

## **Towards More Effective Delivery of Health Services**

*A Position Paper of the Liga ng mga Barangay (LnB) on the Devolution of Health Services and on the Rationalization of the Structure, Programs and Operations of the Department of Health*

### **A. Making devolution work**

Clearly, there have been serious problems in the devolution of health services as mandated under Republic Act 7160 or the Local Government Code of 1991. Assessments of the quality of health services since the advent of devolution conducted by independent experts have confirmed the “slow decay” in the delivery of health services in some areas of the country. (Grundy, et al. 2003)

The experience of the last few years, however, has shown that a strategic retreat from devolution is not only legally problematic --- the Constitution mandates it and a specific law requires it --- but also politically unpalatable. Successive administrations since 1991 have not really endorsed the idea, despite the few cases of re-nationalization of hospitals.

Other than the obvious difficulty (and therefore, unwillingness) of the National Government in assuming the financial burden that re-nationalization will bring about, it must also be admitted that not too many people, across many sectors, have given up on the devolution and decentralization as general strategies for good governance. Indeed, devolution has even come to be associated with democratization.

The transition from a centralized regime to one characterized by meaningful local autonomy is never easy. Indeed, the negative effects of devolution on health care systems in developing countries have been well documented. (Ibid.) Still, the innovative and effective programs some LGUs have implemented in their communities show that devolution can actually work, under certain conditions.

Executive Order 444, in complementing the rationalization of the Executive Branch under Executive Order 366, has presented us with an opportunity to examine these conditions and propose ways to fix, and not abandon, the process in the devolution of health services. The idea is to make devolution work. The situation is very pressing, to say the least. Based on the 2003 National Demographic and Health Survey, more Filipino households visit public health centers than private clinics and hospitals. Barangay health stations, which are supervised by the Rural Health Units (RHUs) and urban health centers have the most number of clients, followed by the RHUs and urban health centers themselves.

### **B. The current state of devolution in the health services sector and the general performance of LGUs in the delivery of health services.**

The Code devolved the delivery of basic services and the operation and maintenance of local health facilities such as provincial hospitals and health centers from the Department of Health (DOH) to provinces, cities and municipalities. Local government units are now responsible for the performance of functions that previously belonged to the said national agency.

These functions are as follows: (1) general control and supervision over devolved personnel and facilities, (2) the operation and maintenance of local health facilities (e.g., provincial hospitals and health centers), (3) service delivery such as promotive, preventive, curative and rehabilitative health programs and services, and (4) regulatory functions such as formulation and enforcement of ordinances related to health, nutrition, sanitation and other related concerns. In a devolved set-up, the DOH exercises oversight and regulatory functions, provides technical assistance, formulates standards and guidelines, and manages the operation of retained hospitals, regional medical centers, regional training and/or teaching hospitals, specialized health facilities and national government hospitals.

The devolution of programs and services implemented under RA 7160 were wide and sweeping, fundamentally changing relationships among health care providers, their managers and their sources of funds. During the first year of implementation, health staff and infrastructure throughout the country were transferred to the management of locally elected politicians and their bureaucracies. (Ibid., Pp 4-5)

Six “facility levels” are managed by different political/administrative units: 1.) Barangay health unit (managed by the barangay and municipal governments); 2.) rural health unit (by municipal governments); 3.) city health offices (by city governments); 4.) Municipal or “district hospitals (by provincial governments); 5.) provincial hospitals (by provincial governments); and 6.) regional hospitals and medical centers (by the Department of Health). (Ibid., p. 5) According to Grundy, et al (2003), among the problems that attended the devolution of health programs and services were the absence of a strategic plan to introduce devolution, no prior development of health staff or local executives and officials for their new roles, the loss of regulatory control by DOH and the resulting conflict between health and political objectives, fragmentation and lack of integration in services, and under financing.

The lack of preparation resulted in: “Decreased hospital occupancy and health center utilization rates; Untimely or decreased procurement of ...medicines and supplies...; Decreased maintenance and operating expenses for health facilities; Loss of managerial and fiscal control of hospitals by hospital administration; Resignation of key personnel; and Low staff morale.” (Ibid., p. 5) Despite the effort of national government to augment LGU budgets, under financing remains a serious problem. This is clearly indicated by lack of personnel, low utilization rates and poorly maintained infrastructure and equipment. Provincial health expenditure statistics, for instance, indicate very high expenditure on personnel but very low expenditures on the delivery of services and capital expenses. (Ibid., p. 7)

Although devolution and decentralization were actually expected to reduce opportunities for corruption, this has in fact continued, especially in the procurement of medicines. Indeed, this has been a major cause of disaffection and demoralization among doctors and other health care professionals in various rural health units (RHUs) and urban health centers across the country. Corruption, however, is not the only major cause of demoralization. According to the Philippine Center for Investigative Journalism (Special Report, *The Manila Times*, May 3, 2005), local government units often give low priority to health concerns. Because of inattention on the part of local governments, local health workers have been denied many of the benefits due them under the law.

