Health Worker Benefits in a Period of Broad Civil Service Reform: The Philippine Experience

Juan A. Perez III, M.D., M.P.H.

Director, Health Intelligence and
Local Government Assistance and Monitoring Services,
Philippine Department of Health

Abstract

Developing countries that have to cope with pressures to reform their bureaucracies have to contend with increasing health worker benefits and salaries that are often intended to retain these health workers in government service. In the Philippines, the pressure to increase health worker benefits and salaries arose as a consequence of the antidictatorship struggle. A broader, parallel political move in the Philippines also led to the enactment of a Local Government Code that led to the devolution of basic services, including health services. In the last few years, national and local efforts in health have been forced to focus on guaranteeing some of these benefits, even as the entire bureaucracy is the target of increased benefits and salary increases to keep pace with the high health worker benefits. Local governments are feeling the financial limitations of their local funds and are calling for an end to the unfunded mandates that these increased benefits constitute. Lessons drawn from the recent years are discussed.

Keywords: devolution, local government, unfunded mandates, civil service reform, health worker, benefit

Introduction

Developing countries continue to be beset by structural adjustment and globalization pressures in efforts to deflate bloated bureaucracies. Many governments are also attracted by the lure of greater efficiency and effectiveness in the delivery of basic services from decentralized government structures.

The Philippines in 1986 was emerging from a period of authoritarian rule built on the foundation of a strong central government lording over puny and resource-poor local governments(1). The new political leadership at that time had a mission to restore popular democracy and increase the autonomy of local governments to decrease the possibility of central government re-imposing authoritarian rule. This was done through the 1987 Philippine Constitution which institutionalized the principles of local autonomy.

After over four years of debate, the Philippines Congress approved the Local Government Code (LGC) of 1991. In the process of debate, the Philippine Department of Health (DOH) was oblivious to political reforms being contemplated by Congress, except at the final stages when Congress was discussing which basic services would be decentralized to local governments. Moreover, it was felt by the legislators that one major basic service would have to be turned over to local authorities to serve as both the centerpiece of decentralization and as an expression of the government's desire to make decentralization a substantial effort.

Health worker organizations in the period of 'democratic space' (post-1986)

Health workers, on the other hand, were also involved in the anti-dictatorship struggle, and organized health workers continued to exert political influence in the post-dictatorship government. With the battle for democratic space won, health workers turned to sectoral issues meant to improve the working conditions and benefits of public health workers. The protracted struggle for the Magna Carta of Public Health Workers thus began immediately after the Constitution was approved.

During this period of "democratic space" the DOH was seen by most non-government organizations as the most progressive of government agencies, an organization which the anti-dictatorship groups could deal with. The early policy pronouncements of the DOH drew broad support from the NGOs. The Philippine Milk Code and the Generics Act were seen as curtailing the influence of multinationals, and improved, non-partisan delivery of health services (EPI, Child Survival Program, TB Control) were seen to be professionalizing the health services from the Marcos days when the DOH was perceived to be one of the "cosmetic" agencies propping up the dictatorship.

Organized health workers, having achieved success in the policy area (generics) had set their sights on improving conditions of work in health facilities. Following the teachers who had a Magna Carta for Teachers passed in the 1970s, health workers launched a campaign to have a magna carta of their own. In the Philippine civil service, teachers and health workers constitute the two biggest sectors, if one leaves out the military.

Mixed signals: Local autonomy and health worker benefits

Within the space of six months from late 1991 to early 1992, health workers were given mixed signals by Congress (in a unitary system such as the Philippines', the legislative Congress sets the policy which the executive agencies are duty-bound to implement). Congress passed a law decentralizing health services to local governments (health lost out to education in the battle to determine which agency would be devolved) in October 1991 (Figure 1, 2, 3) and in a move meant to appease displeased health workers, Congress also passed the Magna Carta for Health Workers in April, 1992 (Table 1).

