Does the Number of Veto Players Matter? Cases of Health Policy-Making Among Municipalities in Bohol, 1999-2003

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Literature on veto player approaches in decision making is increasing in the field of comparative politics. Applying this approach to local government decision making in the Philippines, the study hypothesizes that given structural constraints, local politicians from opposing factions would block policies that could enhance the electability of the faction in power, a condition of high party polarisation. Thus following Tsebelis (2002) veto players' theory, it is expected that systems with more than two veto players would have difficulty effecting policy change. The study uses a discrete-time event history model in examining the timing of Sentrong Sigla certification among selected municipal health centres in Bohol augmented by a comparative case study using loosely the most similar systems design. The analysis highlights historical health expenditures and the dimensions of capacity proposed by Hilderbrand and Grindle (1995). The study found out that systems with two-veto players are more likely to have SS certification with an odds ratio of around 3.0. The result implies that the system, in general, does not tend to exhibit high party polarisation and only has healthy competition that tends towards responsiveness. In the case studies, aside from formal veto players, local bureaucrats could also "veto" policy proposals especially in the area of health.

The Philippine Constitution mandates the protection and promotion of the right to health of the people (Art. 2, § 15) consistent with established international norms (1948 Universal Declaration of Human Rights, Art. 25, § 1; 1978 Declaration of Alma Ata, Paragraph V). This recognition of the right to health is largely due to

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the important role of health in the welfare of the people especially the vulnerable. For instance, the Narayan et al. (2000, p. 95) found out that the "body is sometimes poor people's only asset and is a major source of insecurity". The need to improve health services delivery to meet these normative ends led to the intersection of health and decentralisation. The World Bank (1993) in its World Development Report (WDR) recommended the decentralization of administrative and budgetary authority as one of the measures to improve the management of government health services. The report was reflective of the increasing consensus since the late 1980s on the merits of decentralising fiscal decisions and delivery of health services. For instance, an earlier WDR (World Bank, 1988) argued that "decentralizing both spending and revenue authority can improve the allocation of resources in the public sector by linking the costs and benefits of local public services more closely" (p. 154). Since then, many countries have decentralised health service provision (Bossert & Beauvais, 2002; World Bank, 2005).

In the case of the Philippines, the opening brought about by the post-1986 democratisation (Atienza, 2003) coupled with the emerging international consensus on decentralisation contributed to the enactment of Republic Act 7160 or the Local Government Code (LGC)[1]. Under the LGC, health service delivery, among others, was devolved to local government units (LGUs) (see § 17). In this decentralized system, municipalities and cities are the front-liners in health service delivery as they are tasked with providing primary health services. As support to these devolved functions, LGUs receive internal revenue allotments (IRA) from the national government equivalent to forty percent of the internal revenues collected in the last three preceding years (§284). These amounted to around P100 billion in 2000 (Gatmaytan 2001: 642). Aside from the IRA, the national government also promotes innovations and standards in health services. The Quality Assurance Program, which was piloted in 1998 (cf. DOH, 1998a; DOH, 1998b) and later launched as the *Sentrong Sigla* [Center of Vitality] (SS) movement in December 1999 (DOH, 1999), is one of these initiatives.

An SS certification from the Department of Health (DOH) serves as a seal of approval on the preparedness of the health facility to provide services. While SS certification is also available to hospitals, this study focuses on health centres which are under the control of municipalities for four reasons. First, municipalities are, as discussed above, in the frontline health services provision. Secondly,

together with provinces, municipalities are disadvantaged in the distribution of IRA vis-a-vis the cost of devolution. In 1999, municipalities got 34 percent of the IRA and 47.4 percent of the cost. Provinces got 23 percent of IRA and 45.6 percent of the costs while cities got 23 percent of the IRA and just seven percent of the cost of devolved functions (Philippine Institute for Development Studies, 1998; Gualvez, 1999). Thirdly, while provinces are greatly disadvantaged in this distribution, they have prior experience in health service provision before the devolution. In contrast, municipalities have little previous managerial experience in health service delivery (Atienza, 2003). Finally, municipal officials tend to place health in the lower rung of prioritisation compared to ordinary household members. Municipal officials' professed preferences in the critical area of health are negatively correlated with household preferences (Azfar et al., 2000: 26; also cited in Campos & Hellman, 2005).

By October 10, 2003, forty eight percent of municipal health centres nationwide received SS certification (DOH, 2003) leaving fifty two percent uncertified. This study explores the possible relevance of the local political configuration, particularly the number of veto players, as a possible reason for these differences in outcome. This paper hypothesizes that the number of veto players in LGUs affects the timing of SS certification of municipal health centres. This is tested among the municipalities in the province of Bohol for two reasons. Municipalities in the province are mostly in the lower-income classes[2] making them suitable grounds for looking at investments in health service delivery under resource constraints. Around 87 percent (41 out of 47) of the municipalities are in the fourth and fifth income classification (Bureau of Local Government Finance, 2005). Secondly, the proportion of certified municipal health centres by the time Phase One of *Sentrong Sigla* program ended in 2003, at 46.8 percent (22 out of the 47) closely approximates the national certification percentage at forty eight percent.