Thus, the above study notes that rapid appraisals of health services in two Mindanao provinces confirmed earlier dismal findings made by Asian Development Bank consultants. With devolution, health services have slowly decayed as evidenced by under staffing, low utilization rates, poor maintenance of infrastructure and non-repair or non-replacement of equipment. (Grundy, et al., 2003, p. 7)

### **Specific issues and concerns that bear upon LGU performance**

As already noted, among the problems that attended the devolution of health programs and services were: 1.) The absence of a strategic plan to introduce devolution; 2.) no prior development of health staff or local executives and officials for their new roles; 3.) the loss of regulatory control by DOH and the resulting conflict between health and political objectives; 4.) fragmentation and lack of integration in services; and 5.) under financing. Parenthetically, nos. 2 and 3 are linked since the former is actually among the chief causes of the latter.

A focused group discussion participated in by representatives from the DOH, the different LGU leagues, and provincial and municipal health officers, identified specific issues and concerns that could either be classified under or closely related to some of these problems.

These issues and concerns are as follows:

Absence of a strategic plan to introduce devolution

- Lack of a general collaborative framework for reforms and development which incorporates the entire spectrum of roles and responsibilities of all stakeholders in the devolution process;
- Absence of an LGU management/governance system for each local government level;
- Central government has not given priority and consistent support to capability and regulates it to meet specific standards;
- Lack of clarity in scope, extent and standards in the performance or delivery of functions and services;
- Devolution was not systematically undertaken or pursued, resulting in duplication and redundancy, and thus, inefficiency;
- No operations manuals to guide or facilitate LGU structural and functional reforms or changes, along with new mandates;

No development of health staff or local officials for their new roles in a devolved environment

- Most LGUs lack the capability to generate statistics, profile, facts or data for local planning and decision-making purposes;
- Low level of citizen involvement and participation in local governance due to alienation, exclusion and poverty;
- Lack of innovation and creativity in adapting measures for resource generation, mobilization and asset management at the LGU level;
- Local special bodies, e.g. Barangay Development Council, etc., are either not operative, dysfunctional or simply lack the technical administrative capacity;
- Poorly designed training and development programs for building capabilities of local officials including new health personnel;
- Rapid turnover of health workers (doctors, nurses, and other health personnel) due to demoralization and attraction to high paying jobs abroad;
- Relationships between local chief executives and central government/line agencies were generally “one-way,” through issuances, directives, memos and instructions, and without benefit of consultation or dialogue.

Fragmentation and lack of integration in services

- There is lack of collaboration and coordination among line agencies, without anyone integrating, consolidating, and clustering mandates into a coherent and simplified system to facilitate the delivery and provision of basic services;
- The Referral System employed among health institution is at a dismal state, contributing to mismanagement of resources and detrimental to the delivery of health services particularly in times of emergencies.

Under financing

- Fiscal transfers are inadequate and inequitable wherein provincial and district hospitals perform poorly due to the financial constraints of the LGUs;
- Private and business sectors are still lukewarm or apprehensive in playing key roles as alternative funding sources;
- Devolved or delegated mandates (functions and responsibilities) were not provided with adequate budgetary resources;

**C. What is the existing capacity of LGUs in assuming more devolved functions in the area of health services?**

The situation is not as dismal as it seems, however. According to the Department of Health, in a document entitled The State of the Nation's Health (December 2001), there is, generally speaking, better health care and improved state of health among Filipinos today. Furthermore, the Department claims that the Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR), both very important indicators, have declined, although at a slow rate since 1992.

In the focused group discussion cited earlier (with participants from the DOH, the different LGU leagues, and provincial and municipal health offices), it was observed that 63% of 1<sup>st</sup> to 3<sup>rd</sup> class municipalities, and 37% of the 4<sup>th</sup> to 6<sup>th</sup> class municipalities, have already met the quality standards prescribed by DOH under the Sentrong Sigla program for health centers and stations.

Anecdotal evidence also suggests that effective leadership and stakeholder collaboration can go a long way towards improving the delivery of health services, despite the inadequacy of financial resources. The Municipality of Concepcion, a fourth class municipality in the Province of Iloilo, is a case in point. Here, good priorities and capability-building have made a critical difference.

In October of 2004, Concepcion's Mayor Baniyas could report the following achievements: 1.) Of the municipality's 13 BHS, nine have midwives and eight are Sentrong Sigla accredited; 2.) the Main Health Center is Sentrong Sigla accredited and also Phil Health accredited for the delivery of outpatient services; and 3.) social health insurance covering 3,000 indigents.

