

The Devolution of Agricultural and Health Services

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Did devolution encourage participative governance—or is the politics of patronage still the determinant of local leadership?

The Local Government Code of 1991 revived our interest in a devolved model of government—a model that the author of the law, Senator Aquilino Pimentel, believes to be “the key to national development.” Prior to the enactment of this law, several attempts were made to devolve governance. Nevertheless, the Local Government Code (LGC) is still considered “the most radical” move to decentralize the powers and responsibilities of the national government. Its ratification granted unparalleled autonomy to local government units (LGUs).

The main feature of the LGC is the relinquishing of responsibilities of the national government in favor of local government units in the provision of public goods and social services. To efficiently deliver the devolved tasks, the LGUs were given increased powers to mobilize their own resources.

After ten years of working with the model of devolution underpinning the Local Government Code, it is high time to assess what has happened to the delivery of basic services. Has governance become efficient, as the model professed it would? Has public spending become more efficient and consistent with the wishes of the citizenry? Did devolution encourage participative governance—or is the politics of patronage still the determinant of local leadership? Were the LGUs more efficient and effective in providing goods and services compared with a centralized government?

This paper assesses the impact of devolution on two major sectors that were affected by the implementation of the LGC of 1991, the health and the agricultural sector.

The Local Government Code of 1991: From mandate to actuality

Health sector

The Local Government Code of 1991 clearly specified the tasks that should be devolved to the local government units. In the health sector, the box on the next page indicates the distribution of tasks between LGUs.

Barangay	Health and social welfare services which include maintenance of barangay health center and day care center (Section 17 (b) (1)(ii))
Municipality	Subject to the provisions of Title Five, Book I of this Code, health services which include the implementation of programs and projects on primary health care, maternal and child care, and communicable and non-communicable disease control services; access to secondary and tertiary health services; purchase of medicines, medical supplies, and equipment needed to carry out the services herein enumerated; (Section 17 (b) (2) (iii))
Province	Subject to the provisions of Title Five, Book I of this Code, health services which include hospitals and other tertiary health services (Section 17 (b) (3)(iv))
City	All the services and facilities of the municipality and province...(Section 17 (b) (4))

According to Pimentel (1991), access to “secondary health services” means access to doctors for the treatment of diseases and provision of medicine for indigent patients. Access to “tertiary health services,” on the other hand, means access to hospitals.

With devolution, the role of the Department of Health (DOH) changed from sole provider of health services to provider of specific health services and technical assistance for health to LGUs. The DOH is designated as the national technical authority on health. As such, it is mandated to define and formulate programs and strategies that will ensure the highest achievable standards of quality healthcare, health promotion, and health protection, on which local government units, nongovernment organizations, other private organizations, and individual members of civil society will anchor their own health programs and strategies (EO102 1999).

The DOH is also mandated to maintain national health facilities and hospitals with modern and advanced capabilities to support local services. These health facilities and special hospitals should provide technical support to all rural health centers.

Table 1

Devolved Assets and Personnel in the Health Sector			
DOH Functions	Destination of Devolved Assets and Personnel		
	Municipalities (Barangays)	Provinces	Cities
Basic Primary Health Care (Primary Health Care, EPI, Maternal and Child Health, Dental Health, Nutrition, Family planning, Communicative Disease Control, etc.)	* 2,299 Rural Health Units * 10,683 Barangay Health Stations * 210 Puericulture 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 Services		* 70 Integrated Provincial Health Offices (IPHO) * District Health Offices (DHO) * IPHO and DHO staff	* 60 City Health Officers * Assistant City Health Officers
Equipment and Supplies	Current Inventories	Current Inventories	Current Inventories

Barangay
Agricultural support services which include planting materials distribution system and operation of farm produce collection and buying stations (Section 17 (b) (1)(i))
Municipality
Extension and on-site research services and facilities related to agriculture and fishery activities which include dispersal of livestock and poultry, fingerlings, and other seedling materials for aquaculture; palay, corn, and vegetable seed farms; medicinal plant gardens; fruit tree, coconut, and other kinds of seedling nurseries; demonstration farms; quality control of copra and improvement and development of local distribution channels, preferably through cooperatives; inter-barangay irrigation systems; water and soil resource utilization and conservation projects; and enforcement of fishery laws in municipal waters including the conservation of mangroves (Section 17 (b) (2)(i))
Province
Agricultural extension and on-site research services and facilities which include the prevention and control of plant and animal pests and diseases; dairy farms, livestock markets, animal breeding stations, and artificial insemination centers; and assistance in the organization of farmers' and fishermen's cooperatives and other collective organizations, as well as the transfer of appropriate technology (Section 17 (b) (3)(i))
City
All the services and facilities of the municipality and province...(Section 17 (b) (4))

Table 1 presents the assets and personnel that were actually devolved to the LGUs, aside from the devolved tasks.