The subsequent sections provide a brief survey of the literature on veto player approaches, outline the formal rules in municipal decision-making as it relates to SS certification and the significance of political affiliation in the process, describe the methods used in testing for the significance of veto players in local health decision-making, present the findings (quantitative and qualitative) and discuss its relevance to the problem at hand and, lastly, make some conclusions while pointing to areas for further research.

VETO PLAYERS' APPROACHES AND SOME APPLICATIONS

Ganghof (2003) observed the fast growing literature on veto point and veto player approaches in studying "virtually every policy area" in comparative politics. These approaches are of at least three kinds: 1) (comparative) case studies, 2) quantitative studies that make *assumptions* about players' substantive preferences, and 3) quantitative studies that try to *measure* players' preferences. Comparative case studies systematically look into the role of institutional veto power in legislative processes and policy outputs. Immergut's (1992) study of health politics in the United States, France, and Switzerland is an example.

Quantitative studies that make *assumptions* about players' substantive preferences are usually common in economics. For instance, Volkerink and de Haan (2001), in their examination of budget deficits among 22 OECD countries from 1971-1996, assumed that government fragmentation is synonymous with the number of political parties in the system. One of their findings is that fragmented governments have higher deficits. On the other hand, there are quantitative studies that try to *measure* players' preferences. For instance, Tsebelis's (2002) veto players' theory measures preferences as it counts veto players based on the number of institutions or factions with divergent preferences. Actors with similar preferences are lumped as one collective or partisan veto player. Veto players are institutional and partisan actors that need to agree in order to change the status quo policy.

There had been several applications of the theory on a range of issues (Tsebelis, 1995; Tsebelis & Yataganas, 2002; Hallenberg, 2002; McLean & Nou, 2006; Mansfield, Milner & Pevehouse, 2008; Cunningham, 2006). However, despite the theory's application in various areas, there has been a dearth of application on local governments. Cusack's (1999) study of German local governments is one possible exception. However, he did not use the number of veto players as a variable. He only coded certain attributes of some veto players that he deemed important. This study aims to fill this gap by providing a scheme of counting veto players at the local level at least in the local government system of the Philippines. This is a useful preliminary step in order to be able to test the theory at the local government level. The next section outlines the formal rules of

decision-making among LGUs, specifically municipalities, in the Philippines. These "rules of the game" serve as basis in identifying veto players in the system.

DECISION-MAKING AT THE LOCAL LEVEL

Under the Local Government Code, LGUs were given taxation (§129) and corporate (§22) powers. Income from the exercise of these powers augments the IRA. These funds could only be disbursed in pursuance of an ordinance or law (§305 par. *a*). Since ordinances need the approval of the local council, allocation of funds for whatever legal purposes goes through the local legislative process (i.e. §319, §447 par. 2(i) for municipalities).

Under the law, the local chief executive (LCE) (§318) has the duty to submit the executive's version of the budget, which usually reflects the recommendations of the Local Finance Council (§316). An absolute majority of the council is needed to pass a proposed budget *in toto* or with variations. If the budget has been varied by the council, the LCE could exercise its line-item veto power on certain provisions of the appropriations ordinance without affecting the validity of other provisions in the budget (§55). However, this veto could be overridden by a two-thirds majority of the Council (§54). The allocation of resources reflected in the budget reflects the alignment of preferences between an absolute majority of the council and the mayor or, in cases where the mayor vetoes, among two-thirds of the council.

In identifying veto players in the decision-making process, Tsebelis (2002) distinguishes between institutional and partisan veto players. Institutional veto players can either be individual (e.g. municipal mayor) or collective (e.g. a council) actors that are explicitly provided by law. Partisan veto players, on the other hand, are factions within collective institutional veto players that have divergent interests, at least pertaining to a particular policy. Their agreement constitutes the decision of the collective institutional veto player. The council, in contrast to the single person mayor, is a collective institutional veto player composed of eight regular and two *ex-officio* members. As a collective institutional veto player, factions, if any, need to agree in order for the body to come up with a decision and these factions mark the partisan lines.

While politicians could theoretically change factions as they see fit, Hollnsteiner (1963) observed in her case study of a town in Bulacan that "the

elite make up the core of the factions and are far more stable in the sense of remaining with one party over a long period of time" (p. 36). While Lande (1965) highlighted the instability of factions as to their leadership and support, he emphasized that this instability "does not ... affect the continuity of the typical faction over long periods of time" (p. 23). Even if we assume turncoatism as a norm, the options are limited at the local level. Lande (1965) observed the "predominant pattern of bifactionalism" (p. 18) among local contests in the Philippines. Given the plurality electoral system, he observed that a small group would have little chance of victory while an oversized one would be spending its resources needlessly. In this study, political affiliation is taken as a label that a certain faction in local politics assumes at a certain point in time. The same faction could assume different party labels or political affiliation at different points in time.

