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Health Service Delivery: Issues, Problems, and Prospects of Devolution

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The Department of Health (DOH) is one of the four government agencies mandated to devolve its functions to local government units (LGUs) in compliance with the Local Government Code of 1991 (RA 7160). The prospect of its actual implementation has elicited mixed feelings of anxiety and optimism among the local government officials, health officers and fieldworkers. On the bright side is the issue of narrowing the gap between health officers and fieldworkers leading to a speedier decisionmaking process and program implementation. On the darker side is the issue of the LGU's financial capability of absorbing these devolved functions, thus seeding fear of further deterioration of the health delivery system.

Introduction

The signing into law of the Local Government Code of 1991 (Republic Act 7160) ushers in wide-ranging changes in the total system of governance in the Philippines. Convinced of the need to strengthen local government units, the law views decentralization and devolution of state powers as a crucial step towards realizing the following:

(1) effective allocation of powers among the different local government units;

(2) the establishment of more accountable, efficient and dynamic organizational structures and operating mechanisms responsive to community needs;

(3) a more effective sharing of the responsibility to manage and maintain ecological balance between the national and local governments;

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(4) the establishment of greater accountability of local government units to their respective constituents; and

(5) the greater participation of the private sector in local governance (DILG 1991, Sec. 3).

Local autonomy thus is seen as an extremely necessary condition for more equitable sharing of benefits of the national wealth, distribution of responsibilities of governance, and improvement in the delivery of services to the populace.

Recent moves to implement RA 7160 have raised a lot of anxieties and questions from the two groups of actors in the decentralization process: the four national agencies whose powers and functions will be devolved, and the local government units—the provincial, municipal and barangay governments—to whom these powers and functions will be transferred. The heads of the national agencies, the Department of the Interior and Local Government, as well as the provincial governors and city/municipal mayors meet to finalize the memoranda of agreement that will govern the new relationship between the national agencies and the LGUs under the devolution.

This paper deals with the issues, problems and prospects related to the devolution of health service delivery functions from the Department of Health (DOH) to the provincial and municipal governments. It focuses on the relationship between the DOH, the provincial government of Laguna, and the municipal government of Los Baños in an attempt to provide greater substance and depth to devolution issues, and to provide a clearer picture of how the devolution process is expected to affect service delivery in the local communities.

The paper is organized into four parts: a description of the health service delivery system under the DOH, a presentation of the devolution plans for the health sector, reactions to the devolution from the LGUs, and a summary of issues and conclusions. Data for this paper were obtained through semistructured interviews with key officials in the regional, provincial, district, and municipal health offices of the DOH, as well as officials of the Laguna provincial government and the Los Baños municipal government.[1]

Health Service Delivery

The Department of Health is the government agency mandated to provide health services to the 62.6 million Filipinos. Like other government agencies, the DOH is divided into different administrative units—the central office based in Metro Manila, the Regional Health Office (RHO), the Provincial Health Office (PHO), the District Health Office (DHO), and the Municipal Health Office (MHO).

Central Office

The central office of the DOH undertakes, among others, the following key functions:

(1) formulating and setting policies and standards;

(2) designing and sourcing funds for national health programs;

(3) designing and implementing foreign-assisted projects;

(4) monitoring and controlling the implementation of national programs;

(5) licensing hospitals and food establishments, and analyzing food and drugs;

(6) monitoring and regulating the practice and operations of medical professionals and hospitals in the country, respectively; and

(7) designing and implementing training programs for health workers.

In addition, the central office operates, equips, and maintains large tertiary government hospitals like the Philippine General Hospital and the San Lazaro Hospital. It also maintains a national quarantine office as well as a health intelligence service which investigates, monitors and warns the public on the outbreaks of infectious diseases such as typhoid, cholera, H-fever, and the like.

Among the special programs and projects implemented by the central office are the Field Epidemiology Training Program (FETP), the Philippine Health Development Program, and the Child Survival Program.

