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Consolidating Primary Health Care Financing in a Devolved Setting: Case Study from the Philippines

LEIZEL LAGRADA-ROMBAUA, JOYCE ENCLUNA AND EMMANUEL GLORIA

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Consolidating Primary Health Care Financing in a Devolved Setting: Case Study from the Philippines

Leizel Lagrada-Rombaua, Joyce Encluna, Emmanuel Gloria
GECC Developmental Services OPC, Pasig City, Metro Manila, Philippines

Lancet Global Health Commission on Financing Primary Health Care

The Lancet Global Health Commission Financing Primary Health Care (2020 – 2022) is committed to drawing on robust, evidence-based knowledge to generate useful findings and actionable recommendations to inform decisions made by governments and partners that shape the effective financing of primary health care. Our work is focused on enhancing, protecting and enabling the appropriate resourcing of primary health care as a critical engine for the achievement of universal health coverage.

Country case studies

The Commission organised 10 case studies. Each country lead consultant and team undertook a scoping review to identify 'hot topics' in the financing of PHC in the respective countries. The teams then chose a 'deep dive' topic on which to undertake primary research. The 10 case studies were undertaken in: Brazil, Chile, China, Estonia, Ethiopia, Finland, Ghana, India, New Zealand and the Philippines.

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Table of contents

Acronyms 5

Executive summary 7

1. Introduction 8

2. Background and literature review 10

2.1 Raising resources in municipalities 10

2.2 Inadequate funds at the local levels 11

2.3 Efforts to increase funds for health 13

2.4 Efforts to consolidate resources for PHC 15

3. Methods 18

4. Findings 20

4.1 Study Participants 20

4.2 Characteristics of Case Study Municipalities 20

4.3 Funding sources for PHC 23

4.4 Local planning as a mechanism to consolidate various resources 34

4.5 Forthcoming Changes in Financing PHC 38

5. Discussion 44

6. Conclusion 48

References 49

Annexes 52

LIST OF TABLES

Table 1: Sources of Municipal Funds (in million pesos and percent of total revenues)..... 10
Table 2: Uses of municipal funds (in percent of total)..... 11
Table 3: Current health expenditures, estimated primary health care spending of local governments, and share of health spending on IRA from 2014 to 2019, in million USD..... 13
Table 4: Financing and health service delivery Characteristics of Case Study Municipalities ..22
Table 5: Number and cost of HRH deployment in Case Study Municipalities.....26
Table 6: HNP and PhilHealth Payments for selected PHC benefit packages, 2014-2019 31
Table 7: Number and status of filed Philhealth claims for selected benefits, 2014-2020 32

LIST OF FIGURES

Figure 1: Financing flow for PHC in a devolved PHC provider (RHU) 9
Figure 2: Estimated PHC spending of LGUs and health spending on IRA, 2014- 2019, in USD mil 12
Figure 3: Cost of Devolved Functions in DOH Budget, 2008-202, in Philippine pesos..... 14
Figure 4: Integrated National and Local Planning-Budgeting Framework 16
Figure 5: Primary sources of LGU income and LGU income per capita..... 24

Acronyms

AIP	Annual Investment Plans
AOP	Annual Operational Plan
BLGF	Bureau of Local Government Finance
BLHSD	Bureau of Local Health Systems Development
CHD	Center for Health Development
CHE	Current Health Expenditure
DBM	Department of Budget and Management
DENR	Department of Environment and Natural Resources
DILG	Department of Interior and Local Government
DOF	Department of Finance
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EPCB	Expanded Primary Health Care
FDA	Food Drug Administration
GAD	Gender and Development
GIDA	Geographically Isolated and Disadvantaged Areas
HCPNs	Health Care Provider Networks
HFEP	Health Facility Enhancement Program
HFS	Healthcare Financing Strategy
HFSRB	Health Facilities and Services Regulatory Bureau
HNP	Health Nutrition and Population
HRH	Human Resources for Health
IRA	Internal Revenue Allotment
LDRRMO	Local Disaster Risk Reduction Management Office
LHB	Local Health Board
LIPH	Local Investment Plan for Health
LGC	Local Government Code
LGUs	Local Government Units
NEDA	National Economic Development Authority
MCP	Philhealth Maternal Care Package
MHO	Municipal Health Officer
M-A, M-B, M-C, M-D	MHO of Municipality A, B, C and D, respectively
MNCH	Maternal, Newborn and Child Health
MNCH-FP	Maternal, New-Born, Child and Family Planning
NCP	Philhealth Newborn Care Package
NHIP	National Health Insurance Program

PAPs	Programs/Activities/Projects
PCB	Primary Care Benefit
PCPN	Primary Care Provider Network
PHC	Primary Health Care
PHIC/ PhilHealth	Philippine Health Insurance Corporation
PNHA	Philippines National Health Accounts
OPB	Out-Patient Benefit
OPIF	Organizational Performance Indicator Framework
OOP	out-of-pocket payment
RA	Republic Act
RHU	Rural Health Unit
SDN	Service Delivery Network
SHF	Special Health Fund
SRE	Statement of Receipts and Expenditures
SSM	Sentrong Sigla Movement
THE	Total Health Expenditure
UHC	Universal Health Care (Philippine context)

Executive summary

As key Primary Health Care (PHC) providers in the Philippines, Municipal Health Officers (MHO) are responsible for mobilizing funds from both within and outside of Local Government Units (LGU) and bringing together these fragmented finances to allocate limited resources effectively. This study describes the sources of revenue and financing flows for PHC in the Philippines and explains the mechanisms used to consolidate resources. It also identifies challenges in implementing two key legislations, the Mandanas Doctrine and the UHC Act, which aim to increase financing in LGUs and to integrate financing and service delivery arrangements respectively.

We employed a two-stage approach for this case study: the first stage was a review of published and institutional reports to identify key themes in financing primary care in the country, while the second stage was an in-depth analysis of fragmented PHC financing based on additional review of literature and analysis of data from four purposively selected municipalities, Department of Health (DOH), PhilHealth and the Bureau of Local Government Finance. These were complemented by ten key informant interviews from study municipalities that included a mayor, municipal health officers, municipal accountants, and a midwife and three policy makers from DOH and PhilHealth.

Aside from the municipal line-item budget for Health, Nutrition and Population (HNP), MHOs in the study areas have mobilized funds from other line-item budgets including gender and development and local disaster management. MHOs also mobilized additional funds from DOH, Philhealth and donors to augment the local budget for PHC. Factors that enabled them to utilize more funds from LGU include trust of the mayors in their capacity, increasing awareness of the mayors regarding local health needs and the MHOs management capacities. These include the ability to negotiate using national policy and available data (e.g., low program performance using LGU scorecard for health), prepare an investment plan for health that is responsive to local health needs, coordinate with DOH and PhilHealth and engage local partners in the delivery of PHC. They consolidate these various resource streams through their health plans. However, DOH grants and income from PhilHealth require a parallel planning process. The Mandanas Doctrine aims to address the inadequate funds to deliver devolved services, while the UHC Act will merge the fragmented financing at the provincial level. While all study respondents are hopeful that these laws will bring the country closer to universal health coverage, local respondents are apprehensive of poor implementation based on previous experience in pooling funds with provincial and other municipal government and the political dynamics affecting such pooling arrangements.

Some policy options that could be considered to address the concerns raised by MHOs include (1) mandating a per capita spending target for PHC that is calculated based on preventive and outpatient care; (2) developing the capacity of the health care provider network (HCPN), which is the province-wide integration of municipal health systems, on resource allocation across HCPN facilities, pooled procurement and priority setting for capital investments; and, (3) establishing a robust performance monitoring system that will inform continuous improvement in HCPN and primary care provider network (PCPN) operations.

1. Introduction

In 1991, the Philippines government endeavoured to bring basic services closer to the people through the Local Government Code (LGC), which gave local government units (LGUs) more powers, responsibilities, and resources. Of the five public services devolved to LGUs, health was the largest: 534 public hospitals, 12,580 rural health units, 45,896 personnel and PHP 4.1 billion annual budget for health (Manasan, 2005; Perez, 1995). Public health programs and primary health care (PHC) were devolved to city and municipal governments, while the provincial health office, provincial hospital and district hospitals were transferred to provincial governments and managed by the provincial governors.

To enable them to execute their devolved functions, LGUs are guaranteed by law a share of national revenue equivalent to 40 percent of all taxes imposed by the national government. Called the internal revenue allotment (IRA), it is allocated across local governments so that 23 percent of IRA is divided among provinces, 23 percent among cities, 34 percent across municipalities and 20 percent among barangays or villages (Diokno, 2012). Individual shares of LGUs are calculated based on population (50%), land area (25%), and equal sharing (25%). LGUs also receive a share of funding from the use of national wealth in their jurisdiction, including mining taxes, royalties, forestry and fishery charges and financial grants or donations from local and foreign assistance agencies, including funds from their House Representatives/ Senators. The law also allows the national government agencies, like the Department of Health (DOH), to continue implementing devolved projects, programs, and services, provided that these are funded by the national government under the annual General Appropriations Act (Manasan, 2005). This is the reason that DOH has been funding devolved functions like capital investments, human resource deployment and procurement of medicines to support LGUs[1] in providing PHC in their jurisdiction.

In addition to external financial resources, LGUs are authorized to generate local revenues through local taxes, fees, and charges as well as generate income from investments, privatized and development enterprises. LGUs may use credit financing, build-operate-transfer (BOT) schemes, bond flotations, and other investment strategies to finance their local development programs and projects (Cruz-Sta. Rita, et al., n.d.).

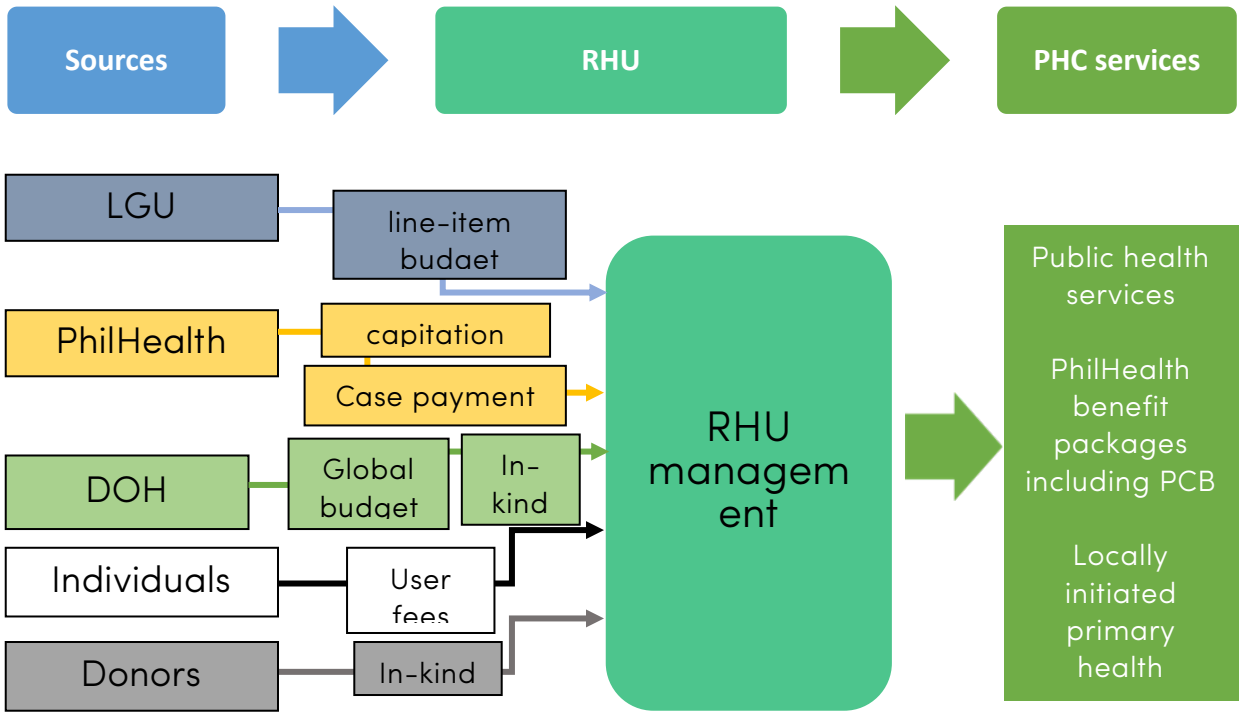
In 1995, another source of funding for health services opened up with the passage of the National Health Insurance Act and the creation of PhilHealth. The law created a single pool for the entire population where resources and risks are shared and cross-subsidization is maximized. PhilHealth was expected to be the main purchaser of health services (Romualdez Jr. , et al., 2011).

The municipal mayor is responsible for leading resource allocation decisions (Sicat, et al., 2019). For health matters, the LGC creates the Local Health Board (LHB), chaired by the mayor and vice-chaired by the Municipal Health Office (MHO), to direct resource allocation for health (Cuenca, 2018). The various resources mentioned above are the main sources of

[1] For the purpose of this report, LGU will refer to municipality unless otherwise stated

funds to operate the public primary care provider called Rural Health Unit (RHU) (**Figure 1**). Mobilizing these diverse financial resources increases the transaction cost of using them in a timely and effective manner. How do the MHOs ensure enough resources are available for primary care? How do they consolidate the funding and allocate effectively to public health programs to ensure service targets are achieved? How do the forthcoming implementation of the two laws, which aim to increase local funding as well as consolidate the fragmented financing, figure in managing the RHU? This study aims to identify the sources of funds for PHC, explain the mechanism in consolidating them and identify the challenges of implementing two new legislations, Mandanas Doctrine and UHC Act, in increasing and consolidating resources for PHC at the municipal level.

Figure 1: Financing flow for PHC in a devolved PHC provider (RHU)



2. Background and literature review

2.1 Raising resources in municipalities

The LGC has established that LGUs will receive higher IRA to fund devolved services. This is reiterated every year through the Local Budget Memorandum[2] issued by the Department of Budget and Management, which instructs LGUs to prioritize the use of the IRA and other local resources to cover the cost of devolved services like PHC. **Table 1** shows that IRA accounts for three-quarters of the total revenues for municipalities between 2014 and 2019, indicating a persistent dependence of municipalities to IRA (see also Diokno, 2012). On the other hand, locally generated revenues contribute, on the average, 18 percent of the total municipal funds. Manasan (2005) found empirical evidence that LGUs which received higher IRA tended to be lax in their tax collection efforts. Similarly, BLGF (2015) reported that 40 percent of first-class municipalities[3] remain IRA dependent because of poor tax collection and poor management of local funds. As a consequence, municipalities have limited fiscal space to finance devolved health functions like PHC.

