SPECIAL ARTICLE

# Implications of the Mandanas-Garcia Ruling on Local Health Systems

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## ABSTRACT

The Supreme Court decision on the Mandanas-Garcia petition regarding the internal revenue allotment given to local government units is a significant ruling in strengthening the concept of decentralized governance and in the delivery of services. While the ruling grants local government greater resources and financial support, the immediate implication is the full devolution of services defined in the Local Government Code, including health services. The urgent concern is how much the Mandanas-Garcia Ruling will affect local health systems. Through a review of related documents and publications, this paper presents some existing and foreseeable issues surrounding the implementation of the Mandanas-Garcia Ruling in relation to the current devolved healthcare system. In particular, challenges in implementing the ruling in relation to health devolution, the local health system process, and the Universal Health Care Act are discussed. Some concrete action points for addressing these issues are also posited for policy-makers and implementors to consider in order to ensure not just the smooth and efficient implementation of the ruling but also the continuity of care for Filipinos.

*Keywords: devolution, internal revenue allotment, local government, health service delivery, financing*

## INTRODUCTION

The Mandanas-Garcia Ruling is a Supreme Court ruling on the petition of Hermilando Mandanas, then incumbent Batangas Governor, and Enrique Garcia Jr., former Bataan Governor, that questioned the manner by which the internal revenue allotment (IRA) for local government units (LGUs) were computed.[1] The ruling clarifies that the IRA of LGUs do not exclude other national taxes like customs duties. Prior to this, LGUs only get 40% of the national internal revenue taxes collected by the Bureau of Internal Revenue (BIR) as their IRA. With the ruling, the Department of Finance (DOF), Department of Budget and Management (DBM), Bureau of Internal Revenue (BIR), Bureau of Customs (BOC), and the National Treasurer have been ordered to include all collections of national taxes in determining the base of the just share of LGUs. Section 284 of the Local Government Code of 1991 (Republic Act No. 7160) has been modified so that LGUs would have a share in the national taxes based on the collection of the third fiscal year preceding the current fiscal year with 30% on the first year of effectivity, 35% on the second year, and 40% on the third year and thereafter.[2]

The ruling is expected to have significant fiscal implications affecting the capacity of both the national government



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agencies and LGUs. In June 2021, Executive Order (EO) No. 138 (Full Devolution of Certain Functions of the Executive Branch to Local Governments, Creation of a Committee on Devolution, and for other Purposes) was issued to facilitate the transition.[3] The EO clarified the responsibilities of national government agencies and LGUs consistent with fully committing to the policy of decentralization. The EO, through a Committee on Devolution, provided for the full devolution of certain functions of the executive branch to the LGUs no later than the end of fiscal year 2024.[3]

This paper aims to present the existing and foreseeable issues and challenges surrounding the implementation of the Mandanas-Garcia Ruling in relation to the current devolved healthcare system and to provide concrete action points for addressing these pressing issues. Through a review of government issuances, published articles, and related policies and reports, this paper examines the possible implications of the Mandanas-Garcia Ruling on local health systems and proposes counter-measures that may help mitigate negative impacts and improve healthcare delivery as a whole.

## SALIENT POINTS OF THE MANDANAS-GARCIA RULING

The Mandanas-Garcia ruling is very straightforward. The main crux is the source of LGU share from the national government income, which, according to the petitioners, deprived LGUs of their just share by making the source smaller.

In the text of the resolution, the Supreme Court cites its own previous ruling in July 2018 that "Court has held that the Constitution itself set national taxes as the base amount from which to reckon the just share of the LGUs."[1] Furthermore, it upholds the petitioners' position that Congress exceeded its mandate by limiting to national internal revenue taxes (NIRT) the base from which to compute the LGUs just share, and essentially deprived LGUs of their just share from "other national taxes, like customs duties".[1] The Supreme Court "reiterate that Congress, in limiting the base amount to national internal revenue taxes, gravely abused its discretion. What the Constitution extended to Congress was the power to determine, by law, the just share. The Constitution did not empower Congress to determine the just share and the base amount other than national taxes."[1]

In line with this, the Supreme Court identifies other sources of "national taxes" to be used as base the just share of LGUs. These include, among others, the NIRTs enumerated in Section 21 of the NIRC, inclusive of VAT, excise taxes, and DSTs collected by the BIR and BOC; tariffs and duties collected by the BOC; 85% of the excise taxes collected from locally manufactured Virginia and other tobacco products; 60% of the national taxes collected from the exploitation and development of the national wealth; and 7.5% of the franchise taxes in favor of the national government paid by franchise holders in accordance with R.A. No. 6631 and R.A. No. 6632.