Table 1. Policy, Leadership and Administrative Changes During the Changeover and Transition Phase

Year	Executive Agencies	Legislative	Local Government Units
1991	1. Local Government Code or Republic Act 7,160 signed as Law, October, 1991.	1. Local Government Code (RA 7160) signed into law, October, 1991.	1. Local Government Code (RA 7160) passed October, 1991.
1992	2. Implementing Rules and Regulations for the Code adopted February, 1992. 3. Secretary Bengzon runs for the Philippines Senate/National and Local elections, May 1992.	2. Implementing Rules and Regulations for the Code adopted, February, 1992. 3. National and Local Elections, May 1992. 4. Magna Carta for Public Health Workers (RA 7305) approved March 1992. This law extended additional benefits to public health workers amounting to P662 Million in 1993.	2. Implementing Rules and Regulations for the Code, February 1992. 3. National and Local Elections, May 1992.
1993	4. Flavier becomes DOH Secretary June, 1992. 5. Implementing Rules and Regulations for Devolution of Health, October, 1992. Local Government Assistance and Monitoring Service (LGAMS) organized, October, 1992.		4. Signing of Memorandum of Agreement (MOA) for Devolution, September, 1992.
1993		5. House Bill 3331 consolidating HB 3812 and HB 26721 excluding DOH form the national government agencies whose functions are to be devolved filed December 7, 1992. 6. Senate Bill 1173 (Providing for a three year period of devolution of health service and facilities to local government units) filed March 18, 1993.	5. HB 3331 filed December, 1992.
	6. Full turn over of assets liabilities equipment and all devolved personnel, April 1993.	7. Health Commission Report recommends suspension of devolution December. 1993	6. Full turn over of DOH facilities equipment assets and devolved personnel, April, 1993. 7. Health Commission Report recommends suspension of devolution, December. 1993.
1994	7. National Survey on Effect of Devolution, June, 1994.	8. National Survey on Effect of Devolution, June, 1994.	8. National Survey on Effect of Devolution, June, 1994.
1995	8. National Health Insurance Law or RA 7875 signed into law, February, 1995. 9. Tan becomes Secretary of Health (March, 1995) as Flavier runs for Senate, May, 1995. National and Local Elections	9. National Health Insurance Law (RA 7875) signed into law, February, 1995. 10. National and Local Elections, May, 1995.	9. National Health Insurance Law (RA 7875) signed into law, February, 1995. 10. National and Local Elections, May, 1995.
	10. President Ramos vetoes Recentralization Bill, June, 1995. 11. Hilarion Ramiro Jr. becomes DOH Secretary, July, 1995.	11. President Ramos vetoes Recentralization Bill, June, 1995.	11. President Ramos vetoes Recentralization Bill, June, 1995.

Figure 1. DOH Structure (Pre-devolution)

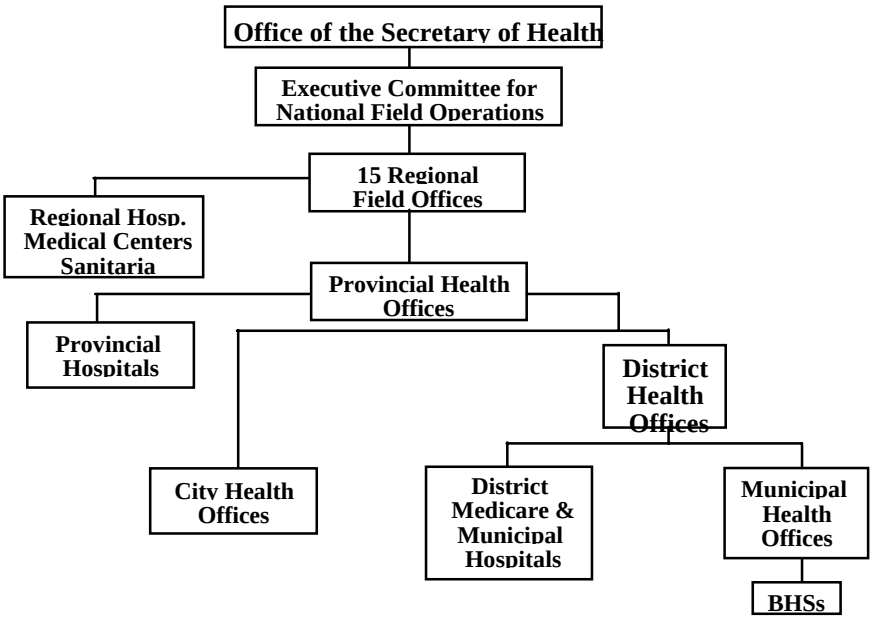
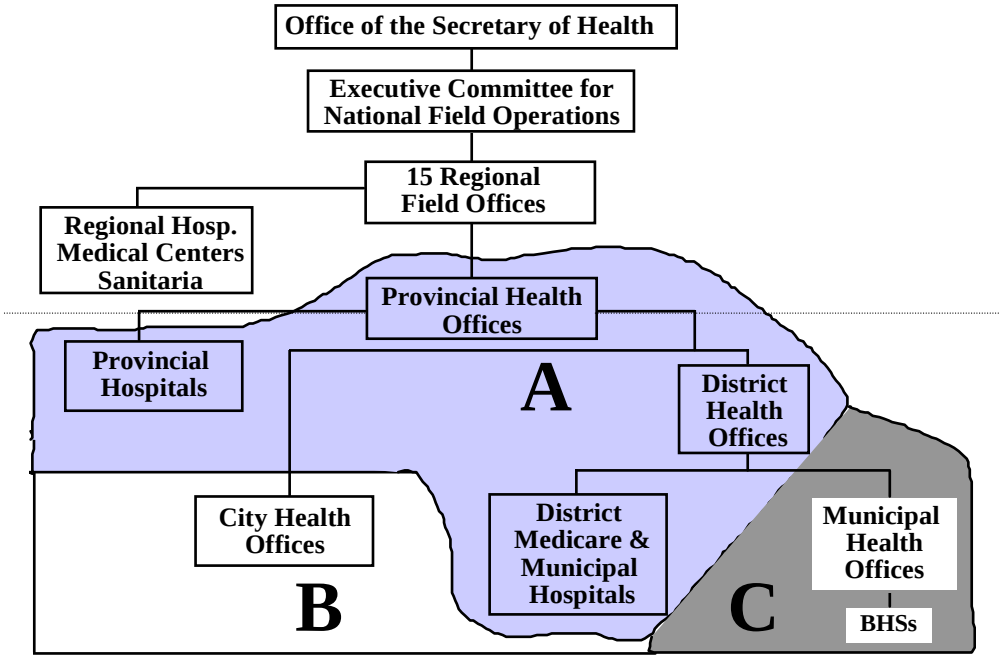