Table 1: Sources of Municipal Funds (in million pesos and percent of total revenues)

Sources of Municipal Funds	2014	%	2015	%	2016	%	2017	%	2018	%	2019	%
Tax Revenues	15,637	11	16,881	10	17,619	9	21,365	10	24,213	10	26,546	11
Non-Tax Revenues	12,702	9	14,031	8	14,994	8	16,854	8	18,390	8	20,309	8
Internal Revenue Allotment (IRA)	116,554	78	132,647	78	146,051	77	165,315	78	177,520	74	192,740	76
Other external resources (exc IRA)	3,661	2	6,566	4	11,509	6	7,230	3	19,838	8	13,019	5
Total	148,554	100	170,125	100	190,173	100	210,764	100	239,961	100	252,613	100

Source: Statement of Receipts and Expenditures 2014-2019 from Bureau of Local Government Finance (BLGF), DOH

[2] For example, Local Budget Memorandum No. 78. Indicative FY 2020 Internal Revenue Allotment (IRA) Shares of Local Government Units (LGUs) and Guidelines on the Preparation of the FY 2020 Annual Budget for LGUs.
[3] Municipalities are divided into 6 classes based on the average annual income during the last 4 calendar years immediately preceding the general classification: 1st class - municipalities that have obtained an average annual income of fifteen million pesos or more; 2nd class - municipalities that have obtained an average annual income of ten million pesos or more but less than fifteen million pesos; 3rd class - municipalities that have obtained an average annual income of five million pesos or more but less than ten million pesos; 4th class - municipalities that have obtained an average annual income of three million pesos or more but less than five million pesos; 5th class - municipalities that have obtained an average annual income of one million pesos or more but less than three million pesos; 6th class - municipalities that have obtained an average annual income of less than one million pesos.

2.2 Inadequate funds at the local levels

Several functions vested on LGUs receive a mandatory percentage of IRA allocation including Gender and Development (set at 5% of IRA), Development Projects (20%) and Local Disaster Risk Reduction and Management Fund (5%). PHC and other devolved health services, however, have no mandatory percentage of IRA allocation despite being a priority in the annual Local Budget Memorandum. As a result, the allocation for health across LGUs is usually too low. Municipalities spent only about 7 percent of their budgets on health between 2014 and 2019, less than half the 15 percent recommended by DOH as a target in the LGU Scorecard (DOH, 2019). During this time, municipal governments spent around half of their budget on general public services while they carved out, on average, 18 percent for other purposes (i.e., non-operating expenses), leaving the funding for devolved social services, including health, at an average of 16 percent (**Table 2**) (see also Diokno, 2012). PNHA reported increasing trends in LGU spending for the same period (**Figure 2**), but this increase may have been due to hospitals managed by provincial and city governments.

Table 2: Uses of municipal funds (in percent of total)

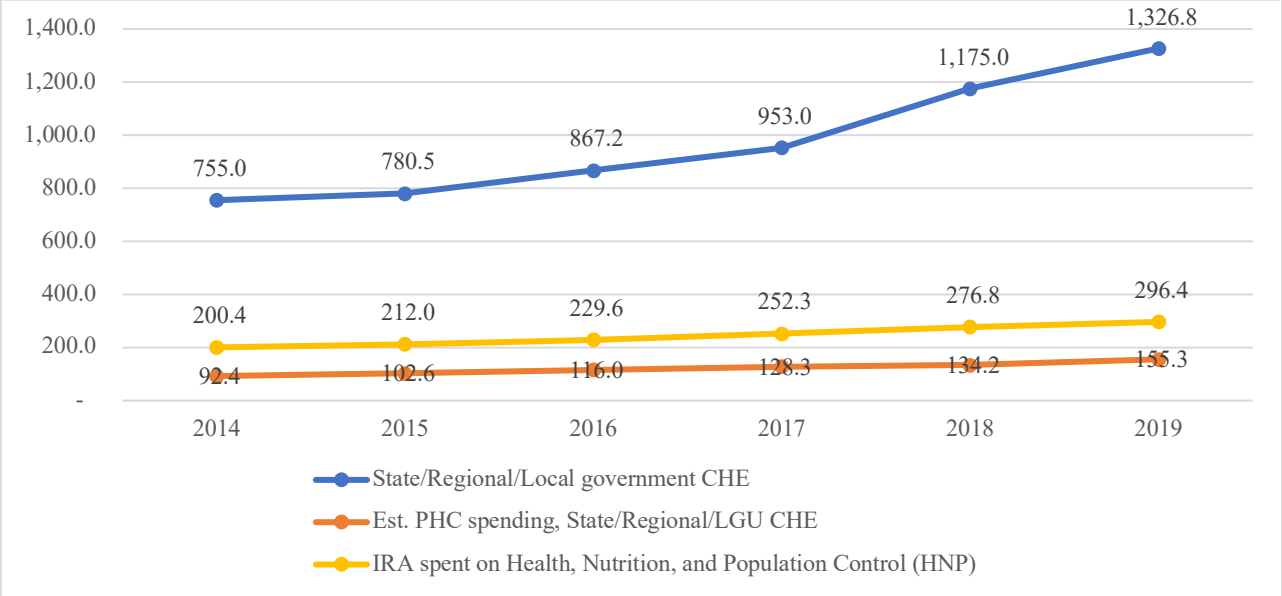
BUDGET SHARES	2014	2015	2016	2017	2018	2019
General Public Services	54.64	52.69	52.86	52.64	50.70	51.94
Social Services	16.81	16.20	15.74	15.73	15.37	15.25
Education, Culture & Sports/Manpower Dev	1.98	1.99	1.72	1.69	1.77	1.87
Health, Nutrition & Population Control	7.65	7.20	7.07	7.03	6.79	6.69
Labor & Employment	0.05	0.06	0.06	0.05	0.05	0.05
Housing & Community Development	1.12	1.09	1.01	0.95	0.81	0.70
Social Services & Social Welfare	6.01	5.88	5.88	6.00	5.95	5.93
Economic Services	14.68	13.89	13.36	12.99	12.42	12.08
Debt Service	0.86	0.76	0.72	0.71	0.67	0.75
Other Purposes	13.01	16.45	17.32	17.93	20.83	19.98

Source: Statement of Receipts and Expenditures 2014-2019, BLGF, DOF

Studies have shown a mismatch between the financial resources transferred to different levels of LGUs vis-à-vis the cost of devolved functions assigned to them. While 23 percent of IRA goes to provinces, 23 percent to cities, 34 percent to municipalities and 20 percent for the barangays, the cost of devolved functions transferred to them is not proportionate to the funding they receive. Provinces absorbed 37 percent of the total cost of devolved functions; municipalities, 38.5 percent; cities, 5.7 percent; and barangays, 18.8 percent (Manasan, 2005), making provinces and municipalities losers as they received less share of IRA compared to the cost of devolved services they are mandated to deliver. This imbalance between IRA share and cost of devolved functions may be traced to the fact that the IRA distribution formula was decided much earlier (i.e., during the Congressional debate on the Code) than the assignment of functions to different levels of LGUs (Manasan, 2005). Consequently, this imbalance led to underfunding of local health services, understaffing and poor maintenance of devolved health facilities (Cuenca, 2018; Magno, 2002; Capuno, 2008; Manasan, 2005).

Inadequate local funding was also reported in a study on planning practices of municipalities. Of 1,373 municipalities surveyed in 2017, only 44.6 percent were able to fund all their Programs/Activities/Projects (PAPs) in their Annual Investment Plans (AIP) using their local budget. About 72 percent of those who had insufficient funds directly requested grant-type funding from national government (Sicat, et al., 2019).

Figure 2: Estimated PHC spending of LGUs and health spending on IRA, 2014- 2019, in USD mil



Source: PNHA 2014-2019 and Statement of Receipts and Expenditures 2014-2019 from BLGF, DOF

Using the data from the national health accounts, **Figure 2** shows the estimated primary health care spending of local governments based on imputed amounts, using the proportion of overall primary health care spending to overall current health expenditure shown in **Table 3**, as well as the share of internal revenue allotment spent on health, nutrition, and population control. Note that primary health care spending was calculated based on the sum of current health expenditures delivered by providers of ambulatory care and preventive health care. Assuming that primary care spending of local governments follows the overall trend, the proportion of total primary health care spending to total current health expenditure has not exceeded 14% from 2014 to 2019 and decreased to around 11% on 2018 and 2019.

Compared to the total internal revenue allotment received by municipal governments, however, the overall spending on health, nutrition, and population control of the municipal governments had not been substantial in the first place and had only been around 7.6-8.6% from 2014 to 2019 (**Table 3**). The nominal amounts of municipal health spending increased from USD 200.4 million in 2014 to USD 296.4 million in 2019.

Table 3: Current health expenditures, estimated primary health care spending of local governments, and share of health spending on IRA from 2014 to 2019, in million USD

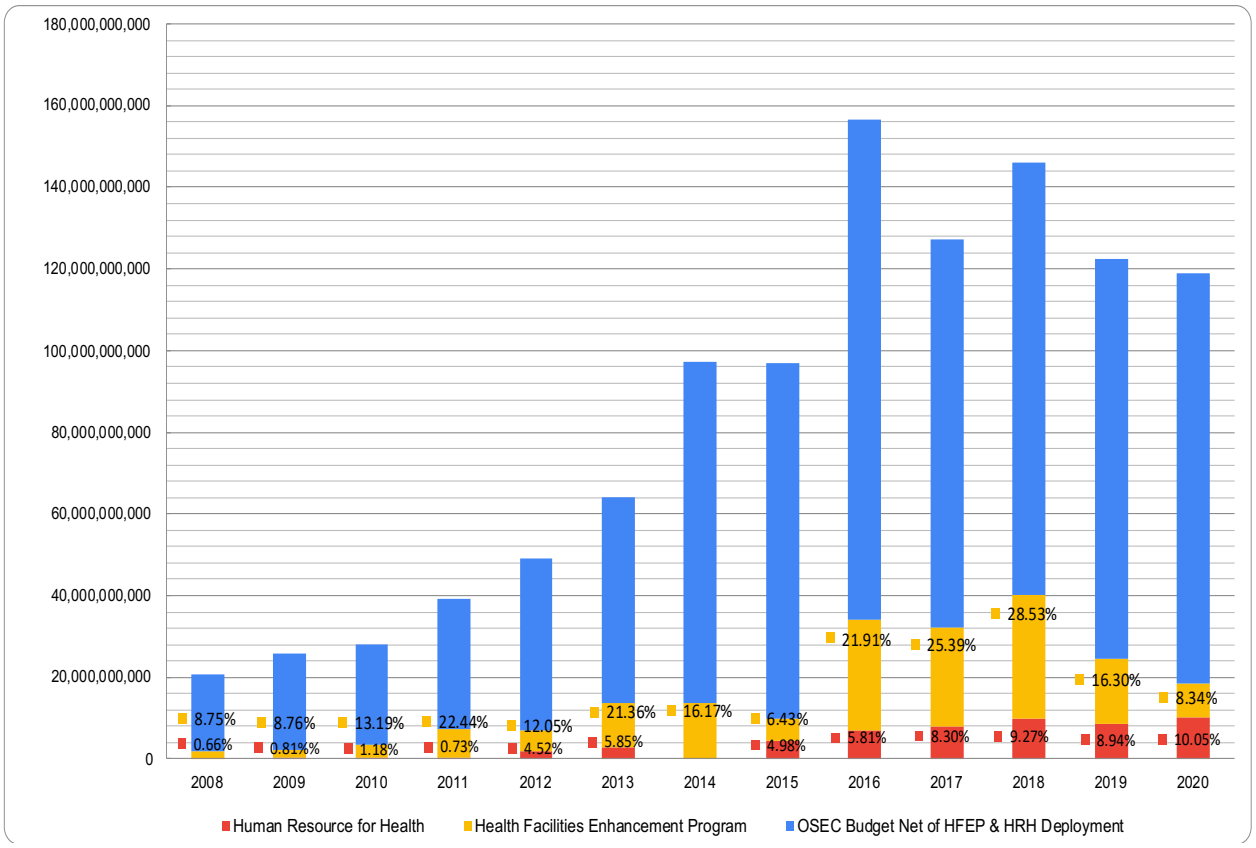
	2014	2015	2016	2017	2018	2019
Total Current Health Expenditure (CHE)	9,781.3	10,871.6	11,969.2	13,114.3	14,295.4	15,851.1
Primary health care (PHC)	1,197.5	1,429.2	1,600.9	1,766.1	1,633.1	1,855.3
PHC % of CHE	12.2%	13.1%	13.4%	13.5%	11.4%	11.7%
State/Regional/Local government CHE	755.0	780.5	867.2	953.0	1,175.0	1,326.8
Est. PHC spending, State/Regional/LGU CHE	92.4	102.6	116.0	128.3	134.2	155.3
Internal Revenue Allotment (IRA) for municipalities	2,331.1	2,652.9	2,921.0	3,306.3	3,550.4	3,854.8
IRA spent on Health, Nutrition, and Population Control (HNP)	200.4	212.0	229.6	252.3	276.8	296.4
HNP % of IRA	8.6%	8.0%	7.9%	7.6%	7.8%	7.7%

Source: Philippine National Health Accounts 2014-2019 and Statement of Receipts and Expenditures 2014-2019 from Bureau of Local Government Finance

2.3 Efforts to increase funds for health

In response to insufficient local funding, the DOH instituted several policies and programs to augment financing for PHC (**Annex B**). Notably, DOH allocated funds to construct or upgrade local health facilities through the Health Facility Enhancement Program (HFEP), with the objective of getting these facilities accredited with PhilHealth to sustain their operations. In addition, DOH deployed critical health personnel in LGUs. In 2018, the Human Resource for Health (HRH) Deployment Program deployed 456 doctors, 16,243 nurses, 5,022 midwives, 2,640 public health associates and 6,796 other allied health professionals (HPDPB, 2019). The annual budget of DOH (**Figure 3**) has increased substantially since 2013 due to the Sin Tax Law, which includes the agency's allocation for local health facility investments and health personnel deployment to local health offices. DOH appropriates an average of 16% for constructing and upgrading primary health facilities between 2008 and 2020 (yellow bar). In the past four years, DOH has also allocated 8-10% of its budget to augment local health personnel through the agency's HRH deployment program (red bar), including the longest running deployment program called Doctors to the Barrios. The blue bar represents the remaining budget of DOH.