SS certification, while not a direct policy output by the municipality as it is granted by the DOH, closely approximates the policies adopted by the municipality that supplied the necessary inputs for a health facility to be compliant with the Quality Standards List (QSL). It could be wholly funded by the LGU or, in some cases, through a matching grant from the DOH (cf. DOH, 2001, 2003). In the second option, the LGU still needs to allocate funds to match the national government funding. In both cases, the allocation of resources goes through the local council where opposition members, if any, could veto. The expectation is that the opposition would oppose measures that would enhance the administration's resources and re-electability. This assumption obtains under high party polarization, a situation wherein factional preferences are clearly distinct from each other (see Jones, 2001).

After complying with the QSL, the local chief executive formally requests the DOH for an assessment of the rural health unit (RHU) using the same QSL used in a self-assessment. If the assessors deem the RHU to have met the QSL, it is accorded the certification. But considering that the same Centre for Health Development regional office (CHDRO) that provides technical assistance also assesses the facility for certification, there is only a slim possibility of rejection.

While it is possible for a compliant health facility not to be SS certified if the LGU does not participate in the program (see for instance, Catacutan, 2006), the study assumes a utility maximizing preference among municipalities, most of them being in the lower income classes that would greatly benefit from the monetary reward that comes with certification. The next section outlines the

operationalisation of political affiliation in determining veto players' configuration at the local level.

METHOD

A comparative case study and a quantitative study that assume the preferences of local politicians are employed to test the proposition that the number of veto players, at the local level affects policy, which in this case is the local policy on health facilities. The following discrete-time event history model is used and estimated using person-period data.

$$\log\left[\frac{h_j(t)}{1-h_j(t)}\right] = \alpha_1 D_1 + ... + \alpha_5 D_5 + \beta Exp_j(t) + \beta NVP_j(t)$$

Where, $h_j(t)$ is the probability of municipality j having Phase One SS certification at time t, $\alpha_1 D_1 + ... + \alpha_5 D_5$ are dummies for each year from 1999-2003 with 1999 as the reference category (following Steele, 2005), $Exp_j(t)$ is a time varying covariate representing the annual health expenditure for municipality j at time t where t is between 1998-2002 (inclusive), $NVP_j(t)$ is another time varying covariate representing the number of veto players for municipality j at time t where t is between 1998-2002 (inclusive), and β, as exponentiated, gives the odds ratio pointing to the possible influence of a covariate on the occurrence of an event of interest controlling for other covariates in the model.

Data for political affiliations came from the Commission on Elections National Office, annual municipal health expenditure figures were from municipal budgets in the Provincial Budget and Management Office, the list of SS certified RHUs came from the DOH Provincial Health Team (PHT), and the names of ex-officio members of the local councils were from the Office of the Association of Barangay Councils (ABC) Provincial Federation President and the *Sangguniang Bayan* (SB) offices of municipalities. The dataset is organized in the standard unit-time format where the unit of observation is municipality-year. It starts in 1999 when Phase One of the SS program was launched and ends in 2003 when it was terminated to pave the way for Phase Two (as implied by DOH 2003, p. 7, par. 2 of Part IV-B (3)). Once a municipality's health center got SS certification, it is excluded from the data set. This translates into 214 municipality-year observations.

Twenty-five municipalities were right truncated[3] as they did not exhibit the event of interest within the observation period. This makes event history analysis more suitable compared to other regression analyses (Yamaguchi, 1991) as it distinguishes between durations with different endpoints: an event or truncation. On the other hand, twenty-two of the municipality-years are events when municipality *j* got SS certification at a certain time or year *t*. Given the latter data, the study takes a conservative approach in the number of covariates pre-determined theoretically to be included in the model. Following Peduzzi and others (1996), the study included only two covariates to maintain the number of events per variable at ten or more. In the equation, aside from the logit of the baseline hazard function, $a(t)$, there are only two variables or predictors since there are only 22 events. The number of veto players was selected based on a proposition derived from the veto players' theory. The expenditure variable is selected as a control variable for at face value policy implementation involves disbursement of funds. The specification of the baseline-logit hazard is not included in the count given its necessary inclusion in an event history model.

SS certification serves as the dependent variable. In municipality-years prior to the certification of municipal health centres, it assumes a value of 0 for policy change (no change, no *SS* certification yet). During the year of certification it has a value of 1. Those municipalities which did not receive certification have 0 for policy change throughout the observation period. The first time-varying covariate is the annual health expenditure which were the actual expenditures devoted to the Municipal Health Office from 1998-2002 as reflected in the actual year column of the Local Budget Preparation Form No. 52 in the municipalities' annual budgets.