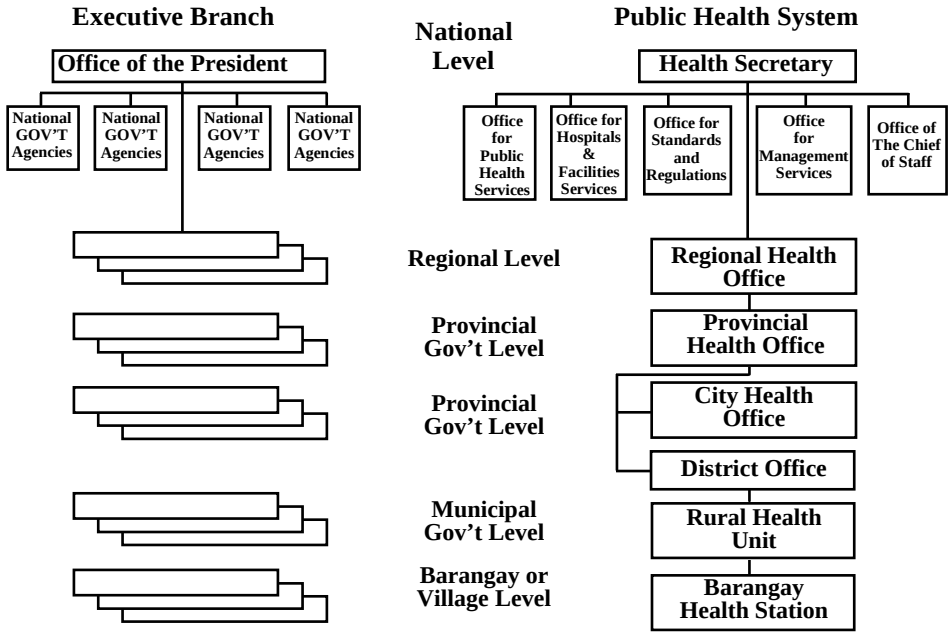
Figure 2. Health Structure (1993, Post-devolution)



A Devolved to Prov'l Gov't **B** Devolved to City Gov't **C** Devolved to Municipal Gov't

Many health workers felt that the political will of Ramos to implement the local government code would have been sapped by the defeat of supporters of that policy, but Ramos had run with the blessings of Corazon Aquino, whose administration boasted of the LGC as its centerpiece achievement. Compounding this was the appointment of a secretary of health with a bias for the periphery (he had built a reputation as a doctor to the barrios) who was willing to give the LGC a chance.

Figure 3. Comparing Governance to Health Structure



A Magna Carta for Health Workers

The Congress of 1992 passed a law to give health workers increased benefits through two mechanisms: outright, across-the-board salary increases for all rural doctors, and laundry and subsistence allowances for all other health workers.