Figure 3: Cost of Devolved Functions in DOH Budget, 2008-202, in Philippine pesos



Source: General Appropriations Act, various years (no HRH line-item data in 2014 GAA

In contrast to supply side financing, PhilHealth spending on PHC is shaped by ways in which health care providers are paid. For instance, primary care providers must first identify and register PhilHealth members before they are paid through capitation for PHC benefit, while they must file claims for PHC related benefits like maternity care package, newborn care package, malaria package, TB DOTS package, before they receive case-based payment for these services. Over the years, Philhealth has also expanded its primary care and related benefit packages (**Annex C**) and increased access points especially for primary care benefit, maternal and newborn care package, and TB DOTS package. In 2019, PhilHealth paid around 5 billion pesos (USD100 million) for primary care benefit, 2.34 billion pesos (USD46 million) for maternal care and 0.35 billion pesos (USD7 million) for TB treatment in primary facilities, constituting around eight percent of the total payment of PhilHealth (PhilHealth, 2020). However, the contribution of PhilHealth in PHC spending remains limited because of a lack of information on PhilHealth coverage, benefits as well as other operational barriers. Philhealth members are uninformed of their PhilHealth benefits, leading to poor utilization (Quimbo, et al., 2008; Bredenkamp, et al., 2017). On the other hand, operational barriers like incomplete claims filing by primary care providers, lack of information on the status of PhilHealth membership and benefit entitlement of patient and poor access of PhilHealth members to accredited facilities, often lead to denial of claims payment by PhilHealth, non-

filing of claims by the provider and poor utilization of PhilHealth PHC and related benefits (Panelo, et al., 2017).

By 2022, the IRA of LGUs will increase substantially by 55.7 percent, from PHP 695.49 billion (USD14.49 billion) to PHP1,082.73 billion[4] (USD22.56 billion) because of the Mandanas Doctrine.[5] Each LGU is expected to receive an estimated increase of 27.61 percent increase of IRA shares. While this increase will not guarantee increase in local health spending as there is no mandatory percentage of IRA allocation for health, the source of funds to implement this ruling is likely to impact on DOH budget for devolved functions, thereby reducing the national government spending on health. Manasan (2020) proposes that HRH deployment, HFEP and social health protection program for the poor, being devolved functions, may be re-devolved to LGUs in 2022. These three PAPs (line-items in DOH budget) total 28.92 billion pesos,[6] constituting about 13 percent of the 225.3 billion pesos increase in the IRA. Devolving the health personnel deployment and health infrastructure program to LGUs is consistent with the guiding principles of E.O. 138 s. 2021[7], which directs the implementation of Mandanas Doctrine.

2.4 Efforts to consolidate resources for PHC

Supply-side financing by DOH and LGUs and demand-side financing paid by PhilHealth create a fragmented financing for PHC and preclude rational resource allocation. It is unclear who is accountable for paying for what services since decisions about health budgets are made at different levels, often resulting in overlaps (Dayrit, et al., 2018). For instance, LGU budgets for its primary care facilities, including the services being paid by PhilHealth and for which DOH also provides logistics. As an example, the management of tuberculosis under directly observed therapy, short course (DOTS) is an essential service provided by LGU health centers. Health personnel are salaried and laboratory supplies for microscopy are budgeted for by LGUs. If the health center is accredited by Philhealth for this service, the health center is also paid for each TB patient. DOH also procures anti-TB medicines for LGUs and allocates funds for other activities necessary in the delivery of the TB program.

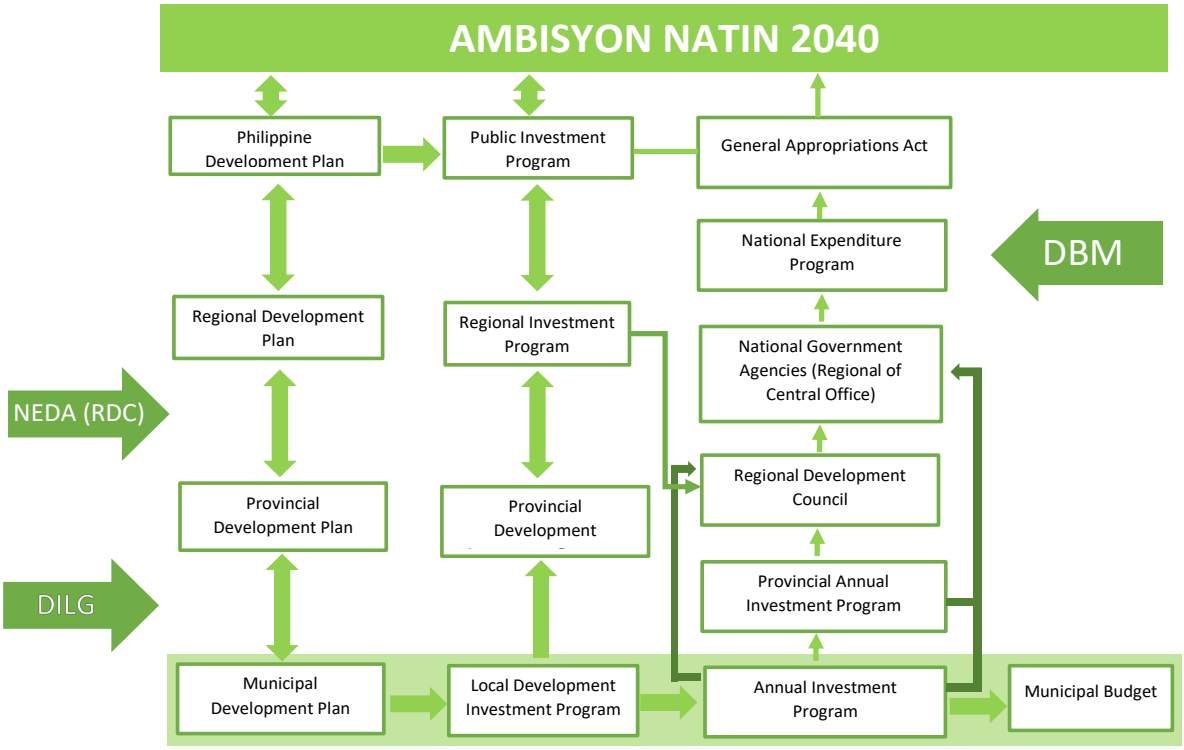
The disconnected responsibilities across three administrative layers (national, provincial, and municipal/city governments) lead to a lack of accountability and considerable administrative workload (Panelo, et al., 2017). LGUs have prerogative and power to make decisions about their health service delivery network even without coordinating with neighbouring LGUs or considering the overall national referral system. Moreover, supply-side allocations, largely through DOH and LGU budgets, do not provide the right incentives for performance, both in terms of quantity and quality. From the demand side, PhilHealth has not stimulated the provision of quality PHC services that will contribute to better health outcomes. Primary care

[4] DBM, (2020), Dir. Macaspac's presentation on DILG webinar series
[5] The Supreme Court ruling in 2018 on the petitions of Batangas Gov. Hermilando Mandanas and former Bataan Gov. Enrique Garcia Jr.
[6] Based on 2020 General Appropriations Act
[7] Executive Order No. 138 s. 2021 entitled Full Devolution of Certain Functions of the Executive Branch to Local Governments, Creation of a Committee on Devolution, and for Other Purposes signed on June 1, 2021.

facilities do not have the ability to retain income and the lack of fiscal autonomy serve as disincentives since well-managed health facilities do not benefit from possible income gains (Dayrit, et al., 2018; Bales, et al., 2018).

Two key approaches have been adopted to consolidate local resources for more efficient delivery of PHC. First, the municipal plans guide the utilization of various funding sources for PHC, which are integrated with national strategic plans as shown in **Figure 4** (Sicat, et al., 2019). In the health sector, DOH promotes the preparation of the Local Investment Plan for Health (LIPH)[8] in every province or large city, to guide the prioritization of funding support for LGUs. The planning process engages the governor and mayors, local legislative council members, the municipal health officers, the local budget officers, and planning and development officers, to adopt the national programs and objectives. However, the LIPH has not resulted to a strategic masterplan for health but has been reduced to mere channel for LGUs to request support from DOH. Some provinces also failed to encourage the full participation of all municipalities within their jurisdiction. Municipalities consider LIPH a project that they may choose to participate or not (Lavado, et al., 2017), as they can still get support from DOH even without participating in the planning process.

Figure 4: Integrated National and Local Planning-Budgeting Framework



Source: Sicat, et al., 2019

[8] Previously, LIPH was known as Province-wide Investment Plan for Health/City-wide investment Plan for heath. LIPH is a medium-term public investment plan for health of LGUs with a three-year strategic time frame, that governs the health operations of the locality and health sector activities, and guides how health system outcomes will be achieved with specific LGU, DOH and stakeholder actions (DOH, 2020).

The development of LIPH also did not push LGUs to be more accountable in managing resources for local health systems. Key LGU accountability issues revolve around budget allotment for health, contractualization and politicization of health staff appointments, procurement of drugs and medical supplies and the use of PhilHealth payments (Dayrit, et al., 2018). LGUs have autonomy to decide how to allocate their income (from IRA, local taxes, etc.) and how much to allocate for health. Mayors can also appoint additional human resources for health, even beyond the available plantilla positions. As head of procuring agency, mayors can also influence the kind of medicines the LGU will procure. Since rural health units do not have fiscal autonomy, some LGUs do not comply with PhilHealth's policy on creating a trust fund for PhilHealth payments and treat this income stream as another source of LGU income to be channelled into the general fund and re-allocated subject to the priorities of LGUs.

The second approach to consolidate local resources is new legislation that aims to establish service delivery networks and pool the financing resources at a higher level of local government to manage the inter-jurisdictional benefit and cost spillovers. The Universal Health Care Act, passed in 2019, opens two avenues in consolidating health resources at the local level: organizing Primary Care Provider Networks (PCPN) and creating a Special Health Fund (SHF). Section 17.3.a of the Universal Health Care Act (RA 11223) describes PCPN as a "*coordinated group of public, private or mixed primary care providers, as the foundation of the health care provider network.*" Similar to Interlocal Health Zones (ILHZs) established in the past but organized to include all municipalities in a province, this network is expected to provide primary care services; serve as navigator to guide patients' decision making in accessing appropriate health care; facilitate two-way referrals and remove barriers to health services; enable accessibility to patient records within the health system; and implement public health services. This province-wide health system will include all LGU- managed health offices, facilities and services, human resources, and other LGU-operated community-based health facilities (RA 11223 Rule V Section 19).

The SHF, on the other hand, is a mechanism to pool and manage all resources intended for health services in the entire province. SHF includes financial grants and subsidies from national government agencies such as the DOH; income from PhilHealth payments; and other sources such as grants and donations from Non-Government Organizations, Faith-Based Organizations, and Official Development Assistance (RA 11223 Section 20). The SHF will be managed by the Provincial or City Health Board. It should be noted that the UHC Act did not amend the LGC; thus, the participation of municipalities and component cities in a province-wide health system depends on their willingness and within the bounds of LGC.

3. Methods

We employed a mixed methods approach in understanding the degree of and reasons for fragmented financing at the municipal level as a consequence of devolution, i.e., a combination of interviews, review of published and grey literature and data from PhilHealth, DOH and BLGF. The Single Joint Research Ethics Board (SJREB) released the ethical clearance certificate on January 12, 2021, with research code SJREB-2020-101.

We developed an interview guide using two elements a) critical assessment and b) analysis of the underlying factors that have enabled / constrained its implementation.

a) To critically analyze the issue, we asked how do MHOs (main actor) ensure enough resources are available for primary care? How do they consolidate funding flows and allocate effectively to ensure patient-centered primary care services? The local team also included more detailed queries on raising and pooling of funds for PHC – mechanisms, challenges, and good practices. Expectations and challenges in implementing the Mandanas Doctrine and the UHC law, two policies that will impact on PHC financing and pooling arrangements, are also explored.
b) The second part explored further the enabling/constraining factors in managing finances from different sources, the factors that affect integration of funding, key considerations in the LGU mandates that may impact the delivery of PHC, and interdependencies of various factors.

Initially, the entire research team (LSHTM and local teams) agreed to use two selection criteria to identify the study municipalities: (1) performance based on published LGU scorecard and (2) the level of LGU financing of PHC based on percentage of HNP over IRA based on the SRE database of BLGF. The plan had been to select four LGUs: (1) high performance, high level of financing; (2) high performance, low level of financing; (3) low performance, high level of financing; and (4) low performance, low level of financing. However, recruiting respondents and doing the interviews proved to be difficult because of several factors:

a) COVID-19 community quarantine protocols prevented face-to-face interviews.
b) The period of data collection corresponded to the DOH nationwide Measles-Rubella Oral Polio Vaccine Supplemental Immunization Activity (MR OPV SIA) campaign. Most health workers were busy with the immunization activities.
c) LGUs located in islands were difficult to reach because of poor mobile phone signal and internet connectivity.
d) LGUs were busy responding to COVID-19 pandemic and preparing for the COVID -19 vaccine deployment.

Considering the above issues vis-a-vis the timeline of the study, four study LGUs with varying characteristics were selected: first-class[9] urban municipality contiguous to Metro Manila; first-

[9] Provinces, cities and municipalities are classified into six (6) classes according to the average annual income realized during the last four (4) calendar years immediately preceding the year of reclassification. Municipalities

class rural (island province); third-class rural (mountainous area); and fifth class (island province). From their own network, the local research team purposively selected key informants based on their knowledge on how health plans are prepared, as well as how the utilization of health budget and PhilHealth income are monitored. While the request for interview included the Mayor, Accountant, MHOs and barangay midwife, only in Municipality A were all four respondents were interviewed. MHOs and municipal accountants were interviewed in three LGUs, but the accountant in Municipal B refused to be recorded. In addition, respondents from DOH and PhilHealth were selected based on their role in financing PHC. These offices include the Bureau of Local Health Systems Development in DOH and Accreditation Department and Primary Care Benefit Development Team in PhilHealth.

Published and grey literature on local health financing, which include DOH and PhilHealth policies, World Bank reports, reports by local research institutes, institutional reports (LGUs, DOH, Philhealth), and peer-reviewed articles were reviewed to understand how PHC is financed in the country while the key informant interviews provided insights and details not found on reviewed documents. Moreover, secondary data analysis of publicly available datasets was also done, including those from the Philippine National Health Accounts, DOH appropriations, BLGF Statement of Receipts and Expenditures (SRE) and PhilHealth claims payment data.

Data were presented to look at the trends in municipal funds for health, support from DOH and income from PhilHealth. Interview transcripts and notes were reviewed to identify illustrative quotes to provide explanation and context.

are classified as follows: 1st class – average annual income of P50M or more; 2nd class - P40M or more but less than P50M; 3rd class - P30M or more but less than P40M; 4th class - P20M or more but less than P30M; 5th class - P IOM or more but less than P20M; 6th Class - Below P10M (DOF Department Order 20-05).

4. Findings

4.1 Study Participants

Key informants from study municipalities include of municipal health officers (4), municipal accountants (4), mayor (1), and barangay midwife (1). Respondents from DOH (1) and PhilHealth (2) who are providing oversight on primary care service delivery and primary care benefit gave the national perspective in financing PHC and interventions. All the respondents have been in service or related capacity for at least seven years.

