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**Decentralization of  
Health Systems:  
Preliminary Review  
of Four Country  
Case Studies**

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Ghana  
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## 2.4 Resource Allocation after Decentralization

### 2.4.1 Local Government

Fiscal policy has been the weakest element of the Ghanaian local government system under Law 207. The transfer of fiscal authority to the district assemblies, in particular, has been limited from the outset, and fraught with difficulties. Although the revenue situation of the districts in 1996 was poor, it was significantly better than prior to the 1988-89 reforms (Ayee 1996). As of 1996, only 3 percent of national revenues were spent through local governments in Ghana, an extremely low proportion even by regional standards (Mohan 1996). The 1992 Constitution called for the establishment of a District Common Fund, through which at least 5 percent of national revenues were to be distributed to the district governments. Although there have been complaints that the allocation formula is less than transparent (Mohan 1996), there has been evidence that district assemblies have made use of DCF resources to support capital investment in the health sector. Formula-based central transfers do not, at present, exceed the districts' own-source revenues (Ayee 1996).

The composition of district-level budgets has also changed in the wake of decentralization.

Investment in development and capital projects has increased from 3 percent of district budgets in 1986 to 13-15 percent in 1991. The lion's share of district budgets (85-87 percent) has continued to be devoted to recurrent expenses, but the composition of these expenses has changed somewhat. The proportion going to salaries has decreased, while administrative expenses, including perks for district officials, has increased. In one district it was noted that the amount spent on vehicles, travel, and entertainment of district officials was four times that spent on the development budget (Crook 1994). In 1995 an attempt was made to channel MOH funds through the DAs via the National District Common Fund Administration, but some of these funds were used for projects outside of the health sector for which they were budgeted. As a result of these problems, the program has been suspended and the Ministry of Finance (Mensah 1997) is holding the funds.

### 2.4.2 Health Sector

The MOH's fiscal decentralization program, based on the newly implemented BMC hierarchy, has already begun to show some significant results. Between 1996 and 1997, the proportion of government recurrent expenditure directed to the health sector rose from 7 percent to 8.4 percent. However, inflation eroded the value of expenditure so that, in real terms, expenditure in 1997 remained constant. The MOH's 1997 Five Year Programme of Work called for significant decentralization of resources to the regions and districts and away from tertiary care, as indicated in the Table 1 (MOH 1998)..2. Case 1: Ghana 19

**Table 1. Percentage of Non-wage MOH Budget Expenditures by Administrative Level Administrative Level 1996 1997**

Headquarters	28.0	29.0
Tertiary Care	31.3	22.0
Regional Health Services	17.0	25.0
District Health Services	22.8	34.0
Total	100.0	100.0

The early results of fiscal decentralization have been quite positive. While in 1995, only 10 percent of the non-wage budget was under district-level control (Hiscock 1995), by 1996 this had increased to 22.8 percent (MOH 1998). The proportion of the MOH budget that is spent on health care at different levels, channeled through the district level, has increased from 22.8 percent to 34.0 percent from 1996 to 1997, with a corresponding decrease in the percentage allotted to tertiary care from 31.3 percent to 22.0 percent over the same period (see Table 1 above) (MOH 1998). Between 1996 and 1997, the most influential increase in the recurrent budget is in salary and wages (MOH 1998). Overall, district recurrent expenditure has risen from approximately US\$ 25 million to US\$ 32 million between 1996 and 1997, a 5 percent real increase (MOH 1998). There is some concern over

interregional equity with respect to internally generated funds (IGF—user fees, cost-sharing, medical examinations, consultations, and drugs), which constituted approximately 19 percent of MOH expenditure in 1997 (MOH 1998: 33). Drug sales account for 46 percent of IGF revenues, while service charges including consultation and hospital fees provide the remaining 54 percent. IGF revenues in 1997 were C 24 billion (US\$ 1=Ghanaian cedis 3,438), a significant increase from the previous year, and nearly two and a half times what was expected. Some survey information indicates that the population feels that user fees are too expensive and that this may be a significant factor in underutilization of public health facilities, particularly in poorer areas. IGF revenues are generally used by facilities to cover non-wage operational costs, and exert a strong influence on the reallocation of health sector resources among levels as indicated in the Table 2 (note that columns do not add up to 100 in original source (MOH 1998: 38) .