Regional Health Office (RHO)

The regional health office on the other hand, undertakes the following tasks:

(1) monitoring and compiling data on the implementation of national programs;

(2) monitoring and reporting the outbreak of diseases;

(3) disseminating health information and providing health education;

(4) licensing hospitals;

(5) analyzing food and drugs;

(6) implementing training programs for health workers;

(7) operating and maintaining tertiary hospitals; and

(8) implementing special projects.

The Region 4 health office services 8.51 million Filipinos in 11 provinces, 215 municipalities, 8 cities, and 5,254 barangays that make up the region, the largest and most densely populated region in the country (DOH 1991). Manning the various health offices in the region are a total of 7,802 health care personnel, about 93 percent of which are regular employees and 66 percent are directly engaged in patient care.

DOH facilities in Region 4 cover a total of 81 government hospitals, 11 of which are classified as tertiary hospitals, 40 as secondary (e.g., the Culion Sanitarium in Palawan), and 30 as primary hospitals (including municipal and medicare hospitals).[2] These hospitals have a total bed capacity of 5,745 and a ratio of 1 bed:1,482 persons. The national standard is 1 bed:500 persons.

Complementing these facilities are 275 main health centers in the rural health units and 1,536 barangay health stations. Generally, the ratio of barangay health station to persons in Region 4 of 1:5,543 is not too far from the national standard which is 1:5,000.

The DOH Region 4 facilities are manned by the following key personnel: 1,002 physicians; 1,258 nurses; 282 sanitary inspectors; 1,459 midwives; 158 dentists; 90 nutritionists/dietitians; 160 medical technologists; 74 pharmacists; 17 health educators; and 28 sanitary engineers.

Special projects implemented by the region in 1991 include the provision of potable water supply sources to control communicable diseases caused by water-borne micro-organisms in all Region 4 provinces, tuberculosis mopping-up operations, a parasite control program located specifically in the towns of Magallanes, Naic, Maragondon and Ternate in Cavite, the family health care development project, and a disaster/calamity health assistance program.

Regular programs being implemented by Region 4 and included in its 1991 Annual Report are the following:

(1) *Malaria Control Program* (MCP). Activities include entomological surveys, case finding through blood examination, treatment and application of chemical, environmental or biological control measures such as spraying, stream seeding, or stream bank clearing.

(2) *Schistosomiasis Control Program* (SCP). Activities include case finding through stool examination, treatment, and information dissemination.

(3) *Maternal and Child Health Program* (MCHP). Activities include the registration of pregnant mothers; record keeping; provision of prenatal care such as tetanus toxoid immunization, food supplementation, and micronutrient supplementation; provision of postpartum services such as food supplementation and initiation into breastfeeding; and food assistance and nutrient supplementation for undernourished children.

(4) *Nutrition Service* (NS). Activities include the weighing of children (i.e., *Operation Timbang*) and food/micronutrient supplementation (i.e., Vitamin A, iron, and iodine).

(5) *Expanded Program on Immunization* (EPI). Program is focused on the immunization of infants and mothers aimed at reducing the number of deaths caused by six immunizable diseases (i.e., tetanus, poliomyelitis, hepatitis B, measles, diptheria, tuberculosis).

(6) *Family Planning Program* (FPP). Activities include the promotion of such birth control methods as the pill, intra-uterine devices (IUD), condoms, vasectomy, bilateral tubal ligation, and natural methods (basal body temperature, cervical mucous, sympto-thermal methods).

(7) *Provision of dental health services.* Activities include giving organ examinations, giving out of oral prophylaxis, providing gum treatment to pregnant women, tooth extraction, pits and fissure sealant application, application of fillings for preschoolers, school children and pregnant women; and preventive measures such as expanded mouthrinsing of flouride solution among 7-14 year-olds and oral prophylaxis among pregnant women.

(8) *Program for the Control of Diarrheal Diseases* (CDD). Activities include monitoring of incidence of diarrheal diseases, promotion of oresol use, training of field supervisors, clinical management training, counseling, and the promotion of breastfeeding during consultative workshops.

(9) *Environmental Health Service.* Activities include the improvement of basic sanitary requirements of communities through provision of potable water supply (inspection, water sample collections, and disinfection of water sources and containers); proper waste disposal (construction of sanitary toilets and through distribution of plastic toilet bowls and concrete water-sealed bowls); sanitary maintenance of food and eating establishments (through inspection, issuance of sanitary orders, seminars and workshops on sanitation); and proper collection and disposal of garbage.