Agricultural sector

Agricultural support, extension, and on-site research services and facilities have also been devolved to the barangays, municipalities, and provinces. The LGC includes both the administrative and technical supervision of the local governments over the field implementers, also known as agricultural extension workers.

The distribution of tasks is as follows:

- ❖ The Administrative Code of 1987 amended the mandate of the Department of Agriculture (DA). Under Chapter 4, Title IV, Book IV, of the Administrative Code, certain functions of DA bureaus are now powers that LGUs may well exercise under the Code (Pimentel 1991). These powers include: (1) development of livestock, poultry and dairy industries [Sec. 18(1)], a function of the Bureau of Animal Industry; (2) control and prevention of pests and diseases that affect farm crops [Sec. 19(3)], a function of the Bureau of Plant Industry; (3) management, accelerated development, and proper utilization of fishery and aquatic resources [Sec. 20(1)]; (4) formulation of measures for effective soil, land and water resource utilization [Sec. 21(2)], a function of the Bureau of Soils and Water Management; and (5) establishment of agricultural cooperatives in the rural communities [Sec.23(2)], a function of the Bureau of Agricultural Cooperatives and Development.
- ❖ In June 1992, upon the full implementation of the LGC of 1991, extension service personnel, on-site research activities, budget, facilities, and other

assets—previously under the DA—were transferred to LGUs. A total of 17,673 personnel of the department were technically and administratively placed under the supervision of the local chief executives (Manasan n.d.).

- ❖ The task to coordinate and supervise the extension plans and programs in each locality became the responsibility of the Provincial Agriculturist or the City/Municipal Agriculturists in cities and municipalities.

Financing devolution

With the bulk of expenditures in health and agriculture transferred to LGUs, the problem now lies in the generation of financial resources to support these obligations. In this devolved setup, local units are assigned revenue-raising powers to source the financing of their responsibilities and obligations. The LGC expanded the assigned specific tax bases for LGUs. In principle, LGUs have the option of increasing their spending by raising their own tax revenue.

Most of the taxes collected by LGUs come from the real property tax (RPT) and the local business tax (LBT). There are also other fees that LGUs are authorized to collect. (Fees are charges fixed by ordinance for the regulation or inspection of a business or an activity located in a local government unit. For example, fees may be charged for the use of facilities or the issuance of business permits.) National legislation defines the tax base of each of these taxes and the limits on the tax rates.

Aside from the tax bases, intergovernmental transfers are designed to augment the budget of the local unit or to ensure a budget for the minimum deliverables of the LGUs. The intergovernmental transfer, referred to as the Internal Revenue Allotment (IRA), is an unconditional grant of the national government to localities bestowed to equalize fiscal capacities of different LGUs to ensure the provision of a minimum—or reasonable—level of public services. (The appropriation of the Internal Revenue Allotment is according to Title 3, Chapter 1, Section 285 of the Local Government Code of 1991.)

Former Budget Secretary Benjamin Diokno (1995) contends that LGUs should enjoy a positive fiscal gap, on average, once tax revenues are augmented by their IRAs.

In addition, LGUs are entitled to a share in the utilization of their natural resources. With all these financing options, LGUs are expected to be able to operate effectively and to efficiently provide the basic services devolved to them. LGUs are to act as economic managers, using their resources and capacity to provide social services for their people. They are expected to be self-reliant, sustainable, and financially independent from the national government.

Issues in the process of devolution

Underspending in the health sector

The health sector accounts for almost half of the devolved functions to LGUs. Table 2 presents the health expenditures of the country by sources of funds. National healthcare spending continued to increase in nominal terms for the past years. But there was a decline in the percentage share of total government spending on health.