The second time-varying covariate that reflects the theoretical thrust of the study is the number of veto players indicated by the number of political parties in power. Table 1 shows twenty-two possible scenarios of alliances in the local council and its corresponding number of veto players. Column 2 'Allies' refers to the number of councilors allied with the mayor. Column 3 'non-allied votes needed' refers to the votes needed by the mayor's allies to have an absolute majority. Column 4 'NAM (Non-allied members)' refers to members of the council that are not allied with the mayor's political party. Column 5 'fragmentation of NAM' refers to the number of opposition political parties and independent members in the council. Finally, the last column 'NVP' refers to the number of veto players given a scenario.

Table 1. Possible veto-player configurations in municipalities

Scenario	Allies	NAM votes needed	NAM	Fragmentation of NAM	NVP
1	6-8	0	0-4	1-4	1
2	5	1	5	1-5	2
3	4	2	6	6	3
4	4	2	6	1-5	2
5	3	3	7	7	4
6	3	3	7	4-6	3
7	3	3	7	1-3	2
8	2	4	8	8	5
9	2	4	8	7	4
10	2	4	8	4-6	3
11	2	4	8	1-3	2
12	1	5	9	9	6
13	1	5	9	8	5
14	1	5	9	5-7	4
15	1	5	9	3-4	3
16	1	5	9	1-2	2
17	0	6	10	10	7
18	0	6	10	9	6
19	0	6	10	8	5
20	0	6	10	5-7	4
21	0	6	10	2-4	3
22	0	6	10	1	2

The counting of veto players is based on the goal of constituting the smallest number of factions (represented by political affiliation), assumed to have varying interests, that would constitute an absolute majority in the council. In the case of Bohol, all the cases have either one or two veto players or political factions constituting an absolute majority in the council. This is consistent with Lande's (1968) observation in the Southern Tagalog areas that '[w]hile the number of factions which compete for political office and spoils varies among constituencies, bifactionalism appears to be the most common pattern, with trifactionalism being less frequent." (p. 727).

To provide depth, a comparative case study employing a most similar systems design (MSSD) (as specified by Anckar, 2008) using four of Hilderbrand and Grindle's (1995, 1997) five dimensions of capacity was implemented. These dimensions take into account the different factors that could affect government capacity to change its policy. The four dimensions are: (1) the action environment which includes the political, social and economic milieus of the municipality including the number of veto players, (2) the public sector institutional context which includes the rules and procedures set for the operations of the municipal government (e.g. the LGC, relevant DBM, DILG, and COA circulars) and the financial resources to carry out activities including health funds, (3) the task network which includes the set of organizations/actors that can influence the policy-making process which resembles the Local Health Board and, finally, (4) the organization of the municipal health office under the municipal doctor which implements improvements in compliance with the QSL.

Based on a most similar system design, two municipality-time periods were selected as cases: San Miguel (from late 2001 to late 2002) and Mabini, Bohol (from August 1999 to January 2000). In an ideal MSSD, other extraneous variables are reasonably similar as approaching to be constant between the two cases (Anckar, 2008). In reality, however, no two cases have the same attributes. In the case of Mabini and San Miguel, it would suffice that both have similarities deemed significant to government capacity. These similarities will be discussed in the comparison of dimensions of government capacity below.

In the MSSD, as much as possible, only the independent variable of theoretical interest is seen to vary to be able to argue that the variable has a relationship with the outcome. Despite the similarities between Mabini and San Miguel, during the decision period from August 1999-January 2000, Mabini only had one veto player with majority of the council allied with the mayor. This satisfies the possibility principle (Mahoney & Goertz, 2004) where there is a significant presence of the main independent variable in the case to warrant possible policy change. San Miguel's case, on the other hand, is counter-theoretical since it had two veto players when discussions about SS certification were made possibly since late 2001 until its certification in the last quarter of 2002.

The subsequent section presents the findings of the methods employed and discusses its implication to the theoretical proposition of the significance of local political configuration especially the number of veto players.

RESULTS

Table 2 shows the results of the logistic regression employing two covariates—number of veto players and health expenditure—while taking into account time which are modelled as dummy variables. The odds of these municipalities having SS certification in 2003, controlling for expenditures and the number of veto players, increases by 11.5. This could be due to the longer time available for municipalities to invest in their health facilities and prepare for certification. The imposition of several moratoriums in SS assessment prior to 2003 which affects the timing of certification in favour of those years where moratoriums were not in place could also explain this result.

Due to discrepancies observed between the ratings of the national and regional assessment teams, a moratorium on SS assessment was put in place in July 2000 (DOH, 2000b) which was lifted in August 2000 in time for the November 2000 awarding ceremonies (DOH, 2000c). Another moratorium was placed in December 2000 as further trainings were made among the assessors (DOH, 2000a; 2001b) and was subsequently lifted in June 2001 (DOH, 2001c). On balance, moratoriums were in place from July to August 2000 and from December 2000 to June 2001.