(10) *Leprosy Control Program* (LCP). Activities include casefinding, administration of multidrug therapy, monitoring of patients under treatment, and creating intersectoral linkages with NGOs and other GOs.

(11) *Sexually Transmitted Disease Control Program* (STD-CP). Activities include casefinding, treatment, preparation of contact reports, health education seminars, and AIDS (Acquired Immunity Deficiency Syndrome) prevention and control through testing for HIV (Human Immunodeficiency Virus) as well as Hepatitis B.

In the regional office, these programs are monitored by the Technical Division which is divided into five sections: Control of Communicable Diseases, Comprehensive Maternal and Child Health, Control of Noncommunicable Diseases, Occupational Health, and Hospital Services. The regular programs listed above are the concerns of the first two sections. Programs not included above are those under noncommunicable diseases, specifically on cardiovascular disease control, cancer control, mental health, trauma and accidents.

Provincial Health Office (PHO)

The provincial health office serves as the conduit of the department to the other health offices lower down the administrative hierarchy. It provides administrative and technical services to the various DOH units under it, namely, the city health office and the district health offices.

As of 1991, the Laguna Provincial Health Office operates and maintains one provincial hospital and supervises six district offices as well as a city health office in the province. Under it are the following health facilities: 37 rural health units; 237 barangay health stations; 23 family planning clinics; 11 dental units; 8 government hospitals with 455 total bed capacity (2 each for tertiary & primary,

and 4 for secondary levels); 1 malaria control unit; 1 clinic for sexually transmitted diseases; and 5 nutrihut units.

These facilities are manned by a total of 683 personnel, including contractual employees. The six district hospitals are located in Nagcarlan, Luisiana, Pakil, San Pablo, Calamba, and Sta. Cruz. The Provincial Hospital, which has a 150-bed capacity and is manned by over 300 health professionals, has the following medical departments and facilities: medicine, surgery, pediatrics, obstetrics and gynecology, EENT, orthopedics, dental medicine, manipulative machine, out-patient, malward, nursery, family planning, pharmacy, laboratory, x-ray, electrocardiogram, anesthesia, ambulance, library, chapel, and central supply.

The provincial DOH manpower complement includes the following: 150 physicians; 179 nurses; 235 midwives (including contractuals); 18 dentists; 62 sanitary inspectors; 12 medical technologists; 12 dieticians/nutritionists; 1 health educator; and 12 pharmacists.

Among the services rendered by the provincial office to the other DOH units are the disbursement of wages to the personnel, and the planning, purchase and/or procurement of equipment, medicine, vaccines, and other medical supplies. For the immunization program, for instance, the PHO procures vaccines and syringes from a local manufacturer in Alabang and distributes these to the various rural health offices it covers.

District Health Office (DHO)

The district health office which covers the municipality of Los Baños is located in Calamba. Its role in the national scheme of health service delivery is to carry out the national impact programs designed by the DOH central office, monitor their implementation for the regional office, provide hospital services, and render assistance to the general population during calamities. The Calamba district health office covers the six municipalities of Laguna province closest to Metro Manila. It supervises and monitors two rural health units in each of these six municipalities.

The hospital managed by the DHO is a secondary hospital manned by six doctors (mostly general practitioners), twelve nurses, one midwife, and eight orderlies. The hospital is organized into the administrative and dietary section, the nursing section (including an operating room, emergency room, out-patient department, and clinical area or ward), and the medical section (including the doctors, the laboratory, the pharmacy, x-ray, social work, auxiliary services, and

dental services). In the wards are billeted the different medical, pediatric, surgical, and obstetric-gynecological cases accepted in the hospital. Medical cases are classified into contagious and noncontagious diseases while the pediatric cases are classified into oral rehydration and other cases. Surgery performed in the hospital include caesarian sections, exploratory laparotomy, acute appendicitis, hernia, intestinal obstruction, orthopedic surgery and other trauma surgery.