**Table 2. Influence of User Fees on Allocation of Resources  
1997 Actual Recurrent Expenditure  
by Level**

	1996	1997 Budget	MOH	MOH + IGF
Headquarters	28.1%	22.3%	29.4%	<b>19%</b>
Tertiary Institutions	31.5%	31.5%	21.9%	<b>27%</b>
Regional	17.1%	16.5%	14.8%	<b>10%</b>
District	23.3%	37.6%	33.9%	<b>44%</b>
Total	100.0%	107.9%	100.0%	<b>100.0%</b>

The level of IGF varies considerably by region, from approximately US\$ 1.9 million annually in Greater Accra to around US\$ 200,000 in the Upper East. Likewise, there are variations within intraregional allocations, with wealthier regions allocating a considerably greater percentage of resources to the subdistrict level than do poorer regions (MOH 1998). This latter trend may be the result of greater concentration of resources in the regional and district hospitals within poorer regions. The lower-income regions exhibit greater limitations in management capacity of lower-level administrative units and primary care facilities, and hence may be more prone to internal fiscal centralization than wealthier regions.

**ZAMBIA****3.4 Resource Allocation after Decentralization****3.4.1 Local Government**

The revenue sources available to local councils include rent from council houses, property taxes, user fees for water, fishing, etc., license fees, and commercial fees. By law, 35 percent of local sales tax, which is collected by the central government, is to be remitted to the district councils. However, these funds are often delayed or not received at all, and the criteria for their distribution are not at all transparent. There is also a beer surtax whose revenues are to be directly allocated to local governments. Here, too, there are problems with delays and failure to transfer funds. Meanwhile, taxes on central government properties in the districts go largely unpaid. In 1992, central government agencies were mandated to provide grants to the councils for sectoral activities, but criteria as to levels and distribution of grants have not been transparent. Not surprisingly, the implementation of this policy has been limited and fragmentary.

As a result of the foregoing, the councils have almost no assets and spend some 90 percent of their expenditures on personnel emoluments (Tordoff and Young 1994). Despite the precarious financial situation of most local governments in Zambia, the central government continues to seek to further withdraw support in favor of local self-sufficiency. In 1992, the Ministry of Finance discontinued central support for nine urban councils, representing one-third of all municipal budgets. The resulting budget gaps generated were subsequently softened with ad hoc grants.

Since the early 1980s, government finance in Zambia has been organized under the Provincial Accounting Control Unit (PACU) system. The Ministry of Finance disburses funds to the PACUs, which in turn disburse them to the provincial headquarters of the various ministries. Originally, PACU money was pooled, without respect to ministry, but after 1992 discretionary transfer of funds between departmental budgets has been discontinued. The PACU system has been unpopular with line ministries, including the Ministry of Health, which have done whatever possible to circumvent it (Tordoff and Young 1994).

**3.4.2 Ministry of Health Deconcentration/Delegation**

In 1993, as part of the Health Reforms Programme, the MOH initiated a pilot project for fiscal decentralization in three districts (Mansa, Monze, Senanga), that has subsequently been expanded to include all 72 districts. Under the old system, allocations to the Ministry of Health were distributed to the four national health institutions and to the country's nine Provincial Medical Offices (PMOs). The PMOs were required to approve all expenditures to be undertaken by district officials who, in turn, approved all health facility spending. Under the new system the district health offices receive direct transfers to their own bank accounts, and have been given authority to develop and manage budget.3. Case 2: Zambia 33

plans with central approval. Drug, supplies, vehicle, and equipment purchase is now generally made through the central procurement apparatus, though there is evidence of some independent local procurement of smaller equipment such as refrigerators (Fielden and Nielsen 1998).

As was mentioned above, centrally approved annual work plans and budgets are monitored through quarterly performance auditing. Moreover, central guidelines specify limits on administrative and capital investment spending, as well as set-asides for different levels of the district health system (i.e., DHO, hospitals, health centers, etc). These are defined in Tables 3a and 3b.