4.2 Characteristics of Case Study Municipalities

Municipality A is a first-class rural town in an island province with 70,502 inhabitants and population density of roughly 54 persons/sq.kms. The largest municipality in the province, it is divided into 18 barangays, of which only two are urban. The primary sources of livelihood are fishing and farming; poverty incidence is around 32%. In 2019, the LGU has an income of PHP 348 million (USD 7 million) from local taxes, permits and licenses, business income, and IRA, 7% of which is allocated for health. This is translated to PHP 345.7 (USD 6.9) health spending per capita.

Municipality B is a first-class highly urbanized town, with a population of 330,191 and population density of around 7,681 persons/sq. kms. Its proximity to the National Capital Region directly impacts on its high population growth as it serves as a strategic residential area for average income families employed in nearby cities. It has an abundant mix of commercial, industrial, and real estate businesses. Considered as one of the richest municipalities, it has a poverty incidence of 0.7 %. In 2019, it has an income of about PHP 2.1 billion (USD 42 million), 6% of which goes to health. This is translated to PHP 385.1 (USD 7.7) health spending per capita.

Municipality C is a 5th class rural town in a mountainous area with a population of 6,299 and population density of approximately 42 persons/sq. kms. The LGU's main products are cattle, rice and hardwood. Poverty incidence is about 8.4%. In 2019, the LGU generated an income of about PHP86 million (USD1.73 million), 71% more compared to the previous year's income. This significant increase is attributed to its share from the Tobacco Excise Tax, which amounted to PHP77 million (USD1.54 million) (DBM, 2019). About 7% of their budget goes to health, or PHP951 (USD19) per capita. The higher per capita budget can be explained by the substantial income from LGU's share in tobacco excise tax vis-à-vis its small population.

Municipality D is a 3rd class rural town in an island province with a population of 34,935 and population density of 195 persons/sq. kms. The main sources of income are farming and fishing, with half of its barangays located along the coast while 50% of its land area is devoted to coconut farming. Poverty level is roughly 48%. In 2019, the LGU generated an income of about PHP 176 million (USD 3.5million). About 4.5% of the LGU' s budget goes to health, or PHP228(USD5) per capita.

Selected financing and health indicators from the LGU health scorecard are summarized in Table 4. DOH uses this scorecard to assess the performance of LGUs in implementing local health reforms as well as reporting their progress in meeting the national health targets set by DOH. These indicators are color-coded based on the LGU scorecard: green when level of performance is equal or better than the national target for the year, yellow if lower than the national target but better than the national average for the reference year (2012) and red if lower than the national average for the reference year. In 2012, the national average for public doctor to population is 1:35,497, for midwife 1:6,591 and for nurse 1:22,947. Health personnel benefits (e.g., hazard pay, subsistence and laundry allowances for public health workers) are devolved expenditures that may not be funded when an LGU does not have enough funds. Having local health facilities accredited with PhilHealth means two that (1) LGUs have upgraded their health facilities and have their personnel trained to get accreditation and (2) patients have access to more facilities where they could use their PhilHealth benefits.

Table 4: Financing and health service delivery Characteristics of Case Study Municipalities

Characteristics	Municipality			
	A	B	C	D
Projected Philippine Population, 2019 Note: Based on 2015 Philippine Population Census and 2010-2015 Population Growth Rate of each municipality	70,502.49	330,191.38	6,298.53	34,935.14
Internal Revenue Allotment in million PHP (USD), 2019 Source: Statement of Receipts and Expenditures, DOF	355.19 (7.10)	564.47 (11.29)	67.76 (1.36)	118.61 (2.37)
Poverty Incidence, 2015 Source: Philippine Statistics Authority	31.96%	0.66%	18.4%	48.17%
Health, Nutrition, and Population Control Budget in million PHP (USD), 2019 Source: Statement of Receipts and Expenditures, DOF	24.37 (0.49)	127.15 (2.54)	5.99 (0.12)	7.95 (0.16)
LGU Income in Millions of PHP (USD), 2019 Source: Statement of Receipts and Expenditures, DOF	348.05 (6.96)	2,081.47 (41.63)	86.42 (1.73)	175.74 (3.51)
HNP Budget as % of LGU Income, 2019	7.00%	6.11%	6.93%	4.52%
HNP Budget Php per capita (USD),2019 *Formula: 2019 HNP Budget in PHP/ Projected Population*	345.66 (6.91)	385.08 (7.70)	951.02 (19.02)	227.56 (4.55)
2018 Local Government Unit Scorecard Indicators				
Health Center Physician to Population Ratio (Target: 1:20,000)	1:35,180	1:23,326	1:6,435	1:35,664
Health Center Midwife to Population Ratio (Target: 1:5,000)	1:4,139	1:12,496	1:6,435	1:7,133
Health Center Nurse to Population Ratio (Target: 1: 20,000)	1:17,590	1:15,904	1:6,435	1:35,664
Provision of full hazard pay, and other allowances under the Magna Carta for Public Health Workers (Target: 100%)	100%	100%	0%	100%
Percentage of Infants (0 - 6 months old) Exclusively Breastfed (Target: 70%)	70.19%	42.23%	37.93%	63.97%
Prevalence of underweight and severely underweight 0-59 mos. old children (Target: 7.15)	5.11	2.35	7.85	12.07
Percentage of Facility-based Deliveries (Target: 90%)	85.77%	89.61%	79.17%	96.25%
Percentage of Households with Sanitary Toilet Facilities (Target: 90%)	63.27%	94.61%	96.43%	90.54%
Percentage of Rural Health Units /Health Centers engaged with PHIC on Maternity Care Package (Target: 100%)	100%	16.67%	100%	100%
Percentage of Rural Health Units Health Centers engaged (accredited) with PHIC on Tuberculosis-Directly Observed Treatment, Short Course. (Target: 100%)	0%	0%	100%	100%

Note: PHP 50=$1

Legend:

Performance in current year is equal to or better than 2018 National Target	Performance in current year is lower than 2018 National Target but equal to or better than 2018 National Average	Performance in current year is lower than 2018 National Average	No data	Not Applicable/ will not be collected for 2018	For baseline data collection

4.3 Funding sources for PHC

LGU budget

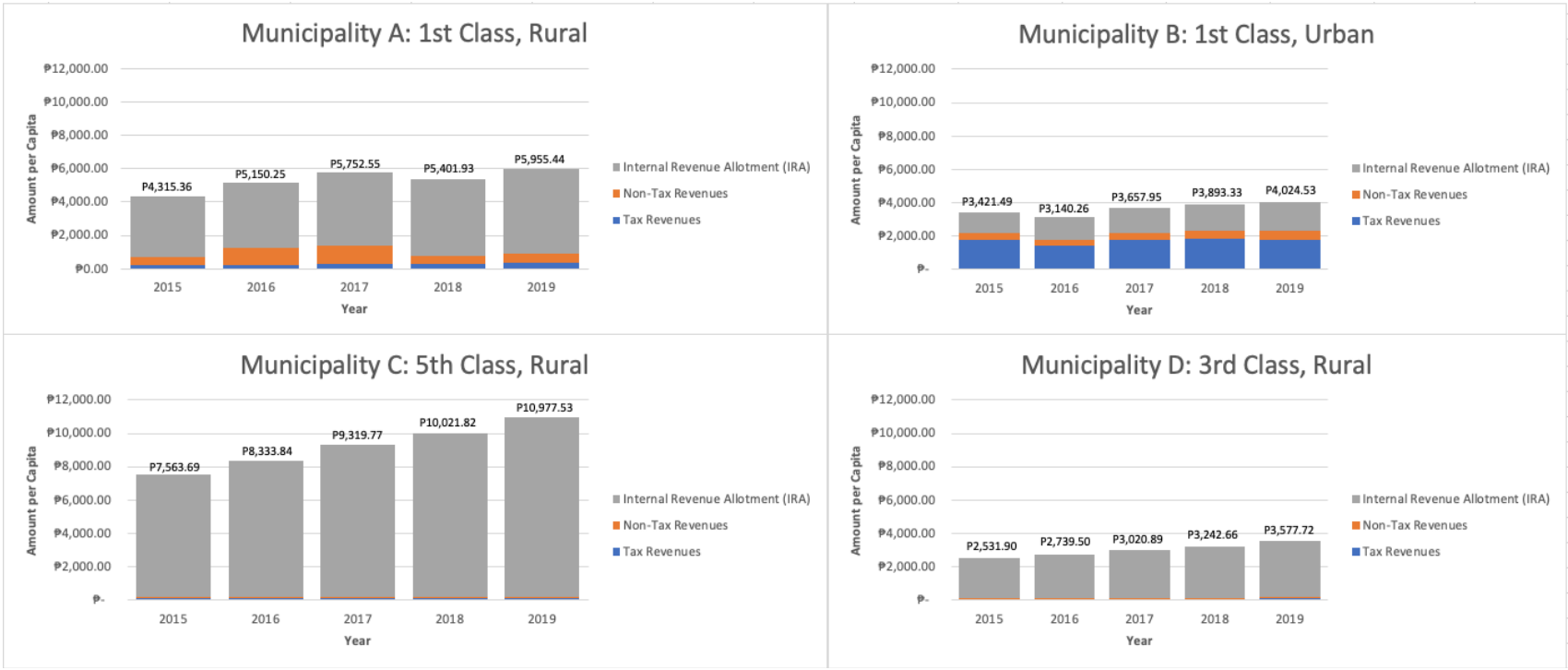
The LGC provides municipalities with several mechanisms to raise revenues, both internally and externally, to enable them to provide primary health care to their constituents. The three major sources of budget in study municipalities come from local taxes (e.g., real property tax, business tax), non-tax revenues (e.g., regulatory fees from permit and licenses, service/user charges) and IRA. Three of four study municipalities rely on their IRA as the main source of funding. From 2015-2019, on the average, about 81% of income of Municipality A, 98% of Municipality C and 96% of Municipality D come from their IRA, indicating IRA dependency among rural municipalities regardless of income classification. This finding is consistent with a previous report that only about 19% of the operating income of municipalities come from local revenues while IRA has become the main source of their funds (Diokno, 2012). Moreover, forty percent of first-class municipalities like Municipality A remain IRA dependent because of poor tax collection and poor management of local funds (BLGF, 2015).

In addition to IRA, eligible LGUs also receive special shares from national taxes like tobacco excise tax, based on their volumes of production and trade acceptances as certified by the National Tobacco Administration and endorsed by the Department of Agriculture (DBM, 2019). This is the reason why Municipality C, despite being the poorest of the study municipalities, has the highest per capita budget on health.

Municipal LGUs can also raise resources through local taxes and fees. Health officers and accountants from study municipalities explained that their LGUs are trying to raise local revenues by updating the Local Tax Code regularly. The health offices contribute to raising revenues through user fees in laboratory services, sanitary permit, medical certificate, and pre-marriage counselling. Considered as local income, these are paid to municipal treasurers and go to the general fund.

> *"I keep track of the income we generate for LGU from sanitary permit and other fees. I want to show that the health office's contribution to local revenues increases every year."*
>
> *M-B, 3 years in LGU service; 15 years as DOH regional executive*

Figure 5: Primary sources of LGU income and LGU income per capita



Source: Statement of Receipts and Expenditures 2014-2019, B

Municipality B, being a highly urbanized town, raised 44 percent of its income from local tax revenues in 2019 while 42 percent came from IRA. About 13 percent was raised through charges and fees. Despite its high income from IRA and local taxes (**Table 4),** Municipality B has low budget per capita (**Figure 5**).

When asked if the LHB is instrumental in securing higher budget for health, the MHOs mentioned that the discussions in LHB meetings center around program target accomplishment rather than financing PHC. It is the MHO's initiative to increase funds from LGU budget. For instance, in addition to the health budget under the Health Nutrition and Population (HNP) line item, all respondent MHOs reported accessing funds from other line items of the local budget. MHO (M-A) mentioned the income from local lotteries, which, by law, are intended for health programs, medical assistance, and PHC. MHO (M-B), being the head of Gender and Development (GAD) Committee, created a program called *Kalingang Pangkalusugan* (Caring for Health), which provides vaccination, NCD maintenance medicines (Using the WHO guidelines), dental services, mobile X-ray for special populations including senior citizens, persons with disabilities, poor families identified, school athletes, children in conflict with the law and those in jail. Aside from additional funds from GAD, MHO C (M-C) also works with Local Disaster Risk Reduction Management Office (LDRRMO) for blood donation program. The MHOs also mentioned using funds from 20% Development Fund to deliver PHC.

Aside from local income, all local respondents identified other resources for PHC, including DOH (funds and in-kind), PhilHealth (claims payments) and donations (in-kind and cash).

DOH support

All four municipalities reported having received HFEP funds from DOH to repair their health centers, provide equipment for these facilities or even build birthing facilities that are consistent with licensing and accreditation standards of DOH and PhilHealth, respectively. Municipality D reported receiving a grant award in reaching the national target for schistosomiasis control program, which the MHO (M-D) also spent on mass drug administration. According to municipal accountants, funds received from DOH are put in a Special Trust Fund and disbursed according to the provisions in the Memorandum of Understanding (MOU) between DOH and LGU. DOH also provides equipment, medicines, vaccines, and other supplies for PHC, which are delivered in-kind. The municipal accountant in Municipality C opined that receiving in-kind support saves them from going through the procurement process as they get few bidders for medical equipment because of their remote location.

> *"The problem in procurement of equipment and medical supplies in our locality is lack of supplier, which results to failure in bidding. So, receiving in-kind support like medical equipment is better."*
>
> *Accountant, Municipality C*

All study municipalities also received deployed health personnel (MD, nurses, midwives) from DOH HRH Deployment program to augment the LGU health workforce. DOH pays for the

salary and benefits of health personnel deployed to municipalities (**Table 5**). While Municipality B is considered one of the richest municipalities, it received the highest value for deployed personnel compared to other study municipalities, as opposed to Municipality C, the study LGU with least income. DOH prioritizes LGUs that are geographically isolated and depressed as well as those having critical gaps in HRH requirement for RHUs and barangay health stations (DOH, 2020).

In addition to financing and in-kind support mentioned by local respondents, DOH respondent mentioned providing a grant (fixed tranche) to LGUs for local health system development, which is calculated based on population residing in Geographically Isolated and Disadvantaged Areas (GIDA) of the municipality and the presence of indigenous peoples. This type of grant, however, was not mentioned by any of the local respondents, despite Municipalities C and D being identified as GIDA.

Table 5: Number and cost of HRH deployment in Case Study Municipalities

HRH Type	Monthly Salary and Benefits in thousands PHP (USD)	Current Number of deployed HRH				Monthly Cost of HRH in thousands PHP (USD)			
		A	B	C	D	A	B	C	D
Nurse II	55.86 (1.12)	4	26	4	10	223.43 (4.47)	1,452.26 (29.05)	223.43 (4.47)	558.56 (11.17)
Midwife II	39.94 (0.80)	8	0	1	4	319.49 (6.39)	-	39.94 (0.80)	159.75 (3.19)
Public Health Associates *	33.66 (0.67)	0	0	1	0	-	-	33.66 (0.67)	-
Total		12	26	6	14	542.92 (10.86)	1,452.26 (29.05)	297.02 (5.94)	718.31 (14.37)
				Annual Cost of HRH		**6,515.02 (130.30)**	**17,427.15 (348.54)**	**3,564.21 (71.28)**	**8,619.71 (172.39)**

$1 = P50. The cost of HRH is based on the salaries and benefits paid by DOH
*The Public Health Associates supports administrative and managerial concerns in the rural health unit (RHU) such as operational health planning, research, disease surveillance, staff capacity building and program management. They are assigned in RHUs to work alongside with other HRH in implementing DOH programs and health plans.