TABLE 2. Regression results

Variables	**Exp(B)**
Dummy variable for Year 2003	11.464*
Dummy variable for Year 2002	4.108
Dummy variable for Year 2001	0
Dummy variable for Year 2000	1.072
Annual health expenditures of the Municipal Health Office	1.000
Number of veto players (reference value is 2)	2.946**
Constant	0.006*
**p=0.05 *p<0.01	

The results also showed that controlling for health expenditure and time, the number of veto players is statistically significant in explaining the timing of SS certification among municipalities in Bohol. The odds of a municipality with two veto players having SS certification while controlling for expenditure and time increases by a factor of almost three (2.9) compared to municipalities with only one veto player. The results are seemingly counter-intuitive because one would expect systems with only one veto player to implement policy change easily compared to systems with two or more veto players. In the latter cases, several actors first need to agree in order to affect policy change. The case studies provide a possible explanation for this counter-intuitive finding while also highlighting variables that were not quantified and included in the quantitative analysis.

Following Hilderbrand and Grindle (1995), the presentation of findings in the comparative case study between San Miguel and Mabini is structured according to the four dimensions of capacity.

ACTION ENVIRONMENT

Mabini and San Miguel are both several tens of kilometres away from the provincial capital and with roughly the same land area. Mabini's average population per barangay in 2000 at 1238 people was only slightly higher compared to San Miguel's 1157 people. The reverse was true in terms of the average population per health station; Mabini had 3893 people per health station slightly lower than San Miguel's 4166 people. Poverty incidence, however, was higher in Mabini in 2000 at more than half of the population as opposed to slightly more than a third in San Miguel in 2003 (a year after the certification). However, these data were not available during that time as these were retrospectively measured only in 2005 and 2009, respectively, and could not have affected policy-making.

In the political arena, Mabini was under the administration of Mayor Venancio Jayoma for three consecutive terms from 1992-2001. San Miguel, on the other hand, was under the administration of Mayor Silvino Evangelista for two consecutive terms (1998-2004). At least from 1997 to 2001, a period including the August 1999 to January 2000 decision period, Mayor Jayoma had majority of the council with five regular and one ex-officio members as allies. On the other hand,

Mayor Evangelista, while having majority of the council as members in 2000, worked with allies which were a minority from mid-2001 until late 2002. It is noteworthy that during this period, specifically during the last quarter of 2002, San Miguel got SS certification while Mabini, during the whole duration where the mayor had the majority, did not. Table 4 shows the veto player configurations of Mabini and San Miguel during the relevant periods[8].

TABLE 3. Facts about San Miguel and Mabini

Town	**Mabini**	**San Miguel**
Distance from the city (km)	104	86
Number of barangays	22	18
Land Area (has.)	10,457	10,404
Population[4]	27,250 (2000)	20,828 (2000)
Income class[5]	4th	4th
Poverty incidence[6]	56.39 (2000) 45.64 (2003)	58.34 (2000) 35.70 (2003)
Number of health stations[7]	7	5

TABLE 4. Number of veto players (NVP), Mabini (1998-2000) and San Miguel (2000-2002)

	Mabini mayor's allies			**San Miguel mayor's allies**		
Period	**Regular**	**Ex-officio (1997-2002)**	**NVP**	**Regular**	**Ex-officio (1997-2002)**	**NVP**
1998 (June 30)[9]	5	1(ABC)	1			
1999-2000	5	1 (ABC)	1			
2000				6		1
2001 (June 30)[9]				3[10]	1 (ABC)[11]	2
2002 (until August 15)[12]				3[10]	1 (ABC)[11]	2
2002 (after August 15)[12]				3	2 (ABC, SK Chairperson)[12]	2

Source: COMELEC ABC-ABC President

Due to the absence of meeting transcripts and the dispersion of items contributory to SS certification in the budget, there are no records to show how the number of veto players mattered in the decision making. Even if the pattern is correlational at best, it is consistent with the quantitative finding that municipalities with two veto players are more likely to have SS certification than those with only one. One possible explanation, at least for the pattern observed in the case of Mabini and San Miguel, is the competition fostered by having strong oppositions. Table 5, for instance, showed that the mayor in Mabini won two consecutive landslide victories with a margin of around thirty percent as opposed to the mayor of San Miguel who won by a slim margin of only around ten percent. This could imply that policy makers comfortable on their hold to power would show complacency as opposed to those who felt that there are always strong groups who can potentially dislodge them from office.