For the effective implementation of the Mandanas-Garcia Ruling, EO 138 series 2021 was made by the administration of President Rodrigo R. Duterte. The EO "directs the full devolution of certain functions of the Executive Branch to the LGUs" and "provides for the creation of a Committee on Devolution to monitor the implementation of said EO".[4] Among the functions and services under the Local Government Code that will be fully devolved are health and social welfare services.

According to a 2021 congressional discussion paper, the IRA is expected to increase by P263.5 billion (37.9%) for 2022.[5] This is echoed by the DBM in their presentation "Implementation of The Supreme Court Decision in The Mandanas Case", where the expected windfall in the IRA of LGUs for 2022 is expected to be P234.39 billion or an increase of 27.61%.[6] With the expected increase in their just shares, LGUs are expected to be better equipped for the responsibility of delivering devolved services.[4] At the same time, LGUs are granted the flexibility to allocate their IRA to priorities they see fit.[5]

EO 138 also requires all LGUs and concerned national government agencies to produce their respective Devolution Transition Plans to facilitate the smooth implementation of full devolution. Committees on Devolution are also created at the national and regional levels. These committees have a four-fold task, namely: 1) oversee the implementation of administrative and fiscal decentralization; 2) monitor the implementation of Devolution Transition Plans; 3) resolve issues and concerns attendant to the implementation of EO 138; and 4) inform the public through strong communications plans and strategies.[4]

The transition period for the full implementation of the Mandanas-Garcia Ruling based on EO 138 is 2022-2024. However, as early as November 2022, the DBM already announced that it will seek an extension of the transition period as many LGUs were still not on track to meet deadlines and other preparatory requisites.[7]

## IMPLICATIONS OF THE MANDANAS-GARCIA RULING

### The Mandanas-Garcia Ruling and Devolution

The 1987 Philippine Constitution mandated Congress to "enact a local government code which shall provide for a more responsive and accountable local government structure instituted through a system of decentralization," that eventually led to the Local Government Code of 1991.[2] The code changed the delivery of basic government health services, from a highly centralized system with the Department of Health (DOH) as the sole provider, to a decentralized system wherein LGUs took up many of the functions previously discharged by the DOH. The full devolution of these services goes at the heart of the Mandanas-Garcia Ruling and recurrent issues borne out of devolution will likewise hound the effective implementation of the ruling.

The devolved system left LGUs responsible for the delivery of basic services, including primary care and hospital care services, as well as the operation of health facilities. Primary health services are the basic health services delivered at barangay health centers, rural health units (RHUs), and barangay health stations (BHS). Secondary health services are medical services accessible in some RHUs, infirmaries, district hospitals, and out-patient departments of provincial hospitals, while tertiary health services are usually provided by medical specialists in a hospital setting.

Under the devolved set-up, the DOH focused on regulation, policy implementation, and provision of technical assistance, while maintaining control over the administration of regional medical centers and specialty hospitals.[8] However, not all DOH powers, functions, and responsibilities have been devolved. The DOH still have residual powers and functions, and these are the aspects that the Mandanas-Garcia Ruling and EO 138 will impact on. Under the full devolution of services, for instance, the DOH's level of involvement in the implementation of primary care and public health programs and services may be reduced further.

Resource constraints have always been an issue in devolution. Prior to health devolution, the DOH recognized that many of the LGUs might be facing resource constraints and it had a policy dilemma of whether or not to devolve health services to LGUs. The issue on financing for health is rooted on the mismatch between the internal revenue allotment (IRA) and the cost of devolved functions. The disparity in IRA distribution and costs of function have also caused LGUs to complain about inadequate funding for the operation of health facilities, particularly hospitals, resulting in lower province-level spending on hospitals.[8] Health financing issues due to the mismatch between the IRA and the cost of devolved functions left LGUs with insufficient funds for salaries, structures, and personnel.[8] Consequently, LGUs in smaller provinces or rural municipalities get a smaller share of their IRA that is often insufficient to support labor-intensive health services. As a result, most LGUs have relied significantly on payments from the Philippine Health Insurance Corporation (PhilHealth) to sustain the operations of their health facilities.[9]

Moreover, opinion about the impact of devolution on local health services continues to vary. In a study by Liwanag and Wyss on optimizing decentralization for the health sector, decision spaces at local levels have been mostly moderate or narrow despite 25 years of devolution in the Philippines.[9] Although one major objective of devolution was to empower communities to address their own needs by bringing decision-making closer to them, this did not happen in reality.