National impact programs being monitored by the DHO in the six municipalities it covers include the following:

(1) Expanded Program on Immunization;
(2) National Tuberculosis Program;
(3) Maternal and Child Health Program;
(4) Sexually Transmitted Disease Control Program;
(5) Leprosy Control Program;
(6) Control of Diarrheal Disease Program;
(7) Control of Vascular Diseases Program;
(8) Total Food Assistance Program (Nutrition);
(9) Control of Acute Respiratory Disease Program; and
(10) Under-5 Program.

Municipal Health Office (MHO)/Rural Health Units (RHU)

The field implementing arms of the DOH are the RHUs which also serve as the municipal health offices. The municipality of Los Baños has two RHUs—RHU I which covers 10 barangays, and RHU II which covers the four other barangays.

The RHUs provide basic services related to general hygiene and sanitation, health problems, and social welfare. Three broad categories of programs are being implemented:

(1) The Impact Programs which include the under-5 program, the maternal and child health program, the EPI program, and the nutrition program, among others;

(2) Environmental and Sanitation Program which includes activities like monitoring of complaints pertaining to sanitation, testing water potability, distribution of toilet facilities, and issuing of health certificates to food establishments; and

(3) Control of Communicable/Noncommunicable Disease Program which provides treatment and care for persons afflicted with acute

respiratory infections, tuberculosis, malaria, leprosy, sexually-transmitted diseases, and cardiovascular diseases.

Health education programs, such as seminars and information dissemination on family planning, are also being implemented.

Each of the RHUs is headed by a municipal health officer who must be a medical doctor. In addition to the municipal health officer, RHU I is manned by two public health nurses, a dentist, a sanitary inspector, and five rural health midwives, each of whom is stationed in his respective barangay health center. Except for the sanitary inspector who is detailed from the Laguna provincial government and a nurse who is being paid by the Los Baños municipality, all the staff are DOH employees.

Devolution Plans

Section 17 of RA 7160 specifies the basic services and facilities to be devolved from the DOH to local government units. For barangays, included in the devolution are the health services and maintenance of the barangay health center. For municipalities, health services to be devolved include the implementation of programs and projects on primary health care, maternal and child care, and communicable and noncommunicable disease control services; access to secondary and tertiary health services; purchase of medicines, medical supplies and equipment needed to carry out the abovementioned services. For provinces, to be devolved are the operation and maintenance of hospitals and other tertiary health services.

Key RA 7160 Provisions

Other key provisions of Section 17 on the mechanics of devolution include the following (DILG 1991:10-11):

On procurement of equipment and materials

> The designs, plans specifications, testing of materials, and the procurement of equipment and materials from both foreign and local sources necessary for the provision of the foregoing services and facilities shall be undertaken by the local government unit concerned, based on national policies, standards and guidelines (item d).

On timetable for the devolution process

> National agencies or offices concerned shall devolve to local government units the responsibility for the provision of basic services and facilities enumerated in this section within six months after the effectivity of this Code (item e).

On funding sources

The basic services and facilities hereinabove enumerated shall be funded from the share of local government units in the proceeds of national taxes and other local revenues and funding support from the National Government, its instrumentalities, and government-owned or controlled corporations which are tasked by law to establish and maintain such services or facilities. Any fund or resource available for the use of local government units shall be first allocated for the provision of basic services or facilities enumerated in subsection (b) hereof before applying the same for other purposes, unless otherwise stated in this Code (item g).

On fate of regional offices

Regional offices of national agencies or offices whose functions are devolved to local government units as provided herein shall be phased out within one (1) year from the approval of this Code. Said national agencies and offices may establish such field units as may be necessary for monitoring purposes and providing technical assistance to local government units. The properties, equipment, and other assets of these regional offices shall be distributed to the local government units in the region in accordance with the rules and regulations issued by the Oversight Committee created under this Code (item h).

Devolution of personnel

Personnel of said national agencies or offices shall be absorbed by the local government units to which they belong or in whose areas they are assigned to the extent that it is administratively viable as determined by the oversight committee: Provided, That the rights accorded to such personnel pursuant to civil service law, rules and regulations shall not be impaired: Provided, further, That regional directors who are career executive service officers and other officers of similar rank in the said regional offices who cannot be absorbed by the local government unit shall be retained by the National Government, without any diminution of rank, salary, or tenure (item i).