**Table 3a. Budget Ceilings by Cost Item****Cost Item Maximum % of Total Budget**

Allowances 20%

Emergency Drug Purchase 4%

Fuel 15%

Capital 15%

**Table 3b. Set-aside Requirements by Level of Service Delivery**

**Districts w/out HMB Districts with HMB Level  
Minimum Maximum Minimum Maximum**

District Office 5% 15% 10% 25%

1

Referral Hospital 20% 40% 0% 10%

Health Centers 45% 60% 60% 70%

Community 2% 5% 2% 5%

Source: Fielden and Nielsen (1998) from District Planning Guide 1998.

As was mentioned above, the centrally defined essential package of health services is considered too expensive for the districts to fund under existing allocations. This may exert some constraint over expenditure allocations or provide latitude depending on the mode of policy implementation and enforcement. In several districts, rural health centers, were given revolving petty-cash funds for maintenance, etc., but there is still evidence of “bottle-necking” of funds at the district level, preventing health facilities from having adequate control over “decentralized” resources (Foltz 1997). One of the more innovative elements of the fiscal decentralization policy has been the extension of public fiscal resources to the support of the mission hospitals. The Ministry of Finance recently signed a memorandum of agreement with the Churches Medical Association of Zambia whereby select mission hospitals will be eligible for funding equivalent to 75 percent of that received by MOH hospitals (Mbanefoh 1997).

The overall development of funding to the health sector shows positive trends within the context of a generally difficult situation (Mbanefoh 1997). Social expenditures dropped dramatically during the 1980s, declining at an average of 12 percent per year. By 1994, these expenditures had reached a mere two-thirds of their 1980 levels. These declines were exacerbated for the health sector under increasing pressure from population growth, estimated at 3.1 percent per year. As a result, per capita real health spending declined from K 39 in 1982 to K 13 in 1994 (US\$ 1=Zambian kwacha 2,797.9). However, more recently the health sector’s share of government expenditures has been on the rise, increasing from 5.3 percent in 1991 to 8.7 percent in 1994 (see Table 4). The MOH can claim that actual expenditure were as high as 13 percent in 1994 because of the public service reform program that requires the government to allocate at least 13 percent of its revenue to health. The share of health sector public resources allotted to primary care through district health services has also expanded dramatically, from 29.9 percent in 1992 to 47.7 percent in 1996. These changes, accompanied by the significantly expanded fiscal decision space provided to the districts, have brought a major reorientation of public resources toward deconcentrated health service delivery, even within the context of continuing fiscal stress.

**Table 4. Health Expenditure, 1990-1995 (K million)**

**Year Total GRZ Health % of GRZ**

1990 31382 1897 6.04

1991 84724 4485 5.29

1992 157741 6371 0.40

1993 303127 19897 0.66

1994 459500 39378 8.57

1995 853900 92781 10.87

USAID 1995: Annex N

The current reform program incorporates a return to the use of user fees at health facilities at all levels. User fees were first introduced in 1987, but were withdrawn after widespread public opposition. A diluted version of the policy was implemented in 1988 and has been in place since. User fees were set at K 10-50 in 1990, and average levels have remained relatively stable in real terms (K 500-1000 in 1997). Fees are very minimal in comparison with costs, but are argued to provide greater user “ownership” of health service delivery and promote accountability in health facilities. The major change that has occurred under the current reforms is that the districts set user fee levels and define exemption policies. Official regulations stipulate that districts receive 25 percent

of user fees collected, but lack of transparent accounting procedures make evaluation of this policy difficult. Fee levels and cost-recovery rates vary widely between districts, the latter ranging from 1 percent to 20 percent of total operational costs excluding salaries and drugs. Many districts permit user fees to be paid in-kind, usually with maize or chickens. Only 50 percent of districts surveyed by Daura et al. (1998) had exemption guidelines, while 75 percent of those surveyed permitted health personnel discretion regarding exemptions. The percentage of users exempted varied from less than 5 percent to greater than 35 percent between districts, but was generally lower in those districts which used in-kind payment (16.7 percent) than in those which did not (21.3 percent) (Daura et al. 1998). Initial experiments with prepayment schemes undertaken in urban centers were shown to have some distortionary effects on demand, for instance providing incentive for users to bypass primary facilities in favor of hospitals (Mbanefoh 1997). Consequently, general outpatient facilities at these hospitals were closed and prepayment schemes were shifted to the districts. At least five districts currently operate some kind of prepayment scheme, though these do not cover all facilities. Where prepayment schemes are operating user fees are generally higher in order to increase level of participation in the scheme.