All local health officers and DOH respondents reported that DOH resources are mobilized through the Local Investment Plan for Health (LIPH). However, the DOH respondent noted that even when equipment or medical commodities are not in the LIPH, DOH still provides these to LGUs. In other words, non-submission of LIPH does not make the LGU ineligible to receive DOH support. This stance of DOH is consistent with its traditional role of enabling LGUs rather than regulating their behavior by imposing penalties when they do not comply with national guidelines.

> *"Our request for equipment or facility enhancement submitted through LIPH has uncertain timeline: sometimes it takes 2-3 years, sometimes we receive our requested equipment one year later."*
>
> *MHO, Municipality D, 33 years in service*

Two of four municipalities mentioned receiving performance grants from DOH, both at the national and regional levels. M-D receives PHP 25 thousand (USD 500) per year for reaching the target for Schistosomiasis control. On the other hand, M-C receives yearly regional health awards, with cash gifts, as long they express interest in being evaluated for different health programs.

> *"The awards include cash. Like when we were accredited as Level 3 Adolescent friendly health facility. We were given 100 thousand pesos (USD 2,000) cash award which we used for the improvement of our adolescent facility."*
>
> *MHO, Municipality C, 23 years in service*

Challenges in mobilizing resources from DOH

First, the administrative cost is higher when using the budget from DOH. For instance, M-A suggested that implementing a training program, if funded by DOH, results in delays because securing the venue for the training is done at DOH regional level. To illustrate, the staff from DOH regional offices prepare the procurement papers, send them to the staff at the RHU, the local staff gets quotations from local hotels, sends the quotations to DOH regional office, the regional office Bid and Awards Committee (BAC) deliberates, the regional BAC sends the contract to the winning hotel and LGU staff facilitates the contracting of the hotel. This tedious process is shorter and more efficient if the LGU uses its own funds and contracts directly with the hotel. Moreover, cost-sharing across different levels of government (national, provincial and local) to implement a particular activity requires so much time and effort as compared to just the LGU bearing the cost of an activity.

Second, commodities or supplies coming from DOH are not always appropriate to local needs. M-A reported that the LGU does not need all the supplies and commodities coming from DOH. The mayor of Municipality A echoed the same sentiment finding that medicines from DOH are not always appropriate for the primary care facilities in her town. Third, the value of what municipalities get from DOH grants is a token rather than real support. M-D felt that the cost of achieving the performance targets is much higher than the actual amount of the financial support that they get through the grant award. The amount they received as incentive for a program is a token considering that the actual cost in mobilizing personnel and engaging the community is much higher. Fourth, the approved program of work is not always implemented because of oversights in planning. For example, M-B said that HFEP budget to construct a health center was reprogrammed because of an ownership dispute on the proposed location.

PhilHealth payments

All study municipalities have PhilHealth accreditation for primary care benefit and other PHC services including maternal care, newborn care, and TB DOTS benefit packages. Like DOH funds, the municipal accountants reported that PhilHealth payments are also put in the Trust Fund, recorded in a subsidiary ledger, and disbursed according to relevant Philhealth policies. This means that only the health officer is authorized to use these funds.

"Once the money is in the trust fund, the sole authority over it is the fund administrator, who is the MHO in this case. Essentially, the mayor does not need to approve the disbursement of these funds but it has become a practice that purchase requests against these funds are still signed by the mayor."

Municipal Accountant A, 9 years in service

All health officers reported that they have control over their PhilHealth income but M-D said that she has to submit a proposal to use the funds for the approval of the mayor and accountant.

PhilHealth paid the primary care benefit, maternal care, newborn care and TB DOTS benefit packages[10] in study municipalities (**Table 6**). These amounts contribute, on average, between less than 1% of the local funds available for PHC (i.e., municipal budget + PhilHealth payments) in Municipalities B and C to 3.43% in Municipality A and 36.69% in Municipality D. Health officers from Municipality A, C and D revealed that their income from PhilHealth is a major source of funding for PHC. Municipality A was able to accumulate PHP 9.5 million (USD200 thousand)11 in capitation funds since it got accreditation in 2013. In 2020, when their health budget was depleted by the third quarter because of COVID-19, the M-A used their PhilHealth income to operate a local quarantine facility. She also explained that the birthing facilities in two populated barangays are fully funded by PhilHealth income, having accumulated PHP 3.4 million (USD 67 thousand) in two years.

"Except for the salary of health personnel, which is budgeted for by LGU, the operation of our birthing facilities are sustained by PhilHealth payments. This was before PhilHealth enforced the electronic submission of claims."

MHO, Municipality A, 7 years in service

Municipality D has demonstrated that PhilHealth income can be substantial as it was able to increase PHC funding by as much as 51 percent in 2016. It is worthwhile to note that Municipality D is located in a region where the PhilHealth regional office supports the LGUs in ensuring that their constituents can avail PhilHealth benefits through the PhilHealth LINK, a system that is useful for families whose premiums are subsidized by LGUs under the Sponsored Program, and who may not be fully aware of the benefits they are entitled to, and how they may be availed of (Picazo, et al., 2013). M-D said that PhilHealth payments enabled them to incentivize pregnant mothers to deliver in their RHU and traditional birth attendants (TBAs) to assist mothers post-delivery, a strategy which increased facility-based delivery and reduced maternal deaths (**Table 4**). In return, these TBAs were given incentives coming from the PhilHealth reimbursements. She also used this income to hire data encoders to help in filing PhilHealth claims. Municipality C was able to extend health services to otherwise underserved areas. M-C explained that their income from PhilHealth allows them

[10] Capitation payment data were not available during the study period despite several attempts to secure the data from Philhealth
[11] Data provided by municipal accountant.

to deliver services in the remote areas of their municipality as their local budget is only enough to provide services at the town center.

In Municipality B, however, the doctor in-charge of a birthing facility manages the income from PhilHealth. Their accountant felt that PhilHealth payments are too little and released irregularly. As such, they do not consider PhilHealth income to be substantial or dependable.

Challenges in raising revenues through PhilHealth

PhilHealth payments do not reflect the full income potential that these municipalities could get as indicated by the years when income from PhilHealth was low or zero (**Table 7**). LGU respondents identified several challenges in raising revenues through Philhealth. First, LGUs face challenges in getting accredited, or even when they do, the opportunity to get reimbursements becomes a secondary motivation because of tedious claims processing. For the past two years, M-B had been submitting accreditation requirements for PhilHealth benefits other than maternal and newborn care but had not been successful because of the tedious process and multiple requirements. By the time the RHU complies with all requirements, the application period is already over. He also paid the accreditation fee from his own pocket as this expense is not budgeted by the LGU and as such he cannot get reimbursement for it. On the other hand, M-C kept their health facility accredited even when they are not getting paid because of challenges in filing claims (i.e., shift from paper claims to electronic, which they were unprepared for). Their Philhealth accreditation is important in maintaining the LGU's Seal of Good Local Governance,[12] as it is one of the criteria in getting or maintaining this nationwide recognition.

Second, filing of claims is not done effectively. In 2017, PhilHealth required electronic submission of PCB reports and claims for benefits paid through case rates. Municipalities A, C and D experienced difficulties in this transition and the number of their paid claims declined thereafter since PhilHealth only processed the payments for patients whose records were transmitted electronically (**Table 6**).

> *"We have not received Philhealth reimbursements since 2017 because of the implementation of electronic medical record and the problem with PhilHealth membership portal. Not only us, but all the municipalities in our province experience the same."*
>
> *Municipal health officer, Municipality C*

[12] Pursuant to "*The Seal of Good Local Governance Act of 2019*" (R.A. 11292)

"Although we are accredited for family planning services and we have a lot of clients, we have not filed our claims because of too many documents that need to be submitted. It is also more difficult to file claims now since we are required to submit electronically. We have poor internet connection; it is a shame that we cannot file our claims.

Municipal health officer, Municipality D

Table 6: HNP and PhilHealth Payments for selected PHC benefit packages, 2014-2019

Study LGU	2014			2015			2016			2017			2018			2019		
	HNP PHP($)	PHIC Income	% Add'l PHC Funds	HNP PHP($)	PHIC Income	% Add'l PHC Funds	HNP PHP($)	PHIC Income	% Add'l PHC Funds	HNP PHP($)	PHIC Income	% Add'l PHC Fund	HNP PHP($)	PHIC Income	% Add'l PHC Fund	HNP PHP($)	PHIC Income	% Add'l PHC Funds
A	15,195 (303.9)	-	0.00	15,691 (313.8)	1,468 (29.4)	8.56	19,931 (398.61)	1,699 (34)	7.85	17,526 (350.5)	574 (11.5)	3.17	22,064 (441.3)	216 (4.3)	0.97	24,368 (487.36)	1 (0.0)	0.00
B	109,311 (2,186.22)	-	0.00	118,240 (2,364.80)	-	0.00	107,829 (2,156.58)	117 (2.3)	0.11	121,155 (2,423)	312 (6.2)	0.26	146,602 (2,932)	114 (2.3)	0.08	127,147 (2,542.93)	288 (5.8)	0.23
C	3,522 (70.43)	31 (0.6)	0.87	4,368 (87.36)	11 (0.2)	0.25	4,582 (91.65)	199 (4.0)	4.16	5,283 (105.7)	13 (0.3)	0.25	6,475 (129.5)	-	0.00	5,994 (119.87)	-	0.00
D	5,713 (114.26)	4,095 (81.9)	41.75	6,632 (132.64)	3,669 (73.4)	35.62	6,794 (135.87)	7,167 (143)	51.34	7,684 (153.7)	4,949 (99.0)	39.18	7,636 (152.7)	2,049 (41.0)	21.16	7,947 (158.95)	3,852 (77.)	32.65

Source: HNP from BLGF, PhilHealth Income from PhilHealth Corporate Planning Department

Note: $1 = P50 | "-" means no paid PhilHealth claim entry

Amounts are in thousands PHP (USD); % Add'l PHC Funds = PHIC Income / (HNP + PHIC Income), where PHIC income is the total payments for PCB, MCP, NCP and TB DOTS packages

Third, even when the claims were filed, study municipalities risked not getting paid because of denied claims. For the benefits filed between 2014-2020, Municipality D had the highest proportion of paid claims because they hired encoders and assigned staff to ensure that claims are filed correctly (**Table 7**).

Table 7: Number and status of filed Philhealth claims for selected benefits, 2014-2020

Municipality	Total No. of Claims (2014-2020)	Number of Paid Claims	Percentage of Paid Claims
A	731	552	76%
B	231	155	67%
C	40	32	80%
D	3,403	2,938	86%

Source: PhilHealth Corporate Planning Department

Note: Only includes the claims for three PhilHealth packages: TB DOTS, MCP and NCP.

While PCB are not filed as claims but as service reports, the shift to electronic submission have also resulted in non-payment due to problems in data transmission using DOH electronic medical records, as reported by PhilHealth respondents and M-A, M-C and M-D. PhilHealth requires the submission of patient records through iClinicSys, the patient electronic medical health record system created by DOH. The software provides an offline feature, which means that RHUs can encode patient records offline and upload once they have internet connection. However, it was later found out that hundreds of thousands of patient records encoded and uploaded by RHUs using the offline mechanism were never received by PhilHealth.

"We have met with PhilHealth several times to address the issue so we can get paid. But until now they (PhilHealth) have not acted on it"

Municipal health officer C

"PhilHealth told us that we have a collectible of around PHP8 million for 2018 and 2019 for primary care benefit. That's a substantial amount and I hope we can still collect."

Municipal health officer D

Fourth, the low benefit coverage and delayed PhilHealth payments discourage the LGUs from filing claims. Despite Philhealth's potential to increase financing for PHC, too many issues in getting reimbursements from PhilHealth make it an unreliable funding source for study municipalities. Municipal accountant B, for instance lamented that they received so little payment from Philhealth that it would take years before the health facility could use this income in a meaningful way. Since PhilHealth does not pay the full cost of its benefit packages, LGUs ensure that the same services are budgeted by the local government. Given that the LGU can operate the health facility with or without income from PhilHealth, LGU health providers are not compelled to make their claims filling efficient. **Table 6** shows that

Municipality B earned less than one percent of their local budget from PhilHealth for the four most used benefits in primary care, while **Table 7** shows that they filed an insignificant number of claims considering the LGU's population size. M-A also expressed the need to develop the capacity of the RHU or the midwife managing the local birthing facility to file claims conscientiously so as optimize the income from PhilHealth. The midwife however, does not see this capacity gap as her responsibility. Even when the LGU gets paid, M-C tends to forget these funds since it is not her but the municipal accountant's office that is informed when PhilHealth payment comes through.

Fifth, poor dissemination of changes in PhilHealth policies prevent health facilities from using PhilHealth. When PhilHealth revoked the point of care (POC) enrolment for pregnant women, the head midwife of a birthing facility in Municipality A felt discouraged. Her strategy was to campaign with the barangay chairpersons to enroll their poor populations in PhilHealth.

> *"We really had difficulty because many of our claims had been denied because of expired PhilHealth membership of our patients. So, I visit the barangay councils in my catchment population to encourage them to enroll their constituents with PhilHealth."*
>
> *Midwife, Municipality A*

The POC was replaced by a similar policy called Point of Service Enrollment Program[13] in 2018, where the insurance premium of the poor was paid by the national government and not by the LGU. Under the new policy, pregnant mothers continued to be covered when they were admitted but the new mechanism of registering these patients was not fully explained to the midwife, thus her team was not filing claims for these patients and missed the opportunity to get paid.

> *"In the past, we could file claims for mothers who have been enrolled at the point of care. But when PhilHealth revoked the policy, our claims were denied because the PhilHealth membership of many of our patients had expired."*
>
> *Midwife, Municipality A*

Although not experienced by the LGU respondents, another reason that MHOs are not keen in getting reimbursement from PhilHealth is that some LGUs do not give the professional fee that is due to the RHU personnel, in violation of PhilHealth accreditation policies (Aldaba & Encluna, 2017; Liwanag & Wyss, 2018).