From these provisions, it is clear that the basic aspects of the national government agencies that will be devolved to the local government units in addition to their functions are their facilities, equipments, personnel, records and other assets and properties, as well as the responsibility for the operation and maintenance of these facilities and equipments, including the procurement and purchase of equipment, supplies and other materials.

DOH Plans

For the DOH, the function of implementing national programs will be devolved directly to the municipal governments while that of operating and maintaining the district and provincial hospitals will be devolved to the provincial government. The regional office will be converted into a field office whose main function would primarily be to monitor the implementation of health programs, provide training services and technical assistance on a needs basis.

The DOH-4 Regional Director envisions that monitoring teams under the supervision of the Field Health Operating Unit or FHUO (the proposed name for the field office that was previously the regional office) will be formed in the PHO, DHO, and MHO levels. The team in the PHO will be composed of three persons: a medical supervisor III, a clerk, and a computer operator. In the DHO, it will be composed of two persons: a medical supervisor I and a nurse supervisor. And in the MHO, it will be composed of a public health nurse and a midwife.

Members of the monitoring teams will be full-time members of their respective health offices, in addition to their serving part-time monitors for the FHOU. In addition, some of them will serve as the DOH representative in the provincial and municipal health boards. The provincial health board will also have the PHO as member while the MHO will serve in the municipal health board.

Following the Section 17 provisions above, all personnel of the PHO and DHO will be absorbed by the provincial government except for contractual employees connected with special programs that are not to be devolved (e.g., malaria control program, STD control program, leprosy control program, and food and drug inspection program). Similarly, MHO personnel connected with these programs will not be devolved to the municipal government.

Memorandum of Agreement

The memorandum of agreement between the DOH and provincial government was signed by the Laguna provincial governor on the third week of September 1992. In the memorandum, the specific functions, programs, and services to be devolved to the provincial government before the end of the year are:

(1) the provision of capital outlay for the hospitals;

(2) purchase of drugs, medicines and medical supplies;

(3) provision of medical and hospital services;

(4) appointment of all personnel according to DOH qualifications and standards; and

(5) all other assets, liabilities, and records of devolved structures, programs and services.

On the other hand, the functions, programs and services to be retained by the DOH are:

(1) foreign-assisted components of national health programs and services;

(2) support programs and services, including facilities and other assets, that cover two or more provinces;

(3) nationally-funded programs, projects and services that are being pilot tested and/or are developmental in nature;

(4) health service and disease control programs that are governed by international agreements like quarantinable diseases and disease eradication programs;

(5) regulatory, licensing, and accreditation functions exercised by the DOH pursuant to existing laws; and

(6) structures and corresponding programs, personnel, assets and funds of the National Capital Region for health as it existed before the effectivity of the Local Government Code of 1991.

In addition to the above programs and services, the DOH will also have the following responsibilities in relation to the local government units:

(1) health policy formulation and development;

(2) national health planning and programming;

(3) formulation of guidelines and standards of operations for health programs and services;

(4) promulgation of national health standards, targets, priorities, and indicators;

(5) issuance of rules, regulations, licenses, and accreditation pursuant to existing laws;

(6) health program and project development;

(7) initiation of health legislation and health advocacy;

(8) monitoring and evaluation of health programs, projects, infrastructures, and services;

(9) review and regulation of health programs, infrastructures, services, and researches initiated by LGUs;

(10) provision of health information and feedback reports to LGUs;

(11) provision of referral mechanism and access to higher and/or more advanced health facilities under the DOH;

(12) extension of technical, administrative, logistics, and financial support services and assistance to LGUs in accordance to priorities and standards set by the DOH; and

(13) extension of other support services which are specific to components of some national health programs.

The provincial government will, in turn, have the following roles and responsibilities in relation to the DOH and other LGUs:

(1) operation and maintenance of all structures, functions, programs and services devolved by the DOH to the provincial government;

(2) acceptance of duly accredited representative of the DOH to the provincial health board;

(3) provision of access to health structures and records by national and international health monitoring and evaluation teams accredited by the DOH and provision of logistics and manpower assistance to such teams whenever necessary;

(4) regular submission of reports and other health-related information required by law or requested by the DOH.