TABLE 5. Comparison of votes

	Mabini			**San Miguel**		
Election	Mayor	Opponent/s	Percentage (Gap)	Mayor	Opponent/s	Percentage (Gap)
1995	5,946	2,799	67.99 v. 32.01 (36)			
1998	5,804	2,960+140+30=3,130	65.97 v. 35.03 (31)	3,983	3,366	54.2 v. 45.8 (8.4)
2001				4,193	3,423	55.1 v. 44.9 (10.2)

Source: COMELEC

PUBLIC SECTOR INSTITUTIONAL CONTEXT

In the public sector institutional context, Mabini and San Miguel differed in income levels during the relevant periods. Mabini had surpluses for the years 1999 and 2000 while San Miguel operated on a deficit in 2001 before returning to surplus in 2002 as shown in Table 6. Mabini had the financial capacity to make investments towards SS certification. While it had larger health expenditures compared to San Miguel, it appears that these expenditures were not towards capital outlay but only for salaries and benefits of personnel and for maintenance and other operating expenses (See Table 7). The same expenses were apparent for San Miguel.

It becomes clear that most of the investments for facilities are programmed outside the allocation for the health office as they are capital outlays that could be sourced from the municipal development fund or appropriated through a

TABLE 6. Mabini and San Miguel comparison of fiscal data

	Mabini			San Miguel		
Year Mabini/ San Miguel	**Total Revenues**	**Total Expenditures**	**Health Expenditure**	**Total Revenues**	**Total Expenditures**	**Health Expenditure**
1999/2001	17,415,483.54	15,531,188.99	1,948.28	19,382,562.67	21,349,448.68	1,613.67
2000/2002	20,969,113.01	20,261,560.50	2,925.80	24,537,626.19	23,440,337.7	1,983.39

Source: Municipal Annual budgets of San Miguel and Mabini

TABLE 7. Health Expenditures (in thousands) Mabini (1999-2000) and San Miguel, (2001-2002)

	Mabini			San Miguel		
Year Mabini/ San Miguel	**Total**	**PS[/a]**	**MOOE[/b]**	**Total**	**PS[/a]**	**MOOE[/b]**
1999/2001	1,948.28	1,898.28	50.00	1,613.67	1,467.67	146.00
2000/2002	2,925.80	2,158.30	767.50	1,983.39	1,807.39	176.00

/a. PS means Personal Services.

/b. MOOE means Maintenance and Other Operating Expenses.

Source: Annual Budgets of the Municipalities of Mabini and San Miguel 2001-2005 (Actual Year Column)

supplemental budget funded by savings. The insignificance of health expenditure in the quantitative analysis is due to its non-inclusion of other health investments in capital outlay that were sourced from other funds in the municipality and not coursed through the Municipal Health Office. In the case of Mabini, it did not invest enough for health aside from those necessary for the routine operations of the health facility. For instance, the RHP cited as one reason for non-certification the deficiency in infrastructure. The health centre needed repair as parts of the floor were sunken and the linoleum floorings were mostly detached. According to him, the municipality, during that time, could not afford to repair the building and procure needed equipment, something that the surplus fiscal position seems to contradict.[14]

On the other hand, San Miguel already had an experience with investing significantly in health projects even before the advent of SS. For instance, as shown in Table 9, before the SS deliberations it already spent millions of pesos

supporting a municipal infirmary that incurred a loss when it started[15]. This infirmary eventually won a *Galing Pook* Award on July 8, 1996 as one of the Ten Outstanding Local Government Programs. The needs for SS certification pale in comparison to these investments that political leaders already made in the health sector. While there are no available records as to the exact amount of additional investments San Miguel poured in order to meet the QSL, past experiences showed that there was a constituency and political willingness to invest in the health sector.

TABLE 9. Subsidy to the Infirmary (in thousands), San Miguel, 1996-2003

Year	1996	1997	1998	1999	2000	2001	2002	2003
Amount	126.60	350.00	400.00	500.00	722.80	1,133.06	1,099.75	1,507.08

Source: Municipal Budget of San Miguel, various years

TASK NETWORK

The task network operating through the Local Health Board was active for both San Miguel and Mabini as both were hailed as Outstanding Municipal Health Boards in Region VII on May 22, 1998. Minutes of the deliberations of the LHBs during the relevant periods also shows that this functionality continued since the receipt of the award.

In San Miguel, the MHO informed the LHB during its meeting on January 18, 2002 that the study tour to Amlan, Negros Oriental by key municipal officals was scheduled on January 30, 2002. The trip aimed to observe, among others, the SS certified Rural Health Unit of Amlan. In another meeting on September 18, 2002, the MHO said that the RHU was due for assessment during the last week of October 2002 but lacked some equipment. Subsequent minutes of meetings in 2002 did not mention the result of the assessment. But given the record of the DOH-PHT that the RHU was certified in 2002, the date of certification could be sometime after October 2002.