Donations

Municipality A, B and C have regular activities with and support that comes from the private sector. M-A reported that private hospitals donate slow-moving drugs (e.g., tranexamic acid) and other supplies (e.g., examination table pads, drape) to RHU/birthing facility in the

[13] PhilHealth Circular 2018-0008. Guidelines on the Implementation of Point of Service (POS) Enrolment Program under the General Appropriations Act (GAA) 2018 Onwards

barangay. M-B described support from government hospitals like East Avenue Medical Center and Philippine General Hospital for regular blood banking activities as well as getting cost-sharing on women's health projects (e.g., hygiene kits for pregnant women, screening for HIV/AIDS) with NGO partners like Zonta International. M-C described the regular funding provided by the town's Association of Overseas Filipino Workers (OFW) to procure needed equipment that remain unfunded. Although not a regular funding source, Municipality accountant D added that their LGU received a donation of PHP 1 million from the provincial government to procure medicines.

4.4 Local planning as a mechanism to consolidate various resources

Planning team, planning, and budgeting process

All respondent MHOs explained that all PHC resources are organized and consolidated through the local health plan or the Annual Investment Program, following the planning and budgeting schedule set by the Budget Call issued by the DBM. The MHOs, as department heads, prepare the health plan of the municipality, which are based on the health needs of the municipality as well as the development goals of the country, the health sector and the LGU.

The leadership of the mayor, in ensuring the compliance of department heads to planning and budgeting guidelines, compels the MHO to prepare the health plan accordingly.

> *"I really appreciate the way that the LGU governs its finances because we strictly follow the proper budgeting, planning and procurement procedures. No office can just request for budget without including that in the AIP. This way, budgeting and spending are straightforward and according to rules. I think it is only with the current mayor that I could see compliance to these procedures. And I really appreciate it much."*
>
> *Municipal health officer C*

In Municipality C, the LGU planning team (Box 1) ensures the development, implementation, monitoring and evaluation of Local Investment Plan for Health (LIPH). They review the current health program, outcomes, and system performance, LGU Scorecard benchmark, previous LIPH/AOP, Annual Investment Plan and other related data to identify any gaps in local health program and performance. M-C described the LGU planning vis-à-vis the LIPH as follows:

> *"First, we do our medium term (3 years) plan, the Local Investment Plan for Health. And from there we cull out our Annual Operational Plan (AOP). And that is where we based the budget that we propose for the LGU. Once proposed in the LGU, we undergo the budget call and budget deliberation where we are able to defend our respective budgets. Until such time that they get approved and included in the LGU annual budget. So, monitoring of the utilization is done through the monthly release of the allotment release obligation. That way we know how much of our budget has been*

implemented and not been implemented. So, for the procurement of medicines and other supplies, they undergo the proper canvassing ang bidding procedures. All supplies and equipment to be bought are to be posted in PHILGEPS".[14]

BOX 1. Composition of LIPH Planning Team and development process, Municipality C
Composition of LIPH Planning Team

The LIPH Planning team is composed of the municipal mayor, the Municipal Health Officer, Development Management Officer, president of Association of Barangay Chairpersons, Sangguniang Bayan (town legislative council) Chair on Health. The planning also involves other health personnel like the public health nurse, rural health midwives, the medical technologist, sanitary inspector, the HRH personnel (DOH deployed), and representatives from Barangay Health Workers (BHW) and the Barangay Nutrition Scholars (BNS). Non-health personnel in the LGU such as the Indigenous Peoples representative, Municipal Budget Officer, Municipal Planning Coordinator, Municipal Accountant, Municipal Treasurer, and the Municipal Disaster Risk Reduction Officer are also involved in the Planning process.

M-B described the annual planning workshop of the LGU as an opportunity for teambuilding among LGU department heads, which also helped him make a case for more investment in health. In collaboration with relevant offices, he was able to develop a public health program under the GAD budget. Similarly, M-C was able to collaborate with Local Disaster Risk Reduction and Management Office in blood donation program.

Prioritization

All respondent MHOs agree that their respective mayors let them identify health priorities and develop the local health plan that will be incorporated in the Annual Investment Plan. They believed that they have their mayor's confidence as the local health expert.

"Prior to LGU planning and budgeting, I would present the health priorities to the health board. This way I could get the support of the mayor."

Municipal Health Officer D

Increasing the awareness of the mayor on the importance of health outcomes, like maternal death, through training can help make the case for increased budget for health. M-A observed that their mayor has become more supportive of maternal and child related projects after she underwent the Municipal Leadership and Governance Program[15] training.

[14] PhilGEPS or Philippine Government Electronic Procurement System, is the single, centralized electronic portal that serves as the primary and definitive source of information on government procurement. https://www.philgeps.gov.ph/

[15] Zuellig Family Foundation (ZFF) has implemented leadership and governance capability building programs for health in various rural municipalities in the country. Assessment of ZFF's initial cohort municipalities in 2012 showed

However, the mayor can also veto a budget proposal for any activity that is contrary to his/her conviction. M-A requested funding to intensify the campaign for HIV/AIDS prevention and control, considering that the town has the second highest number of HIV positive cases in the province. The mayor, however, slashed the budget, interpreting the strategy as spotlighting homosexuality. On the other hand, when the mayor becomes aware of the health issues like maternal deaths and the strategies to prevent them, he or she becomes the MHOs ally in getting more resources for PHC.

> *"When our mayor undertook the Health Leadership and Management Program, she became more active in supporting effective health interventions. Example is investing in and promoting facility-based delivery because she now understands that"*
>
> *Municipal health officer A*

Unfunded PAPs

All four MHOs admitted to inadequate funding for PHC, which was echoed by the mayor of Municipal A. All of them mentioned the DOH recommendation of health financing for LGU at 15% of IRA but they also acknowledged that LGUs are not able to budget accordingly because of so many competing needs. However, two of the four MHOs emphasized that even the unfunded PAPs must be included in the plan.

> *"I am the one who prepares the Annual Investment Plan. There are programs within it that are unfunded but we still put it there because within the year when we have supplemental budget, we get funding for those activities."*
>
> *Municipal health officer D*

> *"In our LGU, we really stick to our plan. The administration actually instructs us: if we want a project to be funded, it has to be included in the plan, then we propose the budget for it. It is very hard to realign funds. So even the unfunded one, should stay in the plan"*
>
> *Municipal health officer C*

All respondent MHOs have deployed various strategies to mobilize resources for unfunded PAPs, including:

a) Using income from PhilHealth. Municipal Accountant D informs the MHO of the balance in PhilHealth income.
b) Increasing the budget of one health program to cover the requirements of another. As exemplified in Municipal A, the MHO proposed a higher budget for health promotion

declining maternal mortality using ZFF's health change model. https://zuelligfoundation.org/our-programs/public-health-leadership-formation/ for more information about the program.

activities for TB control to cover the health education for HIV/AIDS prevention and control
c) Preparing a proposal to tap other line items in the LGU budget like GAD and LDRRM
d) Requesting funding support from DOH through LIPH
e) Counterpartying with private partners and NGOs to implement the programs
f) If within the fiscal year, realigning funds from other line items in the HPN
g) Requesting funds from Supplemental budget

Procurement

The procurement process follows procurement law, and MHOs oversee procurement according to health plans. However, a lack of local suppliers for medical equipment and other medical supplies results to failure of bidding.

Monitoring of budget execution

Two of four respondent MHOs used tools to monitor the utilization of their budget. M-B meets with the Municipal Budget Officer on a regular basis to review the Statement of Allotment, Obligation and Balances (SAOB) of the health department. The SAOB shows the allotment, the obligated amount (for the month and cumulative) and the unobligated balance of the allotment per expense class. M-C, on the other hand, reviews the Allotment Release Order (ARO) that she receives every month. This report also contains the allotment, expenditures, and balances per expense class. At the national level, DOH requires the submission of fund utilization reports at the end of the year and PhilHealth respondents confirmed that they require a service utilization report every quarter.

While the LHB[16] of all study LGUs meet on regular[17] basis, the MHOs usually report on the public health program accomplishments and targets. The DOH respondent recognizes the need to strengthen the LHB especially in integrating the local health systems into province-wide health system as mandated by the UHC Act.

Challenges in consolidating resources in health plans

While M-B, M-C and M-D considered LIPH as an opportunity to request for costly items (equipment, personnel, infrastructure) from DOH, M-A opined that the process is burdensome since the timeline for LIPH preparation is not aligned with the LGU planning cycle (**Annex C**). The respondent from DOH concurred with this observation. M-A also recalled that the Provincial Health Office (PHO) only gives her two days to submit inputs for LIPH and encourages her to use the LIPH as an avenue to request for whatever her municipality needs. Because of this process, she believes that LIPH has become a mere wish-list. She further noted that the menu that DOH provides is restrictive and does not respond to her LGU needs.

[16] The Local Health Board is the governing body mandated by the LGC to oversee the local health system. The LHB is chaired by the mayor, co-chaired by the MHO and includes the Sanggunian Bayan (municipal legislative council) Chairperson for Health, NGO representative and DOH representative as members.
[17] Monthly/quarterly basis, but also called by Mayor if there an urgent matter needs to be discussed.

When it does align, DOH requires cost-sharing[18] in some activities, which becomes a challenge during implementation: procurement at DOH regional office can take so long that the needs for a particular activity are not procured on time (e.g., venue for a training). All respondents, both national and local, recognize the need for better alignment of LIPH and AIP planning timelines and effective monitoring of health spending.

Retention and use of PhilHealth Income

Providing fiscal autonomy to government health facilities, a key strategy in Healthcare Financing Strategy (DOH, 2010), can be achieved by allowing them to collect, retain, and allocate revenues (whether from Philhealth or from socialized user fees that the LGU charges to those who can pay) to reduce their dependence on LGU budgets. While the user fees collected from RHU services are considered income of the LGU, all local respondents agreed that the income from PhilHealth is kept for RHU use and MHOs should decide how this income is used. This becomes possible when the LGU complies with the PhilHealth requirement of creating a special trust fund for PhilHealth payments, and as such, income from PhilHealth can only be used for the purpose the trust fund is created. As explained by the accountant in Municipality A, the MHO is the fund administrator of the trust fund. However, not all LGUs comply with this directive from PhilHealth as previously reported (World Bank, 2019), and the income from PhilHealth gets mixed up with other revenues of the LGU in the general fund.

PhilHealth income is not treated as part of the HNP budget in the preparation of annual health plans because of the unpredictable timing of its release and frequent changes in PhilHealth policies as discussed previously. As a consequence, M-A and M-C do not know the current balance of their income from PhilHealth unless informed by their accountants. On the other hand, the accountant of Municipality D advises the MHO of the remaining PhilHealth income, triggering a work plan against this resource. All respondent MHOs considered PhilHealth income as an additional resource, which is not included in their annual plans. Rather, they use the funds for RHU needs that are not funded by the LGU. Nevertheless, M-A, M-C and M-D expressed dissatisfaction at the loss of income from the PhilHealth capitation payment over the past three years (Table 6) caused by the faulty EMR system that PhilHealth requires them to use. PhilHealth has also suspended the payments for the PCB package since 2020 to focus on piloting the updated PCB package (called Konsulta) in selected municipalities.

4.5 Forthcoming Changes in Financing PHC

Despite various efforts, funding for health remains inadequate (Manasan, 2005; Diokno, 2012; Cuenca, 2018). The implementation of two laws, Mandanas Doctrine and the UHC Act, is expected to raise the financing of PHC. The Mandanas Doctrine will increase the IRA of municipalities by 55 percent by 2022, while removing DOH support for local health facilities and health personnel deployment support to LGUs. The UHC Act, on the other hand, mandates the integration of municipal health systems into a province-wide Health Care

[18] As an example, DOH funds the speakers, their transportation and accommodation and the venue of the training while the LGU covers the cost of per diem and transportation of their participants.

Provider Network (HCPN), within which the Primary Care Provider Network (PCPN) is lodged. The law also creates the Special Health Fund that will pool funds from municipal budget, DOH grants and PhilHealth payments at the provincial level. These pooled funds will be managed by the Provincial Health Boards.

Mandanas Doctrine

Of 13 respondents, only seven (one DOH respondent, two MHOs and four municipal accountants) recognised that this means there will be a substantial increase in their LGU income. The respondent from DOH was also aware of its implications to the agency's budget. As she explained:

> *"DOH will be unburdened with LGU devolved functions particularly on public health programs. For example, LGUs will manage fully these critical public health programs which used to be supported by the DOH, like TB, family planning, procurement of commodities, among others*
>
> *"I can see that with increase in IRA, frontline workers/community navigators (e.g., Barangay Health Workers, Barangay Nutrition Scholars) for health who are currently receiving just a meagre allowance from the LGU will be given proper compensation"*
>
> *Municipal Accountant, Municipality C*
>
> *"Mandanas Ruling will provide significant increase in the LGU budget, but how much will go to health is not known. There is no specific proportion of allocation for health. There are many units in the LGU that will be competing for the allocation. PAPs that are previously supported by the DOH might be affected. Hence, public health programs will suffer"*
>
> *Municipal Health Officer and Municipal Accountant, Municipality D*

The municipalities, however, are less aware of its implications on the resources that they receive from DOH. For instance, the compensation of health personnel deployed to study LGUs as well as the cost of enhancing their health facilities and procurement of medicines and other commodities will become continuing expenses that have to be absorbed by the LGUs. Municipal Accountant C recalled that implementing the Mandanas Doctrine will require LGUs to budget for previously unfunded devolved functions. On the other hand, DOH will be relieved of implementing critical public health programs, which may result in a reduction in the workforce for affected DOH units. The implementation of Mandanas is consistent with Mayor A's opinion that:

> *"the budget of DOH is so large that it should be devolved to the LGUs, where we can really prioritize our health needs. Given that our income will increase, I will create more positions in health. Our town population is increasing so we need to hire more health workers, especially specialist doctors."*

Challenges in implementing the Mandanas Doctrine

Aside from the recommendation of DOH that 15% of IRA should be allocated for local health spending, there is no law or policy mandating a specific percentage of appropriation for health. M-B believed that increasing the LGU income without a clear percentage of allocation for health could jeopardize current health funding. M-D echoed the same sentiment. This is because the current support they get from DOH (health personnel, funding for infrastructure and program management) will be greatly reduced while these expenditures might not be supported at the LGU level since every LGU sets its own priorities and has the autonomy to allocate their budget accordingly.

Municipal Accountant C pointed out that while there will be a substantial increase in their IRA, it would still be difficult for their LGU to manage this increase because so many expenditures have already been identified for it. She believed that health should be prioritized.

Universal Health Care Law

The UHC law delineates who pays for what health services. DOH and LGUs will cover population-based services while PhilHealth will contract and pay health care providers for individual-based interventions, thereby removing overlaps in health spending, preventing duplication in health financing and institutionalizing the gatekeeping at the primary care facilities. Building PCPNs within the province-wide health system is envisioned to rationalize the use of PHC resources, including sharing of health personnel and bulk (pooled) procurement of medicines and other health commodities.

