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By

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## I. Introduction

This report is one of the background papers for the *Philippine Human Development Report 2008*, which has for its theme *Institutions, Politics and Human Development in the Philippines*. To highlight the links between, on the one hand, the poor quality of political/government institutions and organizations and, on the other, human development, the 2008 PHDR focuses on the Department of Education (DepEd) bureaucracy and its relations with other government institutions as they together determine the successful delivery of public education services. Among the government institutions investigated are the local government units (i.e., province, city, municipality or barangay). Since 1991, the LGUs have assumed a greater role in the financing of basic education and in the provision of health services. The decentralization of national government functions to LGUs, or devolution, is an institutional reform that is expected to lead to more efficient and equitable delivery of public services. The expected gains from the devolution are based on the assumption that LGUs have better information about the preferences of their constituents, and also better incentives to act on their superior information because of their direct accountability to the service clients.

It can be argued however that a national government agency can achieve the same informational advantage if some functions of the central office are assigned to the local offices, which like LGUs also have direct and frequent contact with the service clients. In 2001, the DepEd adopted this particular form of decentralization when it deconcentrated administrative and fiscal powers and responsibilities to school-level authorities. Again, the underlying assumption is that school heads know more about local needs and are more directly responsive to parents of schoolchildren and other local stakeholders.

Since both forms of decentralization effectively empowered the local-level bureaucrats, it may be asked then which institutional reform has led to improvements in public service delivery. The issue of institutional design is particularly important in the case of public education sector,

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which remained largely untransformed despite several reforms (Bautista, Bernardo and Ocampo 2008). The underlying policy motivation is to improve overall basic education outcomes, which have remained unsatisfactory through the years and low by international standards, by setting up the education institution more appropriate for the country.

However, the question of whether devolution or deconcentration is the better alternative to achieve the desired education outcome cannot be answered directly because the devolution of basic education (primary and secondary) is untried, while its deconcentration is only recently implemented nationwide. The experience in the health sector is not a perfect predictor since health and education services lead to different outputs or impacts, which are both important but not directly comparable contributions to human development indicators. In principle, their contributions to individual or household welfare or well-being can be estimated and compared with the right data. The household-level information from the FIES and APIS however are less than ideal since none can link household decisions directly to the devolution of health services or to deconcentration of education functions. While special surveys on user's access to and satisfaction with local public services or their awareness of decentralization were conducted in the past, they either have only limited sample or socioeconomic information for firm statistical evaluation. Hence, only broad trends in terms of welfare impact can be established from these data sets.

Still some useful lessons for education reform can be learned from the devolution of health services in the country by looking at the effect of decentralization on the supply side. The key features of the supply side are the decision makers tasked to provide the services and the conditions and constraints that govern their decisions. As decision makers, both local government officials (elected or otherwise) and field-level bureaucrats of a national government agency can be thought of as *agents* whose formal and informal incentives and constraints to provide the services for which they are contracted (hired or elected) changed with the new institutional set up. The question now is whether agents act on their supposed superior information better under devolution than deconcentration. To the extent that the form of decentralization matters, the answer bears on the policy debate concerning the appropriate institutional design for the delivery of basic education services in the country.

This paper attempts to provide inputs to policy discussions in the education sector by distilling the relevant lessons from country's experience with health decentralization. The specific research objectives and methodology adopted in this paper are presented in the next section. An institutional framework for comparing devolution and deconcentration is proposed in section III. Then in section IV, the changes in structural structure and legal bases for decentralization in health and education are reviewed. Some evidence on the effects of decentralization in terms of health and education outcomes, service delivery and financing are discussed in section V. Then in the subsequent section, the various health reform measures

adopted under the devolution are discussed. The lessons learned and their implications for education reforms are summarized in the final section.

## II. Research objectives and methodology

The main objective of the paper is to propose institutional reforms to improve the model of decentralization in the DepEd, including recommendation on which education functions are devolved or deconcentrated. This will include an assessment of the desirability of devolution of education services, and the feasibility of equalizing the quality of basic education through national subsidies under devolution.

Towards this objective, the paper shall:

- Assess the experience of devolution of the Department of Health (DOH), with focus on the identification of the desired and actual changes in institutional structure, and the cases where such changes have been successfully implemented and where they are not;
- Assess the provision of and access to devolved health services across different LGUs;
- Assess the policies designed to reduce inequalities in health service provision and access; and
- Examine the decentralized structure of DepEd and the formal arrangements that have distributed functions and powers to local offices; and to compare the concentration of powers to the national government/head office in DepEd and DOH.

To meet the research objectives, an institutional comparative analysis of the devolved health system and the deconcentrated education system in the public sector is made. A framework based on fiscal decentralization and institutional economics is proposed to highlight the normative issues in decentralization and the institutional factors – i.e., formal and informal constraints – that influence the local decision-makers and stakeholders involved in the provision and utilization of health and education services. The changes in some of the formal constraints are identified here with a review of the laws and policies on decentralization. The impact of the institutional change on health provision and access is assessed here based on a review of past studies and on the analysis of secondary data on LGU financing and innovations in service delivery. Relevant DOH policies and those of the national government since 1991 to correct the inequalities in health service delivery are identified and evaluated for their impact on reducing health inequalities. The review of DepEd's experience with decentralization is also based on existing literature, secondary data and interview of DepEd official (Director YolandaAzarcon).