The share of the local government in healthcare spending continued to increase in nominal terms after the devolution, particularly starting in 1993. The local government expenditures increased in nominal terms from 7.0 percent of total government expenditures in the 1985-1991 period, to 14.7 percent in the 1992-1997 period (Loehr and Manasan 1999).

The LGUs' health expenditure has fallen short of the cost of devolved health functions (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

Table 2

Health Expenditure by Source of Funds, 1991 - 1997							
(in billion pesos)							
Sources of funds	1991	1992	1993	1994	1995	1996	1997
GOVERNMENT	13.61	14.24	15.98	19.14	22.19	27.73	34.12
National	12.23	12.51	10.05	10.41	11.76	15.26	18.64
Local	1.38	1.73	5.93	8.73	10.43	12.48	15.48
SOCIAL INSURANCE	3.39	3.97	4.64	5.57	6.10	6.59	6.37
MEDICARE	3.00	3.62	4.23	5.13	5.70	6.23	6.09
EC ¹	0.39	0.35	0.40	0.42	0.39	0.33	0.26
HIP ²	0.01	0.01	0.01	0.01	0.01	0.03	0.02
PRIVATE SOURCES	20.32	23.52	26.60	30.66	38.32	43.43	47.93
Out-of-Pocket	17.10	19.63	22.62	25.92	32.88	37.12	40.96
Private Insurance	1.25	1.53	1.42	1.46	1.47	1.63	1.99
HMO ³	0.46	0.54	0.70	0.92	1.30	1.73	2.04
Employer-based Plans	1.22	1.44	1.44	1.84	2.04	2.26	2.18
Private Schools	0.30	0.38	0.43	0.53	0.64	0.69	0.77
ALL SOURCES	37.32	41.73	47.23	55.37	66.62	77.75	88.42

Health Expenditure by Source of Funds, 1991 - 1997							
% Share							
Sources of funds	1991	1992	1993	1994	1995	1996	1997
GOVERNMENT	36.46	34.12	33.85	34.56	33.31	35.67	38.59
National	32.76	29.97	21.28	18.80	17.65	19.62	21.08
Local	3.70	4.14	12.57	15.76	15.66	16.05	17.51
SOCIAL INSURANCE	9.09	9.52	9.82	10.06	9.16	8.47	7.20
MEDICARE	8.03	8.67	8.95	9.27	8.56	8.02	6.89
EC ¹	1.05	0.83	0.85	0.76	0.58	0.42	0.29
HIP ²	0.01	0.02	0.02	0.02	0.02	0.04	0.02
PRIVATE SOURCES	54.45	56.36	56.33	55.38	57.53	55.86	54.21
Out-of-Pocket	45.82	47.04	47.89	46.81	49.36	47.74	46.32
Private Insurance	3.34	3.68	3.01	2.63	2.20	2.10	2.25
HMO ³	1.23	1.29	1.47	1.65	1.96	2.22	2.31
Employer-based Plans	3.28	3.45	3.04	3.33	3.06	2.90	2.46
Private Schools	0.79	0.91	0.92	0.96	0.95	0.89	0.87
ALL SOURCES	100	100	100	100	100	100	100

Legend: 1 - Employees' Compensation 2 - Health Insurance Plan of GSIS 3 - Health Maintenance Organization 4 - no available data

Sources: Inercon (1991-1994); NSCR (1995-1997)

Table 3

Total Cost Of Devolved Functions Averaged By Type And Class Of LGU, 1993 (In Million Pesos)			
LGU	Cost of Devolved Health Functions	Total Cost of Devolved Function (CODEF)	Share of CDHF to Total CODEF
	Total	1993	1993
OVERALL AVE.	8.14	10.83	56.18
PROVINCE	33.90	41.64	81.49
Class 1	38.45	47.68	80.64
Class 2	23.70	29.83	79.18
Class 3	35.30	42.96	82.17
Class 4	32.96	39.31	83.85
Class 5	28.87	33.89	85.19
CITIES	3.18	6.11	52.05
MUNICIPALITIES	1.18	2.30	49.21
Class 1	2.22	3.36	66.07
Class 2	2.07	5.53	58.64
Class 3	1.50	2.78	53.96
Class 4	1.01	2.13	47.42
Class 5	0.57	1.39	41.01

level, then a case for underspending in health under the devolved setup can be made. Due to devolution, the share of local governments in health expenditures has increased, but the LGUs are spending less than what the national government used to spend for local health services before devolution.