(5) reproduction and distribution of IEC materials based on national prototype and/or adaptation of such materials to local conditions;

(6) initiation and conduct of local health researches, IEC development, and training subject to standards established by the DOH;

(7) initiation and conduct of local health programs, projects and services subject to standards established by the DOH;

(8) procurement and distribution of drugs and medicines based on the National Drug Formulary, and medical/dental equipment, instruments, and supplies based on standards set by the DOH;

(9) provision of access to health structures, services and personnel for purposes of interagency coordination and maintenance of the vertical and horizontal networking and referral system between the DOH and LGUs, and among LGUs;

(10) cooperation with the health manpower development program of the DOH through provision of authority/permit to local health personnel to attend national and international training, seminars, conferences, and workshops, and provision of budgetary assistance to such personnel when the same is not provided by the DOH or other sponsoring agencies, subject to availability of local funds; and

(11) extension of technical, administrative, logistics and financial, and other support services and supervisory assistance to lower level health facilities devolved to municipalities and component cities within the province.

Issues, Problems, and Prospects

The devolution of health service delivery from the DOH to the LGUs elicit the same sentiments from DOH employees and LGU officials: fear and anxiety. These sentiments reflect concern about the effect of the devolution on the quality of health service delivery. To the extent that a deterioration in quality is expected, the devolution is viewed as full of disadvantages. There are some, however, who see the advantages that can accompany devolution.

Disadvantage

The quality of health service delivery is expected to deteriorate following the devolution for several reasons:

(1) *Inadequate LGU funds to sustain service delivery.* LGU officials initially reacted strongly against devolution because of the costs involved of accepting the responsibility for delivering the services being provided by the government agencies. Acceptance of health service delivery responsibilities in particular is expected to radically increase the funds needed by both municipal and provincial governments.

In the Los Baños municipality, RHU II alone requires at least ₱2 million as budget for 1993. According to the Los Baños secretary of the *Sangguniang Barangay* (barangay council), the DOH plantilla alone costs ₱900,000 and for 1992, the total budget for the two rural health units amount to a total of ₱3 million. In comparison, the current income (i.e., 1992 levels) of the Los Baños LGU is only ₱12 million. This amount is considered insufficient even to cover existing operating costs which do not include the costs of delivery of services under the devolution.

The costs to the provincial government of accepting devolved functions are even more magnified. Under predevolution circumstances, the Laguna provincial government has a total budget of ₱170 million which it is able to cover mainly from real estate tax income and its share in the Internal Revenue Allotment (IRA) from the central government. The devolution, however, would require ₱170 million more in operating expenses, more than 100 percent of its present budget.

The LGUs feel greatly constrained about generating funds locally to cover the shortfall. The Los Baños municipality, a fourth-class municipality, with a land area of 5,650 hectares, a population of 66,700 as of 1990, and composed of 14 barangays, feels that its income-generating capacity is greatly limited. This is due to two key factors.

First, only 40 percent of the municipality's land area is under the control of the LGU and can be sources of real estate taxes. The other 60 percent are occupied by government or favored international institutions which do not pay taxes to the municipality (e.g., the University of the Philippines at Los Baños, the International Rice Research Institute, the Philippine Council for Agricultural Research and Development and military reservations). Although these institutions do not pay taxes to Los Baños, the municipality is still expected to provide services for them, such as the maintenance of roads, health and sanitation facilities, peace and order, and market facilities.

The second factor is that Los Baños had been declared a tourist area, a university town, and a forest conservation area. As such, factories cannot be constructed in the municipality to increase people's incomes and business activities.

The Laguna province feels similar income-generation constraints. As a member of the CALABARZON (Cavite, Laguna, Batangas, Quezon) industrialization project, Laguna has been designated for development of real estate properties to accommodate spillover of the Metro Manila population as well as the factory workers and industrialists who will man the industries in Cavite and Batangas. Only small- and medium-scale industries are found in the province

because of its lack of port facilities (hence, the establishment of heavier industries in Cavite and Batangas instead).