A final element of health sector finance reform has been the introduction of a "basket" or sector-wide approach to donor financing. Under this scheme, major donors including DANIDA, DGIS, IrishAid, JICA, ODA/DEID, SIDA, UNICEF, USAID, and the World Bank, make contributions to a central resource pool for the financing of district health plans. Although no data are available on the level of funding which is now being offered through the "basket," this is considered a significant step toward greater district control over donor resource allocation and reduction of centralized programming through vertical programs (Mbanefoh 1997; Fielden and Nielsen 1998).

In general, a significant expansion of financial decision space can be noted at the district level, both through the greater availability of resources and through increased district control over a diversified group of revenue sources, including central transfers, user fees, and prepayment schemes. The effects of this financial decentralization remain somewhat unclear and ambiguous. The encouraging reports offered by Visshedijk, Liywalii, and Oosterhout (1995) and Foltz (1997) contrast with the more varied and less positive data offered by Daura et al. (1998). In general, however, there appears to be agreement that further decentralization of resources to the facility level is necessary in order to promote the hoped for gains in efficiency and quality. Bottlenecking of transfers in the districts and inability of facilities to retain and administer user fee revenues promote a reconcentration of resources at the district level to the disadvantage of facility management. Successful management of resources at the facility level seems to be, to some extent, dependent on effective local participation and accountability.

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#### **4.4 Resource Allocation after Decentralization**

##### **4.4.1 Revenue Sources and Health Sector Spending**

While the 1993 reforms do not appear to have had a major impact on overall levels of government health expenditures, shifts in the allocation of these resources are noteworthy. Although the proportion of government expenditure allotted for health rose considerably following the NRM's<sup>46</sup> Decentralization of Health Systems: Preliminary Review of Four Country Case Studies

accession to power (from 4.8 percent in 1989 to 7.1 percent in 1992), it has remained fairly steady around 9-10 percent since 1993 (Okuonzi and Lubanga 1995). The majority of the early increases in the health budget between 1986 and 1990 went to capital costs and vertical, single disease-oriented programs, whose recurrent costs are, of course, difficult to sustain (Okello et al. 1998).

Complementary own-source funding is unlikely to do much to compensate for this fact.

Subcounty governments are given authority to collect taxes and fees, including a graduated tax, market dues, licensing and other fees, 50 percent of which can be retained and the remainder of which is transferred to district governments (Kasfir et al. 1997). Hutchinson classifies district revenue into unconditional grants (18.7 percent), conditional grants (62.6 percent), donations (12.2 percent), and local revenue (6.5 percent) (Hutchinson, personal communication). Due to inconsistency in the data, for the health sector the proportion due to donor revenue may be as much as two times that of central government transfers. Although difficult to monitor at the district level and even harder at the lower local level, some of the local revenue is invested in improving health centers and conducting outreaches. Subcounty revenues vary from US\$ 4,000 to US\$ 200,000 per year, and it can be expected that this will negatively affect horizontal equity (Villadsen 1996). Uganda has a tax collection rate of only 6-8 percent of GDP, which is significantly lower than the 18-20 percent average for the African region. Revenue shortages are likely to be exacerbated for rural areas where there the formal economy is largely nonexistent.

The system for central transfers to local governments in Uganda is based on two distinct budgetary categories referred to as "recurrent" and "development." The recurrent budget includes salaries, hospital maintenance costs, district administrative costs, etc. Approximately one-half of the national recurrent budget is spent through the districts. The development budget is so named because it is partially comprised of capital expenditure, but it too incorporates recurrent costs associated with vertical programs. The development budget is over 90 percent donor-financed and provides over 50 percent of the total health budget (Hutchinson 1998). Beginning in 1993, the recurrent budget has been gradually decentralized to the regions. The decision to decentralize the recurrent budget before the development budget is indicative of the authenticity of devolution in Uganda. In programs tending toward administrative deconcentration, it is more common for minor portions of the development budget to be decentralized first, while the central government retains control over the core of recurrent spending (Kasfir et al. 1996).