Lastly, health devolution has resulted in geographical displacement, job loss, income and benefit changes, and increased politicization of health. For instance, midwives have been forced to resign because they were displaced or moved away from their place of residence. This continues to happen due to political differences whenever local political leadership changes. Deployment programs of the DOH like the Doctors to the Barrios Program and the Nurse Deployment Program remain stop-gap measures that mitigate understaffing in local health systems. Implementing the Mandanas-Garcia Ruling, which requires full devolution of health services, will be greatly impacted by the sufficiency or insufficiency of health staff.

## The Mandanas-Garcia Ruling and Local Health Systems

Theoretically, the Mandanas-Garcia Ruling is meant to improve on the current gaps in different sectors of the LGU. According to the National Economic and Development Authority, the increase in IRA will help fund devolved basic services such as health, agriculture, disaster management, peace and order, and safety. It is said that this will enable LGUs across the country to acquire ambulances and medicines, and to construct health centers and hospitals without requesting funds from the national government.[10]

However, the Mandanas-Garcia Ruling itself does not include specific guidelines on how funds will be allocated at the local level. The ruling also ties in with the goal of decentralization or devolution of health care, which on its own has consistently faced varying issues and challenges. The increase in IRA may help address problems closely related to health financing but this is only possible when proper safeguards are in place. For instance, the ruling is silent on the autonomy of local health personnel and the oversight between public health implementers and local chief executives needs to be clarified, consistent with local and national public health goals.

There are several facts to consider. First, increasing funds do not necessarily address gaps in local health systems. There is a historical precedent for LGUs to underspend or fail to spend national tax allotments as expected. A 2021 report by the World Bank reveals that LGUs have lower execution rates as the budget share for capital outlay increases. Mismanagement and misuse of funds are recurring issues that need to be addressed.[11] Moreover, increasing LGUs' share in national taxes does not mean equitable distribution of funds for all local governments as arrangements on the distribution of fiscal resources are determined first before considering expenditure assignments.[12] This can potentially lead to a further mismatch between the cost of devolved functions and the IRA distribution of a locality. According to Liwanag and Wyss, "Decision space for financing and budget allocation was assessed to be moderate-to-narrow because the flexibility in making local funding decisions in the Philippines largely depends on the income classification of the local government."[9]

Second, the poor absorptive capacity of LGUs limits their provision of public services.[13] The problem lies in granting LGUs wide-ranging powers to run their own affairs and effectively administer their own policies.[13] An imbalance stems from a variety of technical, political, and institutional

obstacles that affect the proper design and implementation of decentralization and local government reforms.[6] The service delivery capacities of LGUs also vary widely, leading to challenges in planning and execution of local health programs, particularly for smaller and resource-poor municipalities.[6]

Previous studies have shown decreased spending for health by the local provincial governments across the years and the dominance of narrow electoral objectives influencing financing decisions for health.[14] Furthermore, successful planning relies on the LGU's ability to plan well and on the local chief executives' convening of the local health board (LHB). The LHB is expected to recommend policies concerning planning and implementation of local health programs and is regarded as a venue where the DOH would be able to relate to LGUs. The regularity and continuity of LHB meets often depending on the politicians' prioritization of health concerns during their term of office.[9] Even then, some of the issues, like underfunded mandates on salaries and benefits, are beyond the scope of the LHB to address.

Third, as reported by the World Bank in 2021, there is a real threat to the country's long-term economic growth with the implementation of the Mandanas-Garcia Ruling.[11] As the LGU spending increases, the revenues gained from their localities will remain small. Hence, instead of establishing an independent and autonomous LGU, there is fear that LGUs will become more dependent on their IRA, something contrary to the goal of independence in the Mandanas-Garcia Ruling.

### The Mandanas Ruling and the Universal Health Care Act

The current direction and thrust in health service provision will be largely shaped by the Universal Health Care Act (UHC Act - RA 11223), which seeks to provide a comprehensive range of health services via integrated local health systems.[15] Enacted in 2019 and with ten years towards full implementation, the UHC Act intersects with the Mandanas-Garcia Ruling not just in terms of service delivery but also in terms of resource generation and financial management.

In their content analysis of the UHC Act, Bautista et al. note three areas of integration in relation to local health systems: structural, managerial, and financial.[16] Structural integration involves the creation of city- and province-wide health systems, as well as the formation of inter-local health zones and service delivery networks within such systems. Managerial integration involves the strengthening of LHBs, as well as the representation and participation of various stakeholders, whereas financial integration involves the pooling of resources at various levels (i.e., national, provincial, municipal) into Special Health Funds from which allocations and disbursements will be made.