Concepcion has also established, together with other Northern Iloilo municipalities, the first inter-local health zone. It has also crafted a local nutrition plan that targets children of very low weight. These attempts at capability-building have, in turn, have led to zero maternal mortality and a dramatic drop in malnutrition prevalence rate from a high of 18.7% in 1998 to 3.6% in 2003. (LGSP Policy Forum, Iloilo City, October 21, 2004)

Still, capabilities greatly vary across LGUs, and it should be safe to say that devolution and decentralization of health care services have aggravated the discrepancies and inequities in the distribution of public goods and services. Resource, capability, structural and organizational, as well as governance and participation gaps remain which prevent LGUs in general from taking full advantage of opportunities presented by devolution and decentralization.

**D. What do LGUs recommend as regards further devolution and rationalization in the delivery of health services?**

Further devolution without addressing these gaps will only amplify existing problems. Hence, a set of specific recommendations are in order. These recommendations respond to these gaps and come under the following convenient categories: 1.) Personnel, 2.) capability and capacity, 3.) institutional, structural and organizational, 4.) financial, and 5.) governance and participation.

Personnel

- Increase the benefits and salaries of doctors, nurses and other health care professionals, and exempt them from the Salary Standardization Law;
- The national government should share in the financial burden created by the benefits and salaries under RA 7305 or the Magna Carta of Public Health Workers;
- Full implementation of Republic Act 7883 or the Barangay Health Workers Benefits and Incentives Act of 1995, and other non-monetary benefits such as continuing education;
- Develop career paths for health officials and other personnel at the local level.

### Capability and capacity

- Emphasis on merit: Health professionals and other people who know more about health programs and projects at the local level should manage health services;
- Acquire capacity to formulate coherent health plans and budgets to enable LGUs to effectively attend to the health requirements of their people.
- Fill up vacant positions for rural health practice as well as hire additional manpower and tap OJTs (on the job trainees) to address inadequacies in manpower;
- Develop a system to encourage doctors, nurses and midwives to continue their work even outside Metro Manila and other urban centers;
- Encourage or even require medical and paramedical students/fresh graduates to render rural or urban poor service;
- Incorporate and support a computer network for health information and surveillance, referrals and logistics.

### Institutional, structural and organizational

- A moratorium on the creation of local government units until such time a thorough review has been done to assess the effectiveness and efficiency of the devolution of all services so as to avoid the further depletion of scarce resources;
- Establish and strengthen inter-local health systems and their subsystems (integrated health planning, referral system, health information system, drug management, human resource development, and financial management);
- Develop a system of collaboration and referral among the different levels of government health-service providers to attend to the needs of their constituents.
- Redefine the functional relationship between regional offices and LGUs in the provision of technical assistance and the setting of standards;
- Institutionalize information/public information units up to the barangay level to improve the gathering of health intelligence/statistics ;
- Strengthen inter-agency cooperation on various aspects of health research (Health Intelligence Service, PCHRD, Department of Science and Technology);
- Develop a policy and program to consolidate all emergency medical services in the country with regard to disaster preparedness;
- Medico-Legal functions should be transferred or reassigned to NBI Medical Officers.

### Financial

- Increase the share of health to five (5) percent of both national and local budgets and increase the Internal Revenue Allotment (IRA) for health to a fixed percentage;
- Provide fiscal autonomy to hospitals to reduce their dependence on direct subsidies from government;
- Provincial hospitals should be allowed to retain their income as trust fund to enable them to sustain their operations without unduly burdening the national and provincial governments;
- Review the National Health Insurance Act to make it more responsive to the needs of the urban and rural poor.

### Governance and participation

- The impact and effects of devolution on health services should be evaluated once every three years in a Health Summit attended by all stakeholders;
- Through greater participation, ensure the continuity of relevant health programs regardless of who the local leader will be;
- Empower the local health board.

**E. Programs and services that can be devolved without undermining the core mandate of the Department of Health.**

Since health services were among the first to be devolved pursuant to RA 7160, only a few functions, programs and services can be devolved to LGUs without undermining the core mandate of the Department of Health. These proposals for further devolution of course take as their premise some or all of the specific recommendations outlined above to “make devolution work.”

Immediately (in the next 12 months)

- Programs such as malaria control, leprosy, filariasis and schistosomiasis eradication since LGUs understand better the situation in local communities;
- Regulatory functions such as the issuance of permits to drug stores, dental and medical clinics since the LGU already issues the business permits of these establishments.

Within the next 2 to 3 years

- Maintenance of a health information and surveillance system that will immediately attend to the situation at the ground level.

Within the next 4 to 6 years

- The return to local control and management of renationalized hospitals, particularly those categorized as primary and secondary hospitals (the national government, on the other hand, should retain existing national hospitals and other training hospitals with tertiary capabilities)