It could also be true that LGUs have been able to find efficient ways of providing social services, in which case, getting rid of excess capacity might account for the reduction of spending in health. However, the reduction of spending in health was actually accompanied by a marked decline in the quality of health services—proving that there was indeed underspending in the health sector.

Vague roles

In the area of irrigation in agriculture, the devolution of locally funded communal irrigation projects also created problems. It was found, after their transfer in 1992, that a number of them could not be completed. Even after the transfer of functions took place, some local governments and farmer groups continued to ask for central financial assistance. This highlighted the fact that the respective roles of the central irrigation agency and the LGUs had neither been clearly defined nor adequately explained to farm communities (Siamwalla 2001).

Unfunded devolution

Ironically, after devolution, the national agencies continued to receive increasing budget allocations (Brilliantes 1999). These budgets do not even reflect devolution as a priority. If they did, regional offices should have received more of the budget funds, since they serve as the coordinating arms of the national

agencies to the LGUs in the implementation of their tasks. This is true not only in agriculture but also in health. The central office of the DOH accounts for almost 37 percent of the budget for administration and support. The regional offices share the rest (Magno 2001). However, the case of the agricultural sector is worse—with only 6 percent of the total Department of Agriculture (DA) budget in 1997 allocated to regional offices (Siamwalla 2001).

In the health sector, the function of the regional health offices is limited to managing the regional hospitals and assisting the national agency in the implementation of public health programs. In agriculture, regional offices are tasked to implement and enforce laws and policies, plans, programs, and rules and regulations issued by the DA and to coordinate with LGUs.

As the coordinating arm of the national agencies, the regional agencies are expected to provide technical assistance to LGUs. However, due to inadequate funding and utilization of funds, they are not able to provide the LGUs with enough technical support to allow these LGUs to deliver effectively on devolved services.

Mixed feedback on quality

The Department of Health has achieved a certain degree of devolution with respect to functions. However, the quality of healthcare delivery after devolving the major tasks to LGUs should also be examined. For one, there is poor availability of drugs in comparison with the period prior to devolution. Nevertheless, it was noted that the quality of other health services improved (Perez, Alfiler, and Victorian 1995).

Feedback on the quality of healthcare after devolution is mixed.

- ❖ Experts expressed concern over the deterioration of technical quality, while most of the people expressed more positive views (Azfar, Kähkönen, and Meagher 2001).
- ❖ In the area of technical performance, there was no significant change in the volume of in-patients treated or outpatient consultations.
- ❖ Quality of care deteriorated in terms of supplies, equipment, and infrastructure because of decreased funds for maintenance and other operating expenses (MOOE) and almost nonexistent funds for capital outlay (USAID n.d.).

In the management of devolved hospitals and availability of facilities, the following were observed:

- ❖ Devolved hospitals have deteriorated, since it cost more in 1998 to deliver the same volume of services delivered in 1992 (USAID n.d.).
- ❖ Philippine government hospitals, especially those at the provincial and district levels, have become poorly equipped and undermanned (Proposal 2000).
- ❖ Regional and national hospitals, owing to the unmet health demands at the local level, are congested (Proposal 2000).
- ❖ Networking and patient referral systems between national and local, and between public and private, hospitals are inadequate (Proposal 2000).
- ❖ Government hospitals still rely heavily on direct subsidies from national and local governments (Proposal 2000).
- ❖ On top of all this, there is inadequate and uncoordinated implementation of public health programs in hospitals (Proposal 2000).
- ❖ Only one-third of the total number of hospitals and about one-half of hospital beds are public (CHD 1998).
- ❖ Out of the country's 41,000 barangays, only one-fourth have barangay health stations. These government health facilities have gained notoriety as sorely lacking in equipment, medicines, and staff (CHD 1998).

While feedback may be mixed, a number of researches support the observation that there has been a general deterioration of health services after devolution.