Against the backdrop of such integration, the UHC Act may seem like a strategy for re-centralization, which will run counter to the spirit of the Mandanas-Garcia Ruling. The ruling pushes for full devolution and in this regard, the LGUs are put "in a position of strength with respect to the two other institutional custodians of UHC: the DOH and PhilHealth".[16]

Further, the UHC Act cannot compel cooperation between the LGUs in their zones despite the requisite integration and the provision of resources and support mechanisms for such integration. Thus, inherent weakness between national and local relationships, as well as the vulnerability of local priorities to political administration changes, will persist.

On a different note, Capeding et al. highlights possible gaps in the Implementing Rules and Regulations (IRR) of the UHC Act.[17] Among the concerns identified were "the role of the private sector in local health systems; the integration of different municipal and other component health systems into a province-wide health system; organizational design of the health systems; pooling and utilization of the Special Health Fund."[17] For instance, the articulated challenge of integrating public and private providers under one network centered on financing concerns, particularly the mixing of private and public funds, which was deemed disadvantageous to the private sector because of government auditing and the slow processing of funds.

As for the use of the Special Health Fund, since the identified sources include the DOH and foreign-funded financial grants, PhilHealth reimbursements and capitation, and local budget allocation form the LGU, a main concern is whether or not the pooled funds will be pooled to the province, as doing so affects the municipalities and may add another layer of vulnerability to local political dynamics.[17] How provincial officials will manage the Special Health Fund (SHF) is a key challenge. These should be considered in the Devolution Transition Plans as required by EO 138.

At the end of the day, the synergy between universal health care and the full devolution of health services should be measured against the primary objective of increasing access to health and improving health outcomes. This is necessary given that data on the effectiveness of UHC in improving access to services and health outcomes is not as robust as generally presented by organizations advocating UHC, such as the World Health Organization.[18]

## RECOMMENDATIONS

Decentralization should lead to more systematic involvement of citizens in decision-making regarding health policy goals, design, and financing, and in monitoring service provision in their communities. Citizens need to have access to the information, financial means, and bargaining power required to elicit appropriate responses from health care providers at the decentralized level. If these conditions are fulfilled, decentralization should provide the basis for sustainable financing as well as continuing health advancements.[19]

Thus, the following actions are recommended:

## 1. Address disparities in fiscal and governance capacities of local governments

The substantial increase in the IRA provided by the Mandanas-Garcia Ruling will not address inequities exacerbated by the existing distribution formula. There is a need for equalization programs to address the horizontal disparity among LGUs. Low income and disadvantaged LGUs need additional national government transfers, like the Growth Equity Fund.[3] These equalization grants are common in other countries despite varying equalization transfer designs. Canada and Germany only take into account fiscal capacity when designing their equalization transfers, whereas Australia and Switzerland also take into account expenditure requirements. Legislators should carefully examine the proposed Growth Equity Fund and how it addresses disparities that persist in light of the Mandanas Ruling.

In addition, increasing the IRA share or reformulating the distribution formula may be better means for addressing fiscal disparities. Reformulation of the IRA may address the variables not considered by the existing formula, like poverty incidence and fiscal capacity. For instance, the national government may apply conditions that would have the LGU share rate inversely associated to its fiscal capacity. In addition, other factors such as demographics (e.g., age profile of the local population), local morbidity from specific diseases, and ability of a local residents to pay tax may also be considered in determining the appropriate allocation in each LGUs, such as modeled in Finland.[20]

Moreover, LGUs need independent sources of revenue to truly enjoy fiscal autonomy. New revenue streams must be developed to meet local health needs and reduce dependence on IRA. The restrictive provisions of the Local Government Code of 1991 on increasing own-source revenue must be amended, while strengthening Interlocal Health Zones, especially in resource-poor areas, can ensure inter-LGU sharing of scarce resources and mitigate problems brought about by the fragmentation of health care.[21]

## 2. Ensure adequate local government expenditure on health

Local health services often compete with other non-health services for budget allocation and is subject to the approval of local chief executive. To ensure adequate health expenditure, local decision-makers must have adequate capacity to determine priorities for health services and make financing decisions based on facts rather than political agenda. Local governments must be required to adhere to the minimum allocation from their own local budgets as a counterpart to support local health services to receive accreditation of local health facilities and be eligible for reimbursements from PhilHealth. Moreover, current national regulations on the use of PhilHealth funds by local governments should be strictly enforced to encourage use of the money solely for healthcare-related expenses, with future PhilHealth reimbursements contingent on the local government's adherence to these regulations.[9]

For the long term, regulations requiring local governments to allocate a minimum amount of the national tax allotment for health services must be passed into law. This includes House Bill No. 10392, which mandates the LGUs to allocate at least 15% of their NTA for health services. Shah illustrates the output-based grant system in the Canadian Health Transfers program.[22] Under this program, the federal government provides health transfers to the provinces, with the growth rate of the transfers being correlated with the growth rate of the gross domestic product. Spending is not subject to any restrictions, but access to healthcare is subject to strict guidelines. This output-based grant encourages adherence to the accessibility and service quality requirements specified nationally but has no effect on local government cost-efficiency incentives.