While only two minutes of the LHB meetings mentioned the SS program, these showed that SS certification was discussed in the LHB and the discussion was making progress. The September 2002 minutes, indicating that an assessment was underway, implies that the mayor already sent a letter of intent to the CHDRO VII in Cebu since under the Phase One of SS, assessments could only be done after the mayor has submitted a formal request. The presence of the Chair and

Vice-Chair of the SB as members also showed prior approval on their part for undertaking preparations for SS certification. The support of the elected officials was confirmed by the Public Health Nurse.[16]

On the other hand, Mabini experienced a different turn. On August 27, 1999, the DOH Representative informed the LHB about the DOH's SS program, which would award local government units (LGU) with RHUs that has facilities and equipments that could provide the basic services to their constituents. However, the Rural Health Physician (RHP) said that the LHB needed to wait for the mayor, who was absent from the meeting, to decide whether to join the program due to the need for funds in case some instruments were lacking. On September 20, 1999, the DOH Representative mentioned the SS program to the mayor during the LHB meeting. The latter decided that Mabini would not join because "it is very difficult to follow the criteria"[17], especially the suggestion of the DOH in the QSL for the RHU to have night time and weekend consultations. However, this criterion, while a plus, was just optional for RHUs.

On January 10, 2000, the DOH Representative informed the LHB that the regional evaluators for SS had finished evaluating Candijay, a neighboring town. She again inquired if the municipality would participate in the program. The RHP said that the municipality was yet to prepare, especially the building that needed repairs. However, the mayor was absent during this meeting. This was the last LHB meeting where the Phase One SS certification was mentioned. The perennial absence of the mayor who was based in Manila was one reason for non-certification pointed out by the SB CoH chairperson[18] during that time. For instance, in 2000, the mayor was present in only six out of eleven meetings.

On balance, while the task network through the LHB held meetings in both municipalities, in Mabini, however, the LHB's regular meetings and the DOH Representative's persistent lobbying did not lead to SS certification due to reservations on the part of the mayor. In San Miguel, the functional LHB, while not a direct cause, served as a body that facilitated preparations for SS certification as shown in the minutes of the meetings in 2002.

ORGANIZATION OF THE HEALTH OFFICE

On policy issues related to health, the Municipal Health Office is pivotal as it is the only office in the municipality that has the expertise to advise on and

implement health projects and programs. The cases of Mabini and San Miguel present a contrast of health offices with different organisational culture that contributed significantly to the divergent outcomes.

In Mabini, the Rural Health Physician (RHP) construed SS certification as an additional workload without additional compensation. While an SS certified health facility could get accreditation from the Philippine Health Insurance Corporation and receive capitation fund, his personal experiences of PhilHealth's delayed payments in their family hospital in Guindulman, Bohol drew apprehensions that, since he was about to retire, he would not benefit from such funds. Also, he did not get the full benefits provided in the Magna Carta for Health Workers. Worse, the LGU did not convert his job item as Rural Health Physician into a Municipal Health Officer, a designation equivalent to a head of office, which would have increased his benefits. With the RHP designation, he received a monthly Representation and Transportation Allowances (RATA) worth P2,000.00 while heads of other offices in the municipality received P6,000.00. The situation demoralised him up to the point where he would not avail of foreign funded projects due to additional tasks that they would entail given the compensation that he was receiving. Finally, the RHP, a resident of the adjacent town of Guindulman, lives almost 18 kilometres away from Mabini. He would usually hold office from 9:00am to 3:00pm leaving little time to prepare for the voluminous requirements for SS certification[19]. The RHP confirmed this work schedule although he said he made sure that the patients were attended to[20].

In contrast, the MHO in San Miguel led the efforts for SS certification by pushing for the completion of the requirements for the assessment.[21] He received the full benefits under the Magna Carta and was a full pledged MHO. While the monetary difference might no be substantial, relative perceptions of equity contributed to the upliftment of morale that contributed to the enthusiasm.[22] Also, unlike the RHP in Mabini, the MHO of San Miguel was a resident of the municipality living just a few blocks away from the health centre.[23] This allowed him to devote more time to look after the needs of the health centre.

DISCUSSION

Synthesizing the above comparison, San Miguel's certification in 2002, despite having two veto players since 2001, and Mabini's non-participation,

despite having only one veto player throughout the risk period, validate the quantitative finding above that two-veto player configurations are more conducive to SS certification than one-veto player configurations at least among municipalities in Bohol. This is counter-intuitive from the point of view of veto players' theory since it was expected that systems with more veto players would have more difficulties affecting policy change. However, from the point of view of political competition, it makes sense that a system with more veto players—in this case, two—is more responsive since each faction or party is pressured to be responsive to social needs. This responsiveness is less likely if there is only one dominant faction in the LGU which implies a strong grip of power in the municipality. However, it should be emphasized that competition does not necessarily lead to responsiveness. Competition, which could happen in a divided government, when combined with high party polarization could lead to legislative gridlock (Jones, 2001). The assumption mentioned above that the opposition will oppose administration proposals that could enhance the latter's electability indicates high party polarisation. The results imply that while there is competition among factions in Bohol, high party polarisation is not the norm.

