is expand the 'decision making space' of middle and lower level managers, in order to increase the responsiveness of sub national authorities to local health needs and situations. A recent study of decentralization in four countries indicated that, based on a set of decision-making criteria, the Philippines demonstrated one of the most extensive levels of decision-making in an administrative sense[2]. In reality, however, there is evidence to suggest that decision-making often can be constrained in the devolved context by political priority setting of local authorities, which can sometimes be perceived by health managers to be in conflict with priority setting based on health needs. Additionally, the demonstrated lack of a sufficient revenue base for operational costs of the DHS limits the capacity of middle-level managers to exercise decision-making powers in support of the provision of basic health services.

A third aim of decentralization is to enhance the efficiency and effectiveness of health services management through prompt and appropriate middle level management decision-making. However, the example of the Philippines indicates that the health referral system lost cohesion post-devolution. Logistics, transport, patient referral protocol, distinctions (complementarities) between levels of service were all affected adversely by lack of clarity regarding local government co-operation and under-financing of the operational costs of the DHS. This is consistent with some other international research, which has indicated that the introduction of devolution has been associated with the complication of efforts to construct a logical hierarchy of health services, mainly due to the existence of 'grey areas' of responsibility between system levels and the lack of preparation of middle level management to take on new roles[1,5].

These issues associated with devolution were recognized at both a health management and political level in The Philippines, by the decision of the DOH and the League of Governors in 1999, when they entered into a Health Covenant to achieve a unified integrated health care delivery system based on local government co-operation. This Covenant essentially expressed a political commitment to 'making devolution work.'

The experience of this second wave of reform from 1998 will be the subject of a second paper, which will analyze the process of reform, and seek to draw more detailed lessons learned from implementation of the policy of devolution in the Philippines.

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