## 3. Strengthen the institutional capacity of local health systems

The proper design and implementation of decentralization and local government reforms are often hindered by a variety of technical, political, and institutional obstacles. One of these obstacles is inadequate capacity building, which is defined by WHO as development of knowledge, skills, commitment, structures, systems, and leadership to enable effective health promotion. As such, aside from focusing on developing individual and organizational capacity, capacity building consists of acquiring and applying new or enhanced capabilities to promote health and engage in evidence-informed interventions.[23]

In the Philippines, the managerial capability of local chief executives was not considered prior to the decision regarding the transition to health decentralization. There was also no effective capacity building for local officials and health personnel before the devolution. In general, there was no sufficient preparation that would enable all those affected by the health devolution to cope with the tremendous changes it brought. Consequently, the LGUs faced several challenges to make devolution work.[8] To address this, reforms and activities that aim to build health leadership and governance capacities in all levels of local government should be in place. Although currently in place, the provision of technical assistance for effective planning and for developing the required competencies of decision makers and healthcare workers in the local government should be revisited and improved. The national and local government can also partner with different institutions, organizations, and experts for provision of evidence-based training. Mechanisms for monitoring and evaluation should also be in place to ensure effective function.

Furthermore, capacity building through optimizing decision-making in financing and budget allocation is

recommended. This is to ensure that decision-makers in the localities have adequate capacities for performing priority-setting, putting emphasis on primary or preventive care services,[24] and evidence-informed funding decisions, rather than politically motivated ones. Local decision-makers must also be trained in creating alternative sources of income, short of increasing user fees that may reduce access, that are earmarked for financing local health services.[25]

### 4. Ensure continuity despite changes in political leadership

Sustainability of health reforms is not assured in every change of political administration (i.e., every three or six years). By the time that some health programs take root and reap the expected benefits, they are replaced by new ones due to the change in political administration and/or lack of (political) traction. In addition, since most of the health-related decisions of local government rests with elected officials, politicization is a major concern when it comes to managing human resources for health. This is seen in instances wherein politicians may or may not be supportive of public health goals, setting aside the local health officer who has the technical and administrative capabilities for health services.[8]

In order to address this, an executive order can be developed to ensure sustainability of health programs in every change in political administration and to prevent politicization in health care. The functionality of the LHB should also be strengthened to ensure alignment of the plans and decisions of the local and regional level with the national government and strict implementation of health programs. Strengthening of LHBs can be achieved by increasing its capability to conduct more public health initiatives and community consultations.[9] Community participation must be actively advocated to LGU leaders, health workers, and other stakeholders by the DOH.

Active advocacy can be thoroughly done by discussing the roles, responsibilities, expectations, accountability, and benefits of an active LHB member.[26] More community representatives, who are selected by consensus by the community, in the LHB should be attained. It is highly encouraged that community representatives come from other NGOs engaged in other activities (e.g., environment, social services, agriculture), people's organizations, and unorganized community members to ensure balance of influence of LGU officials.[26] Community representatives in the LHB may also be retained irrespective of the change in political administration so as to maintain the sustainability of programs and human resources.

## CONCLUSION

The Mandanas-Garcia Ruling is not expected to be the sole means by which to improve local health systems. Despite opportunities for independence, self-ownership, and growth for local health systems and their leaders, there are also challenges in the lack of coordination between the national and local government, weak implementation capacity, and other existing institutional gaps in health care service delivery. The impact of the ruling on local health systems largely depends on how other health programs such as the devolution of health and the UHC Act are being implemented. Such have created recurrent if not long-standing problems in healthcare delivery. While the decentralization that underlies the Mandanas-Garcia Ruling can be a powerful instrument in improving health access of Filipinos, significant risks and challenges must be addressed for potential benefits to be realized. Given the current social, political, and economic situation of the country's healthcare system, providing relevant social safeguards while implementing the Mandanas-Garcia Ruling will be necessary to ensure the most benefit for the whole community and its citizens. The additional functions, aside from the increased funding allocation, should be the start of more efficient and responsive local health systems.

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All authors certified fulfillment of ICMJE authorship criteria.

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