In Uganda, three cohorts of districts (composed of 13, 14, and 12 districts, respectively) have gone through a two-year phased decentralization process. The recurrent budget was decentralized to the first 13 districts on the vote-system (earmarked) in FY 1993/94, and then on the basis of block grants as of FY 1994/95. The remaining two cohorts have also completed this two-year phased decentralization process, resulting in the decentralization of the recurrent budget through block grants nationwide as of FY 1996/97. The decentralization of the development budget has now been piloted in three districts, and is expected to be implemented in all 39 by FY 1999/2000 (Hutchinson 1998). At present, secondary and tertiary hospitals continue to receive delegated funds directly from the Ministry of Finance, but this budget is likewise expected to be decentralized in the near future. The 1995 Constitution also calls for the establishment of an equalization grant to promote intergovernmental horizontal equity, but as yet this has not been implemented.

#### 4.4.2 District Health Spending

Under the decentralized block grant system, central transfers are divided into unconditional block grants, delegated salaries, delegated non-wage transfers, earmarked grants for district urban administration, and conditional grants. The formula for block grant distribution has received mixed reviews, considered by some to be equitable and by others to provide perverse incentives to perpetuate high infant mortality rates, and so forth (Hutchinson 1998). Although the Ministry of Finance has provided “shadow” budgets in some cases, the district councils have discretion over the use of non-wage block grant funds. Salaries are paid directly by the Ministry of Finance via delegated block grants, and drugs are provided through “kits” from the donor-financed National Medical Stores. District expenditures of transfers are summarized in Table 5.

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**Table 5. Total District Public Expenditure by Category—All Districts  
1996/97 1997/98**

Item	Amount (‘000 Ush*)	% Amount (‘000 Ush*)	Amount (‘000 Ush*)	%
<b>Unconditional Grant</b>	45,317,604	25.7%	48,111,003	24.5%
<b>Salaries</b>				
Teachers’ Salaries – Primary	61,514,949	34.8%	69,196,998	35.2%
Teachers’ Salaries – Secondary	22,833,000	12.9%	25,407,334	12.9%
Staff Salaries	6,249,669	3.5%	6,879,998	3.5%
Medical Workers Lunch Allowance	-	0.0%	5,149,999	2.6%
Subtotal	90,597,618	51.3%	106,634,329	54.3%
<b>Delegated (Non-wage)</b>				
District Hospital Services	8,020,648	4.5%	6,447,000	3.3%
Referral Hospitals	5,500,110	3.1%	4,020,000	2.0%
District NGO Hospitals	-	0.0%	1,000,001	0.5%
Health Training Schools	489,240	0.3%	1,543,001	0.8%
Transfers to Local Authorities/Sec. Ed.	4,290,000	2.4%	4,299,998	2.2%
Sub-total	18,299,998	10.4%	17,310,000	8.8%
<b>District Urban Administration</b>	3,400,000	1.9%	3,672,001	1.9%
<b>Conditional Grants</b>				
Transfers to Primary Education	14,000,000	7.9%	13,999,997	7.1%
Transfers to Road Maintenance	4,900,000	2.8%	4,990,003	2.5%
Transfers to Primary Health Care	-	0.0%	1,700,000	0.9%
Sub-total	18,900,000	10.7%	20,690,000	10.5%
<b>GRAND TOTAL</b>	176,515,220	100%	196,417,333	100%

Source: Hutchinson 1998: p. 39.

\*US\$ 1=Ugandan shilling 1,492.5.

While the fiscal decentralization described above is fairly radical by African standards, it should be emphasized that the real magnitude of fiscal decision space granted to district governments is limited. Because delegated salaries and vertical program funding comprise such a large percentage of the funding transferred to the districts, the actual amount of discretionary funding is fairly minimal, corresponding to approximately 25 percent of the funds in district annual work plans.