The law also stipulates province-wide pooling of all resources for health services through a Special Health Fund (SHF), including financial grants and subsidies from DOH and other national government agencies, income from PhilHealth payments and other sources like financial grants and donations from non-government organizations and Official Development Assistance. The provincial, component city and municipal governments may also opt to transfer their local health budget to the SHF through a mechanism of cooperative undertaking as provided under the Local Government Code. The SHF will consolidate the various resources intended for PHC.

> *"To efficiently execute these services, municipal health systems will be integrated into province-wide or independent city into a city-wide health system. Resources allocated for the delivery of health services will be pooled in a Special Health Fund (SHF) to be managed by the Provincial or City Health Board, as provided by the law. The SHF will consolidate the DOH financial grants, PhilHealth reimbursements, grants/donation, as well as local budget intended for health."*
>
> *Director, Bureau of Local Health Systems and Development*

All MHOs in study municipalities agree that service delivery arrangements will be improved under the UHC Act but pooling of funds under SHF raises implementation questions. While SHF may serve like PhilHealth's special trust fund in study municipalities, holding all PhilHealth

payments for both PHC services and for LGU hospitals reimbursements, local respondents articulated concern over the management of SHF at the provincial level:

> *"It would be difficult for us to spend the funds if the management of SHF will be at the provincial level. I will provide the services for my constituents and yet I might have hard time to get the funds we need it for the delivery of PHC. It is likely that appropriation and use of SHF will be affected by political dynamics."*
>
> *Municipal Health Officer, Municipality C*

Local accountants in study municipalities opined that while transferring the municipal health budget to SHF is achievable, ensuring that commodities are available in timely manner might be challenging. As the accountant of Municipality B shared: *"Based on experience, it is faster for us at the municipal level to transfer the provincial share of real property tax than the provincial government remitting to us our share."* This is echoed by the municipal midwife who observed that provincial payroll is often delayed, unlike the timely release of salary in her municipality.

The mayor of municipality A had no strong opinion against the SHF but expects local facilities will be better equipped and adequately stocked with essential medical supplies when their municipality contributes to the pooled health funds. She also expects that her constituents will no longer seek financial assistance for health care from LGU because RHUs would provide patients with needed medicines and the provincial hospital located in Municipal A would have complete services. She believes that the system should improve so that patients are not foregoing care because of its cost and that they are not paying out of their pockets to access services.

All respondent MHOs believed that they have been managing the local budget well, responding to their LGU's health needs and mobilizing resources for any unfunded activities.

> *"I am confident that current arrangement of funding for PHC services in my municipality is effectively working. Our Municipal Mayor gave me the autonomy to determine where the funds/budget will be spent since I know the priority programs of the municipality. We already set our systems and we are fine. The Provincial Health Board is not aware of the program priorities of the municipality/s. Allocation of funds may not be fair and equitable if someone outside our LGU will oversee the management of funds. Health programs that are currently working (e.g., zero maternal deaths, elimination of schistosomiasis) may suffer".*
>
> *Municipal Health Officer, Municipality D*

> *"We had experience in pooling of resources under an inter-LGU agreement but fund utilization was not reported to the contributing LGU"*

Municipal Accountant, Municipality D

BOX 2. Pooling of Funds using Special Trust Fund

Through a municipal ordinance, a LGU creates a special trust fund to hold PhilHealth payments for specific benefit packages including PCB, TB-DOTS and maternal/neonatal care package. In cases where a RHU facility has already created a Trust Fund, subsidiary ledgers for each benefit package are maintained to track the utilization of income from these benefits. DOH also requires that the funds for PHC Programs transferred through DOH regional offices are also put in a special trust fund with disbursement guided by a Memorandum of Agreement (MOA), signed by the municipal mayor and DOH regional director. DOH allots grants to LGUs as requested by the LGU in their Local Investment Plan and to support specific public health programs.

The UHC law also mandates the creation of PCPN within the health care provider network, which means transferring the municipal human resources and health facilities under the management of provincial government. This arrangement will require a Memorandum of Agreement among participating municipalities and the provincial government since the autonomy of municipalities remain under the UHC law.

"Creating the HCPN clarifies the roles and responsibilities of providers along various levels of care. In fact, in our part of the province, municipalities have already agreed to sign the MOA ".

MHO, Municipality A

The Joint Memorandum Circular on the Guidelines on the Special Health Fund[19] creates the Management Support Unit (MSU), which will provide administrative and technical support to the Provincial Health Board, coordinate with province-wide stakeholders, support the operations of PCPN in applying for DOH license and PhilHealth accreditation, and manage SHF including the filing of PhilHealth claims. In this manner, the time of health facility staff will be fully dedicated to clinical and program management.

"In our municipality, we hired contractual staff to facilitate any transactions with PhilHealth. This includes preparation of documents for accreditation and claims reimbursements. This unburdened us with paper works and makes us focus with clinical management and execution of public health programs. We were able to submit PhilHealth claims on time and in return PhilHealth pays us. However, lately, there were some delays in PhilHealth payments".

Municipal Health Officer, Municipality of D

[19] DOH, DBM, DOF, DILG, PHIC. 2021. Joint Memorandum Circular 2021-0001. Guidelines on the Allocation, Utilization, and Monitoring of, and Accountability for, the Special Health Fund. Manila, Philippines.

Challenges in implementing specific provisions of the UHC law

Most of the local respondents believe that the lack of a clear mechanism for redistributing the SHF is a major concern in its implementation, especially if allocation decisions are subject to political influence.

> *"If funds will be managed by the Board it will mean lesser work for me, which is fine with me. However, the delivery of services for the constituent will be affected if the money will not be distributed fairly. If the LGU is not part of the ruling political party, that LGU will be left with a meagre budget to be spent for the constituents. I hope this does not happen."*
>
> *Municipal Accountant, Municipality of C*

Another concern for the MHOs is losing control over their resources. Once the municipal government has an allocated budget for health, the MHO has the authority of utilizing this budget. This will change once the municipal governments pool their resources with others under the SHF. As explained by the MHO in Municipality C: *"If funds will be pooled, municipalities that are part of the province-wide health systems will no longer have control over allocation, expenditure, and disbursement of the funds. I am worried on how funds will be managed if DOH grants and PhilHealth reimbursements will be pooled into the Special Health Fund".*

Moreover, municipalities that are earning well from Philhealth may lose motivation as their income could be redistributed to municipalities that are not accredited, and therefore not earning from PhilHealth.

> *"If not all municipalities will commit to pool resources, the priority programs may not be funded adequately. Also, those who are earning more from PhilHealth because they have more accredited services will not have the incentive anymore since their income will be redistributed even to those municipalities that may not be earning from PhilHealth.*
>
> *Municipal Health Officer, Municipality A*

5. Discussion

This study aims to identify the sources of funds for PHC, explain the mechanism in consolidating them and identify the challenges of implementing two new legislations, Mandanas Doctrine and UHC Act, in increasing and consolidating resources for PHC at the municipal level. Inadequate allocation for primary health care at the municipal level triggers various ways to raise resources: internally, from other line-items in municipal budgets, and externally, from DOH, PhilHealth and civil society in the form of donations. Increasing resources for PHC depends on the capacity of municipal governments to raise revenues. Previous studies show that continuing dependence of LGUs on the IRA and other funding support from national agencies like DOH may disincentivize municipalities to raise local revenues (Diokno, 2012; Lavado, et al., 2017; BLGF, 2015). Moreover, varying capacity of LGUs to raise local revenues due to differences in managerial capacity and political will contribute to underspending for health (Panelo, et al., 2017). Although PhilHealth can provide substantial funding for PHC, as demonstrated by Municipal D, cumbersome filing of claims, poorly disseminated PhilHealth policies, PhilHealth payments lower than expected and huge delays in payment render this revenue stream unreliable. A similar finding has been reported in Kenya where primary health care facilities are losing funds as they continue to provide free maternal care under the National Hospital Insurance Fund without getting reimbursements (Vilcu, et al., 2020).

Local health planning as a means to consolidate various funds for PHC

As indicated by the illustrative quotes, the consolidation of fragmented funding sources for PHC is done through the preparation of municipal health plans and integrating these with annual investment plans. Despite improvements in local planning and budgeting procedures, the municipal plans are not always incorporated in the provincial development plans and investment programs (Sicat, et al., 2019). Several factors render health planning an ineffective tool in consolidating financing for PHC. First, the political and technical interplay in prioritization. The LGC has granted decision-making power over devolved functions to the mayor who may not always prioritize public health interventions. Similar to illustrative quotes regarding mayors' priorities in hiring specialists rather than investing in PHC, previous studies have reported that divergent priorities between elected officials and local health officers result in misaligned spending for health. Further, disagreement between them could result in reduced local government support for health facilities and logistics management, forcing MHOs to rely on funding from DOH (Liwanag & Wyss, 2020). Political considerations drive prioritization and implementation of primary care services like maternal, newborn and child health (MNCH) services (La Vincente, et al., 2013), and mayors' re-election status can have significant effects on their ability to mobilize greater resources for local health and improve select health service outputs (Capuno & Panganiban, 2012). Hipgrave and colleagues (2019) reported that while governments can demonstrate political commitment to health like MNCH, the health sector receives comparatively low levels of public financing because departments of health often do not follow through on plans or pronouncements, and capacity to implement varies widely.

Second, a lack of guidance on how much to allocate for primary health care leaves the health budget under the discretion of elected officials. While LGUs are mandated to allocate a certain percentage of their budget to some programs like GAD and LDRRM, the lack of a mandated percent allocation for health, coupled with LGU's autonomy in decision-making, has resulted in substantial variation in health spending among provinces, cities and municipalities, and differences in the amount of health services offered to constituents (Lavado, et al., 2017). The MHOs understood that without a mandated target in local health spending, they need to constantly lobby for more funding for PHC as health competes with other devolved functions. This indicates that LGUs need guidance on how much investment is needed for PHC at per capita level to guide resource allocation. The perception of an adequate local budget for health (i.e., higher health budget in rich municipalities) vis-à-vis administrative burden in generating income from PhilHealth (i.e., cost of accreditation, challenges in filing of claims) may not compel MHOs to optimize income from PhilHealth (World Bank, 2019; Obermann , et al., 2018). The respondent MHOs do leverage their knowledge of DOH policies and local health performance measurements to lobby for increases in the LGU health budget as well as to ensure that PhilHealth payments are used only to remunerate health personnel as well as to fund health services. They also use all available information to make the case for a larger health budget. For instance, MHO C effectively used the red ratings in their LGU health score card to secure more funding for poor performing health programs as well for hazard pay for public health workers in their town. This observation is consistent with earlier findings that decision space at the local levels of a devolved health system like the Philippines is effectively used when the capacity of decision-makers are built (Grundy, et al., 2003; Liwanag & Wyss, 2019).

Third, the timing of preparation of LIPH is not in sync with the municipal annual investment planning, thereby putting additional administrative burdens on recipient municipalities without necessarily producing a masterplan for a province-side health system that can inform the efficient allocation of resources (Lavado, et al., 2017). External resources (like DOH support) do not necessarily become available according to the plan's timeline and any delay in their release is likely to impact on the delivery of health services. This is where DOH can promote accountability by requiring a functional LHB as a precondition to the approval of local health plans and monitoring the satisfactory implementation of local health plans before further support from DOH could be expected (Liwanag & Wyss, 2019).

Fourth, while holding the income from PhilHealth in a trust fund serves as an income retention mechanism for the RHU, thereby allowing the MHO to allocate this revenue for health services, study LGUs do not plan for these funds as they are not a reliable source of funding (Lavado, et al., 2017). Income from PhilHealth is also not considered when LGUs report the percentage of LGU budget allocated for health as this is not included in the indicator's formula (DOH, 2019). Similar to DOH oversight over investment plans for health, Philhealth can improve the utilization of PhilHealth benefits through proper dissemination of policies and monitoring its implementation (Liwanag & Wyss, 2019).

Laws that will consolidate funding for PHC

The Mandanas Doctrine and the UHC Act will address the problems of inadequate funds for devolved functions in LGUs and the fragmented sources of financing in local health systems respectively. While Mandanas will increase funding at the municipal level, respondents articulated the concern that this increase would not guarantee higher allocation for health as there is no mandated target in health spending for PHC. Currently, study municipalities have allocated less than half of the DOH recommended 15% of their local budget (IRA + local revenues) to health. Moreover, their per capita recurrent spending on PHC (between $5 and $19) is less than a third of the projected resources needed for PHC, which is estimated at $59 per capita (Stenberg, et al., 2019). Study LGUs' spending may also be underestimated considering that their reported total income does not take into account the resources from DOH and PhilHealth, which are held in special trust funds. Aside from the LGU Health Scorecard indicator of 15% of municipal budget allocation for health (DOH, 2019), no other national policy sets the expenditure target for PHC. However, there is no indication that this target is mandatory as this has not been incorporated in the budget circulars issued by DBM to guide LGU planning and budgeting.

Internationally, government spending targets for PHC have been debated for decades, including the suggested 5% of gross domestic product (Patel, 1986) and methodological challenges in measuring PHC spending (Vande Maele, et al., 2019). The need to establish normative financing thresholds for primary care is echoed in research priorities of low- and middle-income countries (Goodyear-Smith , et al., 2019). In the Philippines context, this financing threshold is even more critical if the increase in IRA is designed to meet deficits and gaps, as there will be no incentive to use own-source revenue handles and manage spending efficiently (Brosio, 2014).

The UHC Act, on the other hand, will reorganize health service delivery and pool resources at the provincial level to enable the redistribution of available prepaid funds (from PhilHealth, DOH and LGU budget) as well as reduce the administrative cost of managing various pools lodged in component municipalities. However, without amending the LGC, the autonomy of municipalities to manage their respective budget remains. Municipal government participation in the province-wide health care provider network, or the PHC network, as well as their willingness to pool local resources into the SHF is subject to negotiation at every election cycle (mayors are elected every three years, with maximum of three terms). Illustrative quotes indicate major concerns over pooling of resources at the provincial level, as previous reports did not show inclusiveness and effective integration in organizing health investments though province-wide investment plan for health and local planning (Lavado, et al., 2017; Sicat, et al., 2019). Moreover, a recent report in operationalizing the service delivery network in the country shows insufficient funding per capita and a lack of capacity in financial management including service contracting (La Forgia, et al., 2020). Other studies also point out that critical capacity must be in place in priority setting and resource allocation, especially in devolved settings (Vande Maele, et al., 2019; Liwanag & Wyss, 2019; Tsofa B, et al., 2017). Respondents also pointed out that mayors' decisions became more supportive in health planning and prioritization when their capacity is increased. A formative evaluation of the Health Leadership and Governance Program (HLMP), a training provided by the Zuellig

Family Foundation to municipal mayors and their MHOs, shows that the HLMP training is associated with the functionality of the Local Health Board (LHB), which translates to better development of municipal health action plans (Nieva , et al., 2018).