On the other hand, the following are the observations in the agricultural sector:

- ❖ Due to lack of funds and varying needs, the devolution of agricultural extension and of on-site research services to the LGUs has resulted in the adoption of varying thrusts and standards for agricultural productivity. This has resulted in the inconsistent and fragmented implementation of agricultural policies and programs, and has consequently caused confusion among agricultural extension workers (Manero 1998).
- ❖ Many LGUs do not have sufficient funds to implement agricultural development programs. The devolution of agricultural extension services to the LGUs has been identified as one of the causes of low agricultural productivity hindering the attainment of agricultural development and food security (Manero 1998).

Demoralization among rank and file

Devolution resulted in the significant deterioration of employment conditions of devolved personnel, causing demoralization. In the health sector, salaries of devolved workers decreased relative to central government employees (by one-fifth to one-third on average), and civil-servant vertical career mobility was interrupted by the fragmentation of the public health system (Miller 1998). Strong objections from healthcare workers brought about the passing of the

Ironically, after devolution, the national agencies continued to receive increasing budget allocations that do not reflect devolution as a priority.

Magna Carta of Health Workers, which, however, resulted in further disarray.

Some LGU officials became demoralized because some health workers received higher salaries than the LGU executives. These gave the local executives a reason to pressure the national government to fund the implementation of the Magna Carta of Health Workers and provide for the compensation of these health personnel.

Under the Local Government Code, LGUs were supposed to retain all health personnel and adhere to the pay scale of the civil service. But apart from these, the requirements in the Magna Carta of Health Workers had also to be met. Apparently, the budgets available to most of LGUs could not match all the requirements concerning human resources. The national government ended up providing assistance to both the LGUs and the Department of Health.

In the case of agricultural personnel, devolution likewise caused much displacement. Many regular personnel lost their items, became misplaced in their assignments, or were deployed in remote areas, forcing untimely resignations. Some regular personnel suffered demotion in rank, even in salary, while others remained stagnant in their positions with no hope for promotion.

At the municipal level, for example, the only position you can aspire to is that of Municipal Agriculturist or Municipal Agricultural Officer, but it takes a long time for this position to be vacated, unlike at the national level, where upward vertical mobility is possible in many positions.

Some devolved personnel were not assigned to the Office of the Municipal (or Provincial) Agriculturist, where they had been officially devolved. Instead, they were given other assignments not related to their positions and job descriptions as Agricultural Technologists (ATs). In some municipalities, some ATs were assigned as market collectors or as cash clerks detailed with the Nutrition Office, the Department of Health, the Department of Social Welfare and Development (DSWD), the Office of the Municipal Assessor, the Office of the Municipal Treasurer, and other departments and units under the supervision and administration of the local chief executive. In some instances, Municipal Agricultural Officers were given assignments as traffic officers, environmental officers, market administrators, and other nonrelated positions, much to their dissatisfaction. Some devolved personnel even suffered harassment and indignities if they happened to be not on good terms with their local chief executives.

The affected or devolved personnel have little or no chance of availing themselves of any training or scholarships, both local

and foreign, because national employees are prioritized. If ever there is a chance for such training or scholarships, the LGU usually will not have the counterpart funds required. This is unfortunate, as training and scholarships in agriculture and other related fields play a crucial role in the transfer of modern technologies (PAMAOMCA n.d.).

Re-nationalization of some hospitals

Despite the extensive devolution that took place in the health sector, there is a noticeable trend of re-nationalizing some hospitals. The DOH continues to “retain 48 hospitals, 35 of which are classified as *tertiary*: hospitals that are fully departmentalized and equipped to treat most ailments” (Philippine Institute for Development Studies 1998). The number might have risen to 54 because the DOH regularly “brings back to the fold” other hospitals that have been re-nationalized by Congress. The re-nationalization of these hospitals resulted in the DOH putting 52 percent of its budget into the maintenance of these hospitals. This explains the continuous increase in the budget of the DOH, despite the devolution of almost 70 percent of its personnel.

As a consequence of the national subsidy for these hospitals (which are usually in the urban centers), a spatial bias has formed against rural and municipal health centers—the very ones which should have received bigger budgets, since these are where the more numerous but economically deprived members of society access health services.