Given that party polarization is not high, the mayor's sole duty of preparing and presenting an executive budget gives him the power to set the agenda—a first mover advantage (Tsebelis, 2002). The council works with his preferences. Even if they could insert certain items, the mayor could always veto those insertions effectively restoring her preferred allocations. While a veto could be overridden by two-thirds of the council, a single opposition faction seldom has the numbers.[24] This partly explains why notwithstanding the favourable fiscal position and the functioning task network in Mabini, funds were not allocated towards SS certification. The mayor categorically stated during the LHB meeting that the municipality would not join the program.

Aside from elected officials, local bureaucrats—in this case the municipal doctor—could tacitly yet potently veto a policy related to their organisation for various reasons. Its potency, at least as shown in the case examined, is due to the municipal doctor's monopoly of licensed capacity to practice medicine in the municipality. Most municipalities in Bohol only have one doctor. The mayor, which is usually not a doctor, would seek advice from and entrust the health projects to the doctor. Immergut (1990) briefly referred to the notion that doctors' have professional power because of their licensed expertise giving them monopoly

in the practice of the profession. However, the veto power of the doctor, it should be noted, is only implicit as they cannot openly defy the policy set by elected members of the municipality.[25] Because of this, municipal doctors currently in position are not to be expected to speak against these programs in the open. The doctor interviewed here is already retired which explains his candidness.

CONCLUSIONS AND AREAS FOR FURTHER RESEARCH

As preliminary evidence show, the number of veto players in the LGU matters in policy making—in this case, health policy making. However, it was unexpected that two veto-player systems has a greater chance of having policy change. This was partly due to the competition that exists in systems with more than two veto players. This is, however, possible only in systems with low party polarization. It would be fruitful to study further the dynamics of competition and the levels of party polarisation among LGUs to verify further these initial findings. Another veto player which emerged in the case studies, the municipal doctor, showed how local bureaucrats could act as possible veto holders in the decision-making process through their inaction or even dampened enthusiasm. This could be an interesting subject for further studies: the power relationship between the mayor, the SB members, and the local public doctor will provide insights on who among these nominal power holders really pull the strings of power.

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ENDNOTES

[1] All references using the section symbol (§) refers to pertinent provisions in the Local Government Code or Republic Act 7160 unless otherwise stated.

[2] Based on the classification used in Ramiro, L. S., Castillo, F.A., Tan-Torres, T., Torres, C.E., Tayag, J.G., Talampas, R.G., Hawken, L. (2001). "Community participation in local health boards in a decentralized setting: cases from the Philippines." Health Policy and Planning 16(Suppl 2): 61-69.

[3] A subject is said to be right truncated when the start of the subject's risk period but not its exit is covered by the observation period. The subject, while being at risk, did not have the event of interest during the observation period.

[4] National Statistics Office (NSO) 2000 Census of Population and Housing

[5] Based on BLGF MC No. 01-M(15) dated 28 January 2002 covering fiscal years 1996-1999 and BLGF MC No. 01-M(29)-05 dated 16 December 2005 covering fiscal years 2000-2003.

[6] National Statistical Coordination Board (NSCB) (2005: 89) and NSCB (2009: 100)

[7] As per interviews with the DOH Representatives N. Hencianos (San Miguel) on January 2009 and B. Tan (Mabini) on February 4, 2009.

[8] Relevant periods refer to the periods of decision-making in each case municipilaty: from August 1999 to January 2000 for Mabini and from mid-2001 to the last quarter of 2002 for San Miguel.

[9] The cut-off refers to the start of term (§ 43). In the case of San Miguel, this is a reasonable starting point as the moratorium for SS assessment was lifted only in June 5, 2001 (Department Circular 119, s. 2001).

[10]Of the remaining five, four were from the opposition while one was independent and ran as vice mayor in the opposition party in the 2004 elections.

[11] The Sangguniang Kabataan Chairperson was the son of the defeated mayoralty candidate and, as expected, was in the opposition.

[12] The earliest date possible for the assumption of new ABC Presidents and SK Chairperson as provided by § 4 of R.A. 9164.

[13] Interview with Former Mayor Silvino Evangelista (1998-2007), February 4, 2009.

[14] Interview with Dr. W. Liao, February 3, 2009.

[15] Local Health Board. Minutes of the meeting on February 26, 1997.

[16] Interview with Ms. F. Lampios, February 4, 2009.

[17] Local Health Board. Minutes of the meeting on September 20, 1999.

[18] Interview with Ms. E. Tabigue, February 3, 2009.

[19] Interview with Ms. E. Tabigue, February 3, 2009.

[20] Interview with Dr. W. Liao, February 3, 2009.

[21] Local Health Board. Minutes of the meeting on September 18, 2002.

[22] Interview with Ms. F. Lampios, February 4, 2009.

[23] Ascertained by the author during his fieldwork.

[24] For instance, for the whole period under study, only Batuan, Bohol had a single opposition which controlled two thirds of the council from 1998-2001.