The establishment of subdivisions in Laguna, particularly in the San Pedro, Cabuyao and other areas along the South Superhighway, has greatly reduced the agricultural production of the province, particularly of rice.[3] While the influx of people has increased the demand for services and facilities, the province's income has not increased commensurately. This is because real estate taxes are still not being remitted to the provincial government. Moreover, income and residence taxes of factory workers and employees are usually being paid through the main offices of the business firms, and these are usually located in Makati.

The upshot of these constraints is the expectation that the LGUs will be unable to sustain the operation and maintenance of the facilities of the DOH. DOH employees are apprehensive that the LGUs will not have the funds to keep them on the payroll after 1993 when the latter will take over even the responsibility for generating the necessary funds to cover health service delivery. LGU officials are similarly apprehensive and doubtful of the LGU's capacity to generate the needed funds.

(2) *Politicization of appointments of health professionals.* Another apprehension, this time on the part of the DOH employees alone, is that their tenure as government employees will become less secure under the LGUs. This is because of the perceived tendency of politicians to hire and fire (or cause the hiring and firing of) employees on the basis of political expediency rather than of merit. This apprehension seems to exist in spite of reassurances that the hiring and firing of permanent government employees will continue to be subject to rules and regulations of the Civil Service Commission.

(3) *Limited career paths for health workers.* A third apprehension on the part of the health workers is that the devolution would greatly limit their opportunity for growth in their medical profession. This is because with the devolution, their geographical area of concern will become greatly circumscribed, their chances for promotion without a large national bureaucracy such as the DOH will become virtually nil, and their opportunities for exchange with health professionals from outside their geographical assignments become greatly limited.

(4) *Lower quality health service.* The ultimate result expected from the above outcomes of the devolution is a deterioration in the quality of health service that can be extended to the general population. Insufficient funds is perceived to mean possibly inadequacy in the number of health professionals that will be hired or retained, less sophisticated levels of medical services, inability to respond to medical emergencies (e.g., in the hospitals where medicines or other forms of

medical intervention are needed right away), poorer equipment and facilities, and so on. This expectation has led a congressman from Catanduanes to decry the devolution of health service delivery as "anti-poor" (Cagahastian 1992). It is expected that only the poor, who has nowhere to go, will patronize such low-quality health service while the rich will seek private hospitals.

Higher executives of the DOH and proponents of the Local Government Code of 1991 defend the devolution and attempt to respond to the apprehensions expressed above. The DOH secretary, in a statement dated 26 August 1992, assured all DOH employees that they will retain their jobs and will be protected by law despite their absorption by local government units (*Manila Bulletin* 1992). The majority that will be absorbed by the LGUs will be protected by RA 7160 while those that will not be absorbed will be retained by the DOH subject to Civil Service Commission (CSC) rules and regulations. A senator, reacting in July 1992 to the new DOH secretary's own reservations about the devolution, also pointed out that the national government will continue to formulate fundamental health policies of the nation, thereby ensuring the maintenance of health service delivery standards. Moreover, he pointed out that the devolved health services are to be performed by the same DOH personnel although this time under the DOH.

As regards the stagnation of medical health workers, the DOH Region 4 director sees the need for the DOH to strengthen its training functions to provide venues for the devolved personnel to update their skills and knowledge with the DOH. A provision in the memorandum of agreement enjoins the LGUs to allow medical personnel to attend such trainings and other seminars, conferences, symposia through which new knowledge and skills could be gained. However, a mechanism for devising some form of promotion system for medical workers within the LGUs do not yet exist. The potential problem seems yet to be appreciated by the LGUs.

Advantage

While quality of health service delivery is expected to deteriorate because of the issues and problems related with devolution, both LGU and DOH officials acknowledge one major advantage that can be gained. This advantage provides another side of the coin, as it were, to the devolution process, and promises an improvement rather than deterioration of health service delivery.