Approximately 10 percent of these discretionary funds are allotted to health, making it a considerably lower budgetary priority than education or feeder roads (Hutchinson 1998). The relative shortage of discretionary funds available to local governments makes the allocation of these funds somewhat less significant, but nonetheless indicative of tendencies within the decentralization reforms. One of the major issues in the Ugandan health system has been a major bias toward urban and curative care, with over 50 percent of recurrent costs being spent on hospitals, half of which goes to the major national referral hospital (Smithson 1995). Fully 70 percent of trained health staff are urban hospital based, despite the fact that nearly 90 percent of the Ugandan population lives in rural

areas (Okuonzi and Lubanga 1995). While Uganda has made some investment in local health committees and community health workers, the expansion of health services into rural areas has been primarily based on the construction of district hospitals (Macrae et al. 1996).

Unfortunately, decentralized district expenditures on health appear to perpetuate this bias in favor of curative care. While there has been a 110 percent increase in the overall district expenditure on health between FY 1995/96 and FY 1997/98, this has been accompanied by an 8 percent *decrease* in the allocation to primary health care (Hutchinson 1998). While, to a certain extent, this is to be expected given the political attractiveness of capital investment and curative care, it remains an area of major concern for the health sector, particularly as the development budget is likewise decentralized. Ministry of Finance grants have been structured to provide incentives for a focus on primary education and feeder road construction as of FY 1996/97, and more recently a conditional grant has been established to encourage spending on primary health care as well. Originally, this grant was equivalent to only 0.9 percent of total district recurrent expenditures, or 10 percent of overall district spending on primary health care, at which level conditional grants are unlikely to have much impact (Hutchinson 1998). In FY 1998/99, however, the primary health care conditional grant was to be expanded from Ush 1.7 billion to Ush 6.358 billion, which would significantly improve its effectiveness.

As was mentioned above, hospitals currently remain centrally financed through direct subventions from the Ministry of Finance. To date, non-wage financing has been on the basis of available beds, but the MOH is in the process of shifting towards a catchment basis (MOH 1997). It remains to be seen when hospital management and financing will be devolved to local governments and what this will entail.

## PHILIPINE

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### **5.4 Resource Allocation after Decentralization**

As was mentioned above, the devolution of central government functions to LGUs was accompanied by a major fiscal decentralization program. Local government expenditures increased by 10.7 percent in 1992 and again by 51.9 percent in 1993 (Diokno 1995). This is particularly significant for the health sector, given that health services account for 66 percent of the total cost of devolved national government functions (Perez et al. 1995). The primary mechanism for fiscal decentralization is the IRA. Prior to LGC 1991, the LGU share of IRA was equal to 20 percent of total taxes collected, with distribution based on a formula incorporating population, land area, and equal sharing elements. Following decentralization, the LGU share of the IRA has been expanded to 40 percent of total revenues collected, with a three-year lag.

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The previously existing National Assistance to LGUs program was abolished, but the expanded IRA allotment was augmented by a one-time P 4 billion allocation for the initial cost of devolution. The code specifically adopts a vertical allocation formula for the IRA, which assigns 23 percent to provincial tier governments, 23 percent to city governments, 34 percent to municipal governments, and 20 percent to barangays. The formula for the horizontal distribution of these resources to individual LGUs within a given tier is calculated on the basis of 50 percent for population, 25 percent equal share to all, and 25 percent by land area (Miller 1998).

The IRA is relatively unburdened with earmarking, set-asides, and other expenditure constraints. LGUs are required to spend at least 20 percent of the IRA on “development” projects, and although LGUs must furnish the DILG with copies of its development plans, this categorization is relatively fungible (Perez et al. 1995). A further 5 percent of the IRA must be set aside for disaster relief efforts, and no more than 45-55 percent (depending LGU revenue class) of LGU regular income may be

<sup>10</sup> This lag, of course, leads to significant erosion by inflation of the resources allotted to LGUs..5. Case 4: Philippines  
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spent on personnel (Diokno 1995). These minimal requirements actually leave significant latitude to Philippine LGUs in expenditure decisions.