Lack of coordination

Another problem that devolution has aggravated is the lack of coordination between LGUs. In the health sector, this lack of coordination results in free riding and negative externalities. The health of an individual affects the health of other individuals. Therefore, the quality of health of individuals in a municipality influences the health of adjacent municipalities. The healthcare services that a municipality provides have positive externality on the health status of individuals in the other municipalities. In this case, health becomes a public good. This results in under-provision of healthcare and free riding of some municipalities. Aside from that, there is also free riding on the cross-border use of devolved facilities. Thus, underspending in the LGUs can be traced not only to lack of budget but also to free riding and negative externalities. Capuno and Solon (1995) explore these issues in a study of how these factors explain the underspending in the local government health services.

In the case of the agricultural sector, the Philippine Association of Municipal Agricultural Officers/Municipal and

City Agriculturists (PAMAOMCA) points out that the devolved personnel, especially in areas where the priorities of LGUs are not in agriculture or where political differences exist, can hardly implement special projects spearheaded by the national agency. Even if a special project is undertaken, political patronage is the rule, which eventually means more costs for the project. A concrete example is the implementation of the proposed safety nets of General Agreement on Tariffs and Trade (GATT) in the agricultural sector. The Regional Office of the DA has no authority to appoint devolved field personnel to undertake the project, unless sanctioned by the LGU, jeopardizing implementation of the national program. PAMAOMCA further suggests that, since the power and authority of the Department of Agriculture now stops at the regional level, it cannot demand prompt submission of much-needed reports, data, and information on agriculture from the provinces and municipalities. Coordination attempts made by the DA regional field office are more on a personal basis rather than institutional, and thus do not help in effectively monitoring performances.

Furthermore, while devolution transferred the task of implementing agricultural extension services to the LGUs, local officials are not involved in the agricultural planning and policy formulation process, which has been retained at the central level, often resulting in badly coordinated programs (Siamwalla 2001).

Thus, the delineation of responsibilities and functional relationships between national government agencies, including the DA, LGUs, and other stakeholders, remain unclear, and the linkages among research, training, and extension remain weak (Manero 1997).

Neglecting agriculture

Compared with the rest of the member-countries of the Association of Southeast Asian Nations (ASEAN), the Philippines lags behind in terms of agricultural growth and productivity.

The Philippines posted the lowest agricultural performance at 1.0 percent from 1980 to 1990, with Indonesia at 3.4 percent, Malaysia at 3.8 percent, Thailand at 4.0 percent and Vietnam at 4.3 percent. Although Philippine performance improved slightly from 1990 to 1998, when the country registered an agricultural growth rate of 1.9 percent during the Asian currency crisis, the Food and Agricultural Organization (FAO) Index rated the Philippines as the lowest overall in agricultural per capita output performance in Southeast Asia (Barcelona 2000).

The Department of Agriculture attributed this low agricultural productivity to several factors, namely:

- ❖ Very limited access of farmers to land, production inputs, credit, and other resources needed for increasing productivity and farm incomes.
- ❖ Slow and inefficient delivery of government support to the agriculture sector, and very limited impact of such support.
- ❖ Previous government development policies that have undermined the country's comparative advantage in agriculture and have created a biased incentive structure, which favors the urban and industrial sectors at the expense of the agriculture sector (World Food Summit 1996).

It cannot be concluded that devolution of the agricultural sector is responsible for the lag in our agricultural productivity. However, with LGUs neglecting to improve the technical capacity of extension workers, whose major task is to provide assistance and guidance in increasing farm productivity, it can certainly be said that devolution is also a contributing factor to the stagnant condition of agriculture.

The lack of available data among LGUs regarding agriculture is in itself already an indicator of neglect.

The delineation of responsibilities and functional relationships between national agencies, LGUs and other stakeholders remains unclear.

What went wrong?

Dependency on the IRA

The failure of local government to maintain the devolved hospitals, the decline in the quality of healthcare services, the lack of plans for the implementation of programs for the development of agriculture, the inability of LGUs to sustain their technical personnel, and the inability to shoulder the required costs can all be attributed to lack of funds by the LGUs, despite the fact that the power of the LGUs to source its own funds was expanded by the Local Government Code of 1991.

As has been clearly presented, the Internal Revenue Allotment (IRA) of the LGUs is not enough to cover the whole cost of devolution. Nevertheless, the purpose of the IRA is not to fully cover the total cost of devolution, but to simply augment the budget of the local government. Although some LGUs have been able to source international assistance and to design more efficient programs of delivering services, the majority of the LGUs are very dependent on the IRA and lack the initiative to source and mobilize their own funds, the funds that are needed to address their responsibilities.