The one key advantage cited is that the lines of responsibility and accountability between field implementors of health programs and their superiors (i.e., the local chief executive) will become shorter and closer. This will mean that decisionmaking processes can become faster and clearer, in contrast to the present

setup under the DOH where decisions are often referred by the MHOs to the DHOs or the PHOs, and even to the regional health offices, before any action can be done. Because of greater proximity of fieldworkers to their superiors, health problems can potentially be responded to and acted upon more quickly.

Another advantage is that the LGU will be able to supervise health workers and make them accountable for their performance in the field. A common complaint of LGU officials is that, because health workers and other members of the national government bureaucracy are currently not under their jurisdiction, they cannot make demands on these people to perform their duties along certain standards. For instance, in Los Baños, the LGU cannot command RHU workers to respond immediately to the problem of malaria in one of its barangays. Because malaria treatment was outside their own job description, RHU workers refused to do so on the grounds that some other unit of the DOH was responsible for this. Moreover, the LGU cannot demand that RHU workers go out to the field more often or to come to their office or clinic on time because they have no authority to do so.

Summary and Conclusion

The devolution of health service delivery functions and responsibilities to the LGUs has elicited many anxieties. On the part of the DOH personnel, fears have revolved around the health workers' security of tenure. On the part of the LGUs, on the other hand, fears have revolved around the LGUs' financial capacity to sustain the health service delivery operations of the DOH. The combined fears of DOH workers and LGU officials tend to obscure the advantages that could be gained from the devolution. Thus, while the devolution process can potentially improve health service delivery, greater attention seems to be focused on the many reasons why deterioration, rather than improvement, could occur.

The central government is said to be appreciative of the financial constraints of the LGUs in fourth, fifth, and sixth class municipalities and provinces. At the recent meeting in the Philippine International Convention Center, the central government has reportedly promised over ₱4 billion to augment the shortfall of IRA funds needed to cover operating costs of devolved services in the next fiscal year. This is reported to be the key reason why, in spite of their reservations, many local chief executives signed the memoranda of agreement with the DOH and other departments. In addition to providing such subsidies, the central government can postpone the deadline for turnover of functions and provide the other means of technical and financial assistance to help less-resource-rich LGUs cope with the labor pains of devolution.

As the DOH-4 regional director points out, the way to the realization of local autonomy will not be an easy one, especially at the start of implementation of RA 7160. Both the devolved personnel, the LGUs, and even the central government will need to learn to live with one another or adopt a congenial *modus vivendi* so that they could work side by side effectively in a *modus operandi* satisfying to both. Until the effective modes of living and operation will have been acquired, central government will need to watch the devolution process closely and be ready to extend a helping hand where it is most needed. In the meantime, actors in the devolution must recognize their fears of the changes that devolution will bring as such—namely, just fears that are, right now and perhaps even later, simply "all in the mind." Recognizing this, they must then learn to face and solve each problem of local governance and health service delivery as it comes. For only through this process of problem-solving can the goals of local autonomy be finally realized.

Endnotes

[1]Interviewed were the DOH-4 Regional Director and the chief of the Technical Division, the Provincial Health Officer, the District Officer and the Chief Nurse of the Calamba District Health Office, the Municipal Health Office in Rural Health Unit I of Los Baños, the Provincial Planning and Development Officer of Laguna Province, the Secretary of the Sangguniang Bayan of Los Baños, and the Chairperson of the Committee on Health and Sanitation of the Los Baños Sangguniang Bayan.

[2]Hospital classifications are based on bed capacity, hospital organization (e.g., by departments or not), manpower complement (e.g., presence or absence of medical consultants and/or specialists), and kind of surgical procedures a hospital is capable of doing. Tertiary hospitals are the largest and more organizationally complex while primary hospitals are really more like clinics with 10-bed capacity. They tend to specialize on primary health care and refer more serious health cases to the secondary (i.e., the district hospitals) and tertiary hospitals (usually the provincial hospitals).

[3]A decline in rice production was observed starting in the 1970s and 80s (from over 6.2 million cavans in the mid 70s to around 4.2 million in the late 80s) coupled with a steady increase in demand (from about 3.3 million to about 6.0 million in the same period). Data from *Kalagayang Sosyo-ekonomiko ng Lalawigan ng Laguna*, a mimeographed profile of the province produced by Laguna circa 1991.

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