Over a five-year period, the DOH was also authorized to increase other benefits such as medico-legal fees, overtime pay, hazard pay and hardship allowances for health workers laboring under difficult circumstances.

Under the law, the DOH would set up a mechanism for managing health worker and management issues through multi-level consultative councils. The law also provided for a code of conduct by health workers, with penalties for any violations.

By 1997, a national consultative council had been in operation for three years, but local government participation in the consultative process remained poor or, in some cases, only token in nature. During its early years of implementation, it was clear that if implemented, the magna carta would create the highest paid sectoral workforce in the Philippines civil service.

DOH's dilemma

The new leadership of the DOH quickly agreed to also implement the Magna Carta of Public Health Workers (MCPHW), which quickly brought things to a head. Would local governments agree to implement the law once the transfer of health workers had occurred as a consequence of the LGC?(2)

The civil service in the Philippines covers all government workers in national and local agencies, but the salaries in local governments are up to thirty percent lower than their national counterparts. Salaries in local governments are tied to the income classification of their local governments who are classified from 1st to 6th class. One could already anticipate the difficulty of running a local government which would have to implement two salary scales. It was particularly galling that the newcomers (devolved health and other workers) would be getting nationally-pegged, higher salaries.

As the DOH started to implement the Magna Carta before the actual transfer, local governments quickly realized that health workers in particular would be transferring with salaries even higher than most other government workers. In 1993, devolved health workers were the highest paid workers in the civil service (for their salary grade, which had only recently been standardized for national agencies).

When the implementers of the LGC went around the country in early 1993, mayors regularly confronted them with the realization that rural doctors would be getting higher salaries. Only a directive from President Ramos in June 1993, ordering the implementation of the LGC (with veiled threats of suspensions), could persuade the most difficult mayors and governors to accept the transfer. By the end of 1993, the transfer was complete; only 217 out of 45,000 health workers were rejected by local governments for reasons of redundancy.(3)

The DOH realized in 1992, that lack of funds would hinder the implementation of MCPHW (Magna Carta for Public Health Workers-the magna carta for teachers had unfortunately also run out of steam after the implementation of a few provisions and token salary increases), therefore the health secretary ordered that the implementation of the benefits would be phased over the next five years, up to 1997.

'Unfunded mandates': Implementing national benefits in local governments

After devolution, the health workers continued to appeal to the DOH for their benefits initially granted in 1992, consisting of the subsistence allowance and the laundry allowance.

Both allowances totaled 1000 pesos (around $35), about one-tenth of the average health workers' monthly salary. Rural doctors were more persistent, particularly because their benefits were more substantial, which included a salary increase (roughly a 30% increase, from P7,000 to P10,125) and representation and transportation allowances (P2200).

Along with subsistence and laundry allowances, the take-home pay of rural doctors would nearly double their pre-Magna Carta salaries.

Other benefits like hazard, overtime, medico-legal and on-call pay were deemed for later implementation. Local governments would raised a protest about arbitrary increases in health worker benefits during the period of transition.

A feature of the Magna Carta was that it was specifically meant to address the difficult situation of rural doctors serving in hardship posts. Hospital doctors were specifically not included in the salary increases, along with city-based doctors.

As most local government units (LGUs) felt that **the Magna Carta was an imposition by national government (an 'unfunded mandate')**, magna carta benefits were given lower priorities in their budgets. Local officials also readily gave certifications that they were short of funds and therefore eligible for augmentation funds from the DOH. Appeals from both local governments and health workers became so voluminous that DOH set up a quick response system lodged in its **Local Government Assistance and Monitoring Service (LGAMS) in 1995[(4)].**

Unintended consequences: Health's magna carta infects other government workers

In the first two years of implementation of the magna carta, many agencies thought of it as "**that DOH problem**," but they eventually realized that health workers are present in most government agencies outside DOH. The phenomenon of "**health-related agencies**" also quickly proliferated, to qualify for Magna Carta benefits.

When hazard pay was implemented for health-related reasons, more agencies clamored to have their offices certified as hazardous. The DOH created a hazard evaluation committee for this purpose in 1995, headed by an assistant secretary to give it importance. Non-payment of hazard pay became the cause of demonstrations in some Manila hospitals, and agencies outside Manila reported walkouts when their offices could not produce the funds to pay what the DOH had certified.