The LGC was implemented to bring health services closer to the people by transferring the decision-making authority and resources from the national government to local government units to provide devolved health services. However, the pooling structure became fragmented into distinct pools as IRA was transferred to 1,715 LGUs[20] to finance devolved health services. DOH support and PhilHealth payments further contributed to fragmentation by adding two more pools that further increased the administrative cost and reduced the efficiency of using these various funding streams. As efficiency gains from these pooled funds diminish, dependency in OOP spending can increase (Mathauer, et al., 2019). International literature highlights the importance of pooling resources in spreading financial risk across the population, thereby protecting patients and their families from having to pay the full costs of health care. However, this UHC goal is not achieved because of fragmented pooling structures in countries pursuing universal health coverage (McIntyre, et al., 2008; McIntyre, et al., 2013).

The interdependencies across the (1) laws that provide decision-making authority to LGUs and the policies that guide the planning and budgeting at the municipal level, (2) the management capacity of both elected officials and municipal health officers in generating resources for PHC, priority setting and resource allocation, and (3) the accountability mechanisms that can be enforced by the national agencies (DOH and PhilHealth) are critical in consolidating fragmented resources for PHC. The forthcoming implementation of Mandanas and UHC Act calls for increased management capacity of local policymakers and MHOs, especially on effective financial and technical management (Office of the President of the Philippines, 2021; La Forgia, 2020).

Limitation of the study

Although cities also provide PHC, this study focused on municipalities since cities have better earning capacity from local taxes and may not face the same challenges in raising resources for health as municipalities do. Time and quarantine protocols constrained the team from engaging more LGUs as well as securing more LGU documents. As such, the insights generated from this study do not provide the picture for the entire country. However, it would be interesting to do an expanded study with more study LGUs when Mandanas Doctrine and UHC Act have been fully implemented.

[20] 81 provinces, 146 cities and 1,488 municipalities as of September 2020. Regional and Provincial Summary – Number of Provinces, Cities, Municipalities and Barangays as of 30 September 2020 – Facts and Figures – DILG

6. Conclusion

This study highlights the degree of fragmentation in health financing in the Philippines, particularly in funding PHC. The fragmented pooling structures are brought about by devolution, with funding transferred to various layers of the government. The MHOs, being responsible in providing primary health care in the municipality, maximize the opportunities to raise more resources by tapping other municipal line-item budgets, requesting support from DOH through local investment planning for health, getting income from Philhealth and mobilizing support from various external partners. They attempt to consolidate these various streams of funding using their health plans. However, the influence of the mayor in prioritization as well as the huge administrative cost because each funding stream requires specific process and documentation make health planning burdensome and ineffective. Putting RHU income and grants in special trust funds, although protective of its purpose, creates another layer of structure that requires another planning and procurement process.

Fragmentation is also the unintended consequence of evolving policies that do not address the fundamental issue of a fragmented governance structure. The UHC Act addresses this by merging resources at the provincial level. However, without amending the autonomy of each LGU in managing its own resources under the LGC, the prevailing concerns of MHOs arise from the political dynamics between the provincial and municipal governments that may or may not be favorable to them, the loss of their voice in allocating resources, and inadequate capacity of the provincial government to manage the pooled funds that would impact negatively in service delivery. Moreover, lack of clear guidance on how much to allocate for PHC and inadequate local capacity in raising local revenues and resource allocation are also identified as barriers in financing PHC.

Some policy options that could be considered in addressing the concerns raised by MHOs include (1) mandating a per capita spending target for PHC that is calculated based on preventive and outpatient care; (2) building the public financial management capacity of elected officials and MHOs as leaders of HCPN to encompass resource allocation across HCPN facilities, pooled procurement and priority setting for capital investments; and, (3) establishing a robust performance monitoring system that will inform continuous improvement in HCPN and PCPN operations. The mandated target for PHC spending, based on resource needs for both population interventions and general outpatient care, becomes an objective yardstick in allocating resources for PHC. Clear public financial management procedures and decision-making processes will realize the efficiency gains from merging the resources at the provincial level and promotes financial protection. Regular generation of robust evidence that demonstrates achievement of UHC goals will cement the confidence of local politicians and the public in the system and protect the pooling arrangements from negative political interventions.

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Annexes

Annex A. National programs that augment LGU funding for PHC
Annex B. Primary care and other related benefits covered by Philhealth
Annex C. LIPH and LGU Planning Timelines

Annex A. National programs that augment LGU funding for PHC

Over the years, DOH has adopted various strategies, either to augment LGU funding or drum up support to increase local financing for devolved health services (Capuno, 2008; Dayrit, et al., 2018). These include:

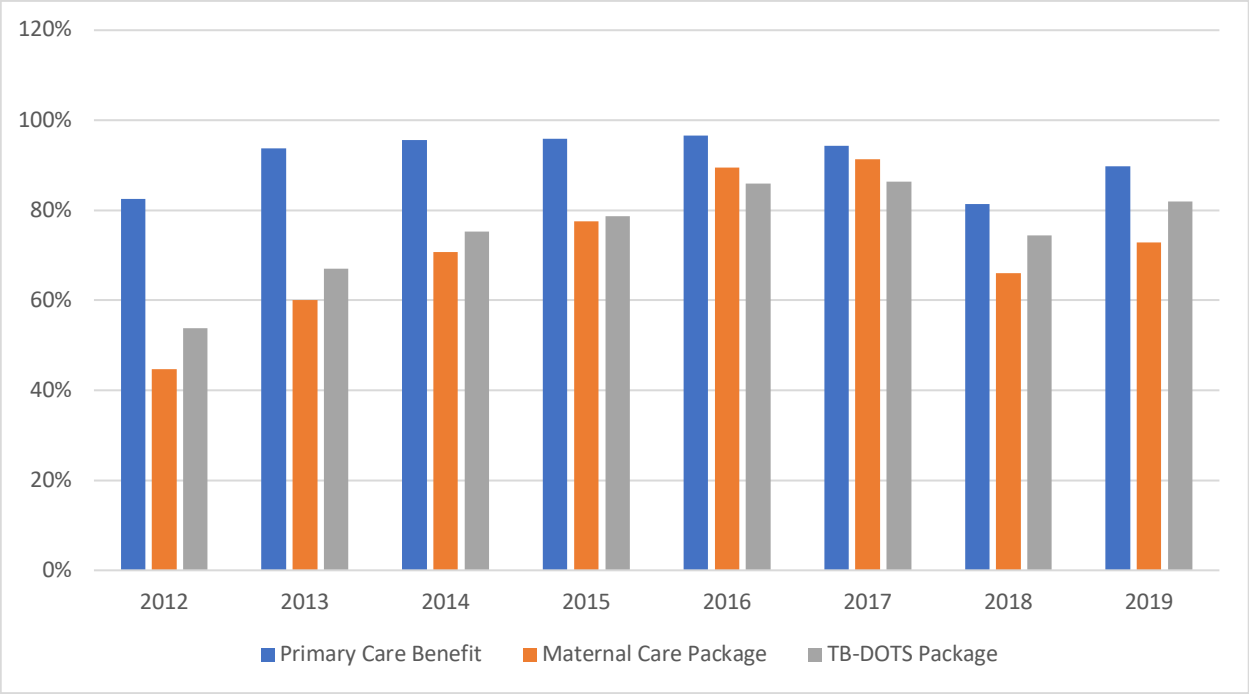
1. Sentrong Sigla Movement (SSM) is a certification program that imposed strict criteria to a PHC facility to qualify to receive an award. The award consists of a seal of excellence (Sentrong Sigla signage), cash awards and public recognition to the best among the qualifiers. The SSM criteria became embedded in PhilHealth accreditation, which guarantees PhilHealth payments for the services rendered by the primary care clinics.
2. DOH grants to construct or upgrade local health facilities through the Health Facility Enhancement Program (HFEP), with the objective of getting PhilHealth accredited. Income from PhilHealth becomes an incentive to upgrade the LGU facility to get accredited for more services that can be reimbursed by Philhealth.
3. DOH also deployed critical health personnel in LGUs. In 2018, the Human Resource for Health
4. Deployment Program deployed a total of 31,157 health professionals to augment the health workforce in LGUs. These include 456 doctors, 16243 nurses, 5022 midwives, 2640 public health associates and 6796 other allied health professionals (HPDPB, 2019).
5. Local Investment Plan for Health (LIPH) formulation process engages local chief executives, local legislative council member, the local budget officers, and planning and development officers, which builds better rapport and understanding between the local health officer and non-health LGU officials.
6. DOH allocating resources for capacity building and drugs and medicines for national public health programs like TB control, malaria control and maternal and child health care.
7. DOH also promoted Inter-Local Heath Zones (ILHZs) among provincial and municipal governments to take advantage of economies of scale in service delivery, the benefits of a working hospital referral system, and to contain negative interjurisdictional spillovers and health risks. Members of ILHZs are expected to share financial resources to fund common facilities, share critical health personnel and coordinate local health plans.

Annex B. **Primary care and other related benefits covered by Philhealth**

Benefit	How much per case
Expansion of the Primary Care Benefit to Cover Formal Economy, Lifetime Members and Senior Citizens (Revision 1)	An average of Php 800 ($16) per family per year
Outpatient Benefit Package for the Secondary Prevention of Rheumatic Fever/Rheumatic Heart Disease	Php 12,000 ($240) per patient per year
Enhancement of PhilHealth Newborn Care Package	Php 2,950 ($ 59) per case
Medical Detoxification Package	Php 10,000 ($ 200) per case
PhilHealth Subdermal Contraceptive Implant Package	Php 3,000 ($ 60) per case
Outpatient HIV/AIDS Treatment (OHAT) Package *(PhilHealth CIrcular 19, s.2010) Revision 1*	Php 7,500 ($150) per quarterly release payable to the HCI.
Revised Guidelines for the PhilHealth Outpatient Anti-Tuberculosis Directly Observed Treatment Short-Course (DOTS) Benefit Package	Php 4,000 ($ 80) per case

Source: various PhilHealth circulars

Percent of LGUs with Accreditation for Primary Care Benefit, Maternal Care Benefit and TB DOTS Package



Source: PhilHealth stats and charts, various years

Annex C. LIPH and LGU Planning Timelines

Planning	Local Investment Planning for Health	Annual Investment Plan*
Basis	Department Memorandum no. 2018-0386 2020-2022 Local Investment Planning for Health (LIPH)	Joint Memorandum Circular No. 1 Series of 2016 Updated Guidelines on the Harmonization of Local Planning, Investment Programming, Resource Mobilization, Budgeting, Expenditure Management, and Performance Monitoring and Coordination in Fiscal Oversight
Activities in Year 1 (Pre-election Year)		
November	• Issuance of DOH Memorandum on 3 Year LIPH Guidelines • CHD & LGU Orientation on LIPH Guidelines • LGU 3 Year LIPH and Year_1 AOP Planning Workshop	
December		
Activities in Year 2 (Election Year)		
January	• LGU Submission of Investment Needs to CHD • Review of LGU needs to be incorporated in the CHD Budget Proposal for Succeeding Year • LGU Investment Needs forward to National Program Managers • Review of LGU needs to be incorporated in the DOH Budget Proposal for Succeeding Year	
February		
March	• Finalization of DOH Budget Proposal for Succeeding Year • Feedbacking from CO → CHDs → LGUs regarding LGU needs consideration in the DOH Budget Proposal for Succeeding Year	
April		
May	• Incorporation of the feedback in the 3 Year LIPH and Draft Year_1 AOP • LGU Completion of three year LIPH and Year_1 AOP • Election Local Budget Call for Succeeding Year	
June		
July	• LGU and PDOHO review of 3 Year	• (Election Year) Reconstitution

	LIPH and Year_1 AOP • LIPH presentation to incoming LCE • LGU Submission of LIPH & Year_1 AOP to CHD • CHD Appraisal • Enhancement and final revision of LIPH & Year_1 AOP`	of Local Planning Team • Preparation of work plan for updating/preparation of CDP • RaPIDS/LDIS financial indicators from BLGF made available to cities and municipalities by DILG
August		
September		• (Election Year) Reconstitution of Local Special Bodies (Local Development Council, Peace and Order Council, Local Health Board, and Local School Board)
October	• LGU Approval & Endorsement to CHD of Final 3 Year LIPH & Year_1 AOP • The signing of Terms of Partnership between CHD and LGU for Year_1 AOP • LGU Planning for Year_2 AOP	• Authorization of the Budget (DBM)
November		• Mayor to present Structure List of PPAs • Medium-Term Forecast for Current Operating Expenses prepared by Local Finance Committee • BLGF to provide Medium Term Forecast to Local Treasurers
December		• Medium-Term Revenue (Own-Source and External) Forecasts for Planning Purposes generated by Local Treasurers • Sectoral Development Plans completes (Ranked List of PPAs completed) • Preparation of First Draft of LDIP: *New Development Investment Financing Potential component*
Activities in Year 3 (Post-Election Year)		
January	• LGU Submission of Investment Needs to CHD • Review of LGU needs to be incorporated in the CHD Budget Proposal for Succeeding Year • LGU Investment Needs forward to	• Finalization of LDIP: Finalization of Local Resource Mobilization Program and Medium Term Financing Plan • Drafting of Implementation Instruments: Legislative Requirements, CapDev

	National Program Managers • Review of LGU needs to be incorporated in the DOH Budget Proposal for Succeeding Year	Agenda and Monitoring and Evaluation Strategy
February		• Finalization of Implementation Instruments
March	• Finalization of DOH Budget Proposal for Succeeding Year • Feedbacking from CO → CHDs → LGUs regarding LGU needs consideration in the DOH Budget Proposal for Succeeding Year	• Approval of CDP to include the Implementation Instruments (LDIP, Legislative Requirements, CapDev Program, and M&E Strategy • Submission of CDP to the Province for review
April		
May	• Incorporation of the feedback in the Draft Year_2 AOP • LGU Completion of the Year_2 AOP • Local Budget Call for Succeeding Year	• Preparation of AIP by the Local Finance Committee
June		• Approval of AIP by the Local Sanggunian • Issuance of Local Budget Memorandum on IRA level for ensuing year by DBM • Issuance of Budget Call
July	• LGU and PDOHO review of Year_2 AOP • Year_2 AOP presentation to incoming LCE • LGU Submission of Year_2 AOP to CHD • CHD Appraisal • Enhancement and final revision of Year_2 AOP`	• Conduct of Budget Forum • Preparation and Submission of Budget Proposals (Department Heads
August		• Conduct of Budget Hearing
September		
October	• LGU Approval & Endorsement to CHD of Final Year_2 AOP • The signing of Terms of Partnership between CHD and LGU for Year_2 AOP • LGU Planning for Year_3 AOP (The AOP Planning Cycle is Repeated)	• Preparation of Executive Budget • Submission of Executive Budget to Local Sanggunian for Approval • Enactment of an Appropriation Ordinance
November		
December		

Note: (*) The activities presented are from the perspective of the Municipalities.