The expansion of the central-local transfer system was accompanied by an increase in the LGU share in taxes. The real property tax (RPT) has been given a maximum limit of 2 percent total, including a baseline of 1 percent of assessed value, plus an additional 1 percent to be set aside for the "Special Education Fund" (SEF), which is given directly to local school boards. The non-SEF portion (1 percent) is divided among LGUs as follows: 35 percent to provinces, 25 percent to barangays, and 40 percent to the municipal governments that collect it. Tax collection is a major problem for local governments, with the revenue collection rate for the RPT falling below 55 percent and the cost of collection exceeding the actual revenues. These problems are in part related to antiquated assessments and poor property inventories, but can also be attributed to incentive problems. Because the municipalities which collect the RPT receive such a small proportion of the tax, it is suggested that they have relatively little incentive to do so efficiently. The only level of local government that has been able to successfully increase the proportion of its revenue accounted for by local taxation is the city (Loehr and Manasan 1999).

LGUs also gained the authority to take out loans from government banks to finance development projects, with stipulations limiting debt service to no more than 20 percent of regular local government income.

It has been recognized that the benefits and costs of decentralization have not fallen equally on all LGUs or on all levels of government. Loehr and Manasan (1999) find that while the IRA is sufficient to cover the devolved functions in aggregate, the barangays and cities have been fiscal net winners and the provinces and municipalities net losers as a result of LGU 1991. While the provinces and municipalities receive 57 percent of revenue transfers, they have borne 92.5 percent of the costs of devolution. The cities and barangays, for their part, have received 47 percent of the transfers and borne only 7.5 percent of the costs (Eaton 1998). In the health sector, for example, the tertiary hospitals devolved to the provincial governments constitute the most costly element of devolution to local government, but this has not been accounted for in any way in the IRA. This is particularly problematic because the provinces have such a limited tax base. As a result, by the end of 1997, at least four of the 72 provincial hospitals devolved to provincial governments have been returned to the DOH and a further 10 are under consideration (Perez 1998). In an effort to rationalize the distribution of central transfers, the government has developed the Devolution Financing Burden, an indicator which categorizes LGUs according to their fiscal capacity to assume devolved functions.

In terms of horizontal equity, Miller (1998) indicates that per capita allotments from the IRA vary by a factor of 23 between the top and the bottom province. Per capita own-source revenues are even more disparate, varying by a factor of 83 among provinces. While Miller (1998) contends that the revenue distribution system as a whole is mildly regressive, Loehr and Manasan (1999) state the IRA per se is mildly equalizing, though not intentionally so. This is due to the high weighting (25 percent) of land area in the IRA distribution formula, which tends to favor the more extensive, low population density, rural LGUs, which also tend to be the poorer areas.

Despite the dramatic decentralization of resources towards the LGUs under LGC 1991, Loehr and Manasan (1999) indicate that public sector finance in the Philippines remains relatively centralized. The revenue decentralization rate, i.e., the proportion of total government revenue controlled by local governments, expanded a scant 0.9 percent from 4.9 percent in the 1985-91 period to 5.8 percent in the 1992-97 period. The expenditure decentralization rate, i.e., the proportion of total government expenditures made by LGUs, expanded from 7.0 percent in the 1985-91 period to 14.7 percent in the 1992-97 period.

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Also noteworthy is the degree of local government dependency on central transfers. Total local government receipts expanded from 1.7 percent to 3.4 percent of GNP

between the 1985-91 and 1992-97 periods, but the percentage of these receipts accounted for by own-source

revenues declined from 50 percent to 35 percent. Not surprisingly, the increase in local government dependence on central transfers has led to a corresponding increase in substitution effects of central for local resources.

There is also evidence of a “creeping renationalization” in government finance. Despite a massive devolution of functions and personnel, central government spending between 1992 and 1994 only decreased from 11.6 percent to 11.4 percent of GNP and by 1998 it had actually increased to 13.2 percent of GNP (Loehr and Manasan 1991). Continued high levels of central government spending have been particularly noted in the two agencies most affected by devolution, the Department of Health and the Department of Agriculture (Miller 1998).