These incidents provided impetus for the national government to implement another round of salary standardization increases for all government workers. While the initial round of salary increases was meant to keep government pay competitive with the private sector, this second round was partially attributable to the impact the Magna Carta was having on most government workers.

The DOH found that the new round of salary increases starting in 1994 was becoming another ground for dissatisfaction by the devolved health workers who felt disadvantaged by the fact that most LGUs (particularly lower-class municipalities) were unable to comply with increased salaries which they considered unfunded mandates.

The unabated clamor of health workers for their lost benefits led to the development of a series of interlocking augmentation funds coming from national government to assist

local governments in paying magna carta benefits. The national government imposed a policy that would annually reduce the level of support; by 1997 the local governments would have to shoulder the entire amount for magna carta:

Table 2. Level of National and Local share for Magna Carta.

Year	National		Local		Total
	Million Peso	%	Million Peso	%	(million Peso)
1993	423.0	100.00	0	0	423.0
1994	662.0	100.00	0	0	662.0
1995	400.4	54.74	331.0	45.26	731.4
1996	234.9	32.12	496.5	67.88	731.4
1997	69.4	9.49	662.0	90.51	731.4

Capping the benefits: President Ramos intervenes

However, by December, 1994, President Ramos, facing a different election in the following year, decreed that no new benefits for Magna Carta would be allowed until the LGUs could bear the financial cost. Ramos effectively froze the benefits to those being implemented to that year. This was met by dismay by the health workers who expected that 1995 would be the year when hazard pay would be implemented with an accompanying 10-20% salary increase. Ramos cushioned the blow by announcing a P50Million augmentation fund for devolved health workers.

The DOH also committed its savings at the end of every year as a fund to further augment salaries as a measure of solidarity with its former colleagues in the national agency. Surveys in the past two years indicate that the policy may be working: the level of implementation by local governments has increased from 73% in 1995 to 77% in 1996. Support for salary standardization has also been increasing to 83% in 1996[(5)].

The level of dissatisfaction is still pronounced among devolved health workers because relatively few municipalities are able to fully implement either magna carta or salary standardization.

The level of frustration has also increased among local governments who are now asking that the devolved workers be supported by the national government. If the national government is unable to do so, they contend, the national agencies should find a way to get them back[(6)].

The more discerning local executives, however, are beginning to ask questions about the budgets of national agencies and the sources of support for salary increases that are available for national agencies but closed to local governments[(7)].

Local governments are increasingly moving away from the position of absolute autonomy that was apparent in the early years of decentralization into agreements to coordinate with national agencies. This year the theme of the Philippine Health Assembly (a

tri-partite meeting between LGUs, DOH and NGOs) is "**Enhancing Health Care Delivery Through Inter-LGU Cooperation.**"[(8)].

Lost in the debate of providing for health worker benefits is the fact that benefits for health workers are only half the story of the Magna Carta: the law also provides for a Code of Conduct for Public Health Workers. The Code of Conduct discusses the values that a health worker must adopt as well as a set of duties and obligations to the community, the clientele, co-workers and to the government[(9)].

Some health workers have brought some local executives (mayors, governors) to court for non-payment of benefits with varying degrees of success. In other areas, an inter-agency committee (Regional Transition Action Team, RTAT), created in the post-devolution period to mediate disputes between local governments and devolved workers, has had an impact in helping health workers get their benefits.

The current year (1997) has seen increased efforts by many sectors to review the LGC and provide amendments. The experience of the health workers in the implementation of Magna Carta inevitably is discussed in the context of compensation for local officials.

Applying political savvy to DOH's Dilemma

The struggle for the improvement of the conditions of work for health workers in the Philippines stemmed from an anti-dictatorship fight that had been won with the help of organized health workers (one of the fifty people who drafted the Philippines current constitution was the head of the Alliance of Health Workers, who went on to lobby successfully for the Magna Carta).

Fortunately for health workers, the DOH that implemented the Magna Carta was highly sympathetic with their fight, with the leaders of the department apportioning part of the annual budget for benefits (currently, 1/24 of the DOH budget goes to Magna Carta benefits).

If decentralization had not involved the health services, the morale of health workers would have been the highest for any sector in the civil service and its leaders would have gained higher office with ease (three of the DOH's secretaries in the past ten years were engaged in politics; only one remains in office today).

The dilemma of a health department caught between decentralization and the implementation of health benefit reforms led to the characterization of DOH's actions as an exercise in ambiguity and political brinkmanship. The early years of its implementation called for political skills unheard of for a department of health; the secretary of health was characterized as the "**country's most astute politician**" by the president of the governors' league at a time when the secretary had never run for political office.