Recent data provided by the National Statistics Coordination Board (NSCB) show heavy reliance of LGUs on the IRA. In 1999, local governments depended on the IRA for more than two-thirds of their income. In the same year, 70 of the 78 provinces depended on the IRA for up to 50 percent of their income (Gatmaytan 2001).

It is recommended that the IRA be reformulated to factor in a mechanism that will encourage the local governments to source their

own funds. The dependency on the IRA is not compatible with one pillar of devolution—fiscal autonomy.

Lack of technical resources

LGUs lack the technical capacity to efficiently deliver the devolved tasks. Because of insufficient financial resources, the LGUs cannot maintain the technical personnel devolved to them. Furthermore, due to devolution, local government officials are expected not only to administer their localities but also to act as economic managers. Their lack of appreciation of devolved tasks resulted in the underutilization of technical personnel, particularly in agriculture.

Plain politics

The re-nationalization of some hospitals is a result of the lack of budget of some of the LGUs to efficiently manage these medical centers. However, not all cases of re-nationalization are due to fiscal incapacity. Some cases are just the result of politics, especially when the congressional representative of the district and the elected officials of the LGU have different political affiliations.

Congressional representatives have been filing bills to re-nationalize some hospitals so that the local government will lose control of the health services provided by these hospitals. In the words of Dr. Juan Antonio Perez III, former director of the Local Government Assistance and Monitoring Service of the Department of Health: “Re-nationalization of devolved hospitals was resorted to by legislators who were at odds with local authorities in their home districts” (Perez 2000).

The provision of social services depends not on what is needed but on what activities will get greater mileage for the political career of government officials. Most appointments for position in the local government are based not on merit and credibility, but on the personal relationship of individuals to local leaders. As a result, individuals without enough competence and skills are made to manage the delivery of social services and agricultural extension services.

Congressional initiatives to address the problems of devolution

A number of initiatives seek to address the problem in healthcare delivery. There are bills that aim to provide incentives and additional benefits to barangay health workers and rural health doctors. There are bills that address the modernization of the healthcare delivery system. There are also bills that suggest the formulation of a National Health Code, and a comprehensive national health facilities program. A particular bill tries to address the lack of operational budget of hospitals by authorizing government hospitals to utilize all their income for their maintenance and operating expenses.

However, a number of bills still attempt to re-nationalize hospitals that were devolved to the LGUs. There are two possible reasons for this. One is that LGUs lack the capability to maintain the hospitals. The second is politics.

In agriculture, most of the congressional initiatives pertain to the establishment of research institutes and breeding stations, and the construction of irrigation facilities. There are minimal initiatives in policy reformulation in the agricultural sector.

One of the most important provisions in the Local Government Code of 1991 that need to be amended is the formula for IRA. Several proposals try to utilize other variables to allocate the IRA, such as poverty incidence and the initiatives of local government to collect local taxes. These formulas attempt to address the problem of the LGUs' dependency on the IRA and to factor in the LGUs' fiscal capacity and needs.

Some bills have the tendency to duplicate and supercede the tasks that were already devolved to the LGUs. These bills should be reviewed very carefully to continuously push for genuine local autonomy.

Conclusion

We cannot discount the fact that there are successful cases where the delivery of social services in health and in agriculture really improved. However, in many cases, the obligation of LGUs to their constituencies has become a tool for politics. In this instance, the effectivity and efficiency of decentralized governance is compromised. Proponents of devolution believe that decentralizing the provision of basic services will help people freely identify the kind and amount of services they want to receive.

Genuine relinquishing of national government powers to LGUs involves the provision of enough funds. When authority is given to accomplish something, the means and the resources needed to do so must also be provided.

The problems with the IRA formula have to be addressed because these are an important factor in determining fiscal autonomy, which is a major pillar of devolution.

It is too early to say that our experience in devolution is a failure. We are still in the period of transition and adjustment for the LGUs, the national government, and the constituencies. And with our (as yet) minimal experience in devolution, it will be too premature to prescribe re-nationalization as the solution to improving the current state of social services delivery.

When authority is given to accomplish something, the means and resources needed to do so must also go hand in hand.

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