The attraction of recentralization

The countercurrent represented by the dissatisfied health workers and centralist Congressmen continues to exert political pressure on the DOH management to relent on its position to give local autonomy a chance.

The most serious challenge occurred in 1995 when a bill from Congress was presented to President Ramos that would reverse the decentralization of basic health services (Table 1). Upon the strong advice of major agencies like Local Government, Budget and Health, Ramos stuck to his decentralization policy, effectively telling Congress that the solution to the problems of decentralization lay in the revision of the funding mechanism for the basic services.

The political climate in 1995 also was in Ramos' favor, with the administration basking in the reflected glory of an election victory in May, 1995.

The countercurrent has embarked instead on a program of attrition by selectively renationalizing provincial hospitals. In the period up to October, 1997, four provincial hospitals out of 72 have been returned to the DOH, with around ten more hospitals awaiting executive action. The numbers are still small (490 hospitals were decentralized in 1993), but this reflects the political efforts at the local level to eke out political spheres of influence, particularly by Congressmen who lost political clout over the public health care system.

For a Department of Health, dealing with political pressures is a different arena where there is little experience to guide its action. Only a clear documentation of its position on recentralization of hospitals can make the DOH a decisive stakeholder in the decisions being made in this area of health care delivery.

Conclusion

Political savvy alone could not suffice to get the department and its health workers through the difficulties of the past five years, but it served to keep the threat of more massive action at bay.

Transparency in policymaking made sure that health workers always had a voice in the crafting of augmentation schemes. The DOH admitted health worker groups to the highest level of decision-making in the department (national staff meetings, management committee meetings). Health workers also had a place in the National Health Worker Management Consultative Committee where policies were crafted on the magna carta.

Equity in developing augmentation schemes for magna carta benefits was adhered to by the DOH; there was never any complaint about the way the augmentation was provided once a proper explanation was provided. To achieve equitable distributions, DOH had access to databases developed for the decentralization process; DOH knew to the last centavo, the

cost of providing salaries for the lowest health workers in the hardest-to-reach municipality. Thus the impact of augmentation could easily be measured.

Feedback of new information, policies or augmentation was paramount to avoid the spread of misinformation. In this matter, the role of LGAMS and DOH representatives nationwide was of great importance. The means to convey such information was a regular publication, the *Bulletin of Devolution* (later renamed the *Local Health Bulletin*). The continuity of this unit through the tenure of four secretaries since 1992, made sure that there was no deviation in policy even while the DOH leadership was in constant flux.

Consultation with local governments at various levels minimized the friction between health workers, politicians and the organic local personnel (who often resented the intrusion of national workers into their area). The DOH itself often initiated dialogues with the leagues of local governments (national organizations of mayors and governors), eventually sponsoring annual health assemblies where differences could be thrashed out. Consultations often ended with the signing of a Memorandum of Agreement (MOA) which would delineate the role of the different institutions.

References

1. Diokno, B. **A Policymaker's Guide for the Use of Central-Local Transfers: The Philippine Case**. Manila: University of the Philippines Economics Foundation, 1995. (Unpublished paper)
2. Department of Health**. Managing Health Services: Post Devolution Perspectives and Strategies**. Paper presented at Department of Health-Donors Roundtable Discussion on Devolution, Asian Development Bank, Manila, July 7, 1993. Manila: Department of Health, 1993.
3. Department of Health. *Bulletin on Devolution No*. 9, October 15, 1993.
4. Department of Health. **Proposal for the Creation of Regional and Provincial Devolution Action Teams**. Manila: Department of Health, 1993.
5. Local Government Assistance and Monitoring Service, Department of Health. **An Assessment of the Devolved Health Care System, 1996**. Paper presented in the Pre-National Health Assembly in 1997. Manila: Department of Health, 1997.
6. Local Government Assistance and Monitoring Service, Department of Health. **Report from the Quick Response System group**. Manila: Department of Health, 1997.
7. Local Government Assistance and Monitoring Service, Department of Health. **Proceedings of the preparatory meetings of the Third National Health Assembly**. Manila: Department of Health, 1997.
8. Local Government Assistance and Monitoring Service, Department of Health. **Proceeding of the Third National Health Assembly**. Manila: Department of Health, 1997.
9. Department of Health. **Implementing Rules and Regulations/Code of Conduct for the Magna Carta of Public Health Workers (R.A. 7305)**. Manila: Department of Health, 1992.