## III. Framing decentralization

According to North (1990), "Institutions are the rules of the game in a society or, more formally, are the humanly devised constraints that shape human interaction." He further

distinguishes an institution from an organization, which is a team of players governed by the rules of the game and whose objective is to win it. It may be asked thus that when the government or a public agency decentralizes, what sort of constraints or incentives are changed that will align the objectives of the government officials with that of the public they serve.

According to the theory of fiscal federalism, decentralization relaxes the information constraint, which enables incentives to be more closely based on performance. In a hierarchical organization such as a system of government or a government department, the lower-level officials interact more with the constituents or service clients. Because of their frequent contact, the lower-rung officials would know more than their superiors about the needs of the target beneficiaries and the local condition. Also, they could respond more directly and promptly to their clients' needs. Thus, an organization gains an information advantage if it delegates the appropriate authority to the lower-level officials.

Yet, the information advantage alone is not sufficient to justify decentralization. As Bardhan (2002) suggested, those high up the organization could also have the same information by commissioning surveys, focus group discussions or client interviews. Thus, it is also necessary that the authorized lower-level official should have the incentive to act on her superior information and proximity to the service clients. She would have a strong incentive to do so if she is also accountable for the consequences of her decisions.

A greater focus on accountability can be discerned from the recent literature on fiscal decentralization (Bardhan and Mookherjee 2006, World Bank 2004). In principle, decentralization could improve accountability since

> "At the local level, citizens can more easily learn of the activities and programs that their local leaders have promoted and supported, discern how much effort they have devoted to improving public services, and confirm whether they have delivered on campaign promises. In other words, the information that citizens need to make judgments is more readily accessible under decentralization." (Campos and Hellman 2005)

Under decentralization, the citizens can directly their feedback about their preferences to local officials or service providers, instead of transmitting the same to policymakers. However, they can still provide other information to policy makers to hold the local officials or civil servants accountable for their performance.

In addition to incentives and accountability, three other aspects are important in the design of decentralization policies. One important aspect is the determination the functions to assign to each level in the organization or government. The guiding principle often used is that a function should be assigned to that level whose jurisdiction covers all those who would be

affected by the discharge of that function. The idea is that the level should internalize all the benefits and costs arising from the performance of its assigned function.

Thus, for example, the responsibility for formulating education or health policies and strategies or setting the minimum service standards should be assigned to the national government (or central office of the department), since these functions affect all Filipinos. If these functions were assigned to regional offices, then too many policies or standards, possibly contradicting each other, will be enforced. The different policies and standards could also lead to inequities in access to public services. They could lead to externalities as when one region ignores the health risks it imposes to its neighbors.

Another important aspect is building the capacity of each level so that it can perform its assigned responsibilities. The required capacity would include the powers or authority to determine, raise and use the inputs and the processes needed to deliver the public service. The inputs would include funds, human resources and organizational capital. Where the lower-level official or unit unable to mobilize these inputs, then the higher-level official or unit should transfer the financial resources, provide the training and other technical assistance.

Finally, a system of monitoring activities and performance, and supervising tasks and personnel should be in place. The responsibility to monitoring and supervise lower-level units or personnel should be assigned to higher-level units or officials. This is to avoid conflict of interest. In the education sector, for example, district officials could be assigned the function monitoring the performance of the school heads within the district. In the health sector, the provincial health officer could track the immunization coverage of the different municipal health offices within the province.

The details of the policy design will depend on the form of decentralization to be undertaken, which also depends on the nature of the public good or service to be provided. There are three general forms of decentralization in government. The first is devolution wherein the LGUs are given full autonomy and control over their assigned public services, subject only to oversight by the national government. In 1991, for example, most health functions were devolved to LGUs in the country. In this case, the devolved health personnel answer directly to local elected officials, who are responsible to their constituents.

The second form is deconcentration wherein the lower-level offices are bestowed additional functions, powers or responsibility previously held by the higher-level offices within the same government department or agency. Beginning in 2001, for example, more responsibilities were delegated to sub-national education officials in the country.
In this case, the lower-level officials are still accountable to their superiors in the department.

The third form of decentralization is the delegation of government functions to parastatal units, private sector groups or non-government organizations who now act as agents of the national government. The private sector group or NGO may be involved in service production, delivery or financing, or in the monitoring and regulation of public services. When the DOH, for example, commissions a medical association to train or certify local health personnel or screen facilities for licensing, then it delegates some of its functions to a private organization. The accountability of the private organization in this case is to the contracting government agency.

In many Asian countries, the national/federal government and sub-national governments (i.e., state, province, city or municipality) divided between them the responsibilities over certain health and education functions (Table 1). In China, Indonesia and Thailand, the LGUs are assigned the responsibility over and the provision of both services. In contrast, the federal and state governments in Malaysia retain complete control over these services. In the Philippines, the central government retains responsibility over both health and education services, while sub-national governments are involved in their provision.

**Table 1. Assignment of responsibility over health and education services in selected countries**

| Country | Health services | Education services |
|---|---|---|
| China | Local | Local |
| Indonesia | Local | Local |
| Philippines (R) | Federal | Federal |
| Philippines (P) | Federal, State, Local | Federal, State, Local |
| Thailand (R) | Local | Local |
| Thailand (P) | Local | Local |
| Vietnam | State, Local | State, Local |
| India (R) | State | Federal, State |
| India (P) | State, Local | Federal, State, Local |
| Japan (R) | Federal, Local | Federal, Local |
| Japan (P) | Federal, Local | Local |
| Malaysia (R) | Federal, State | Federal |
| Malaysia (P) | Federal, State | Federal |

Note: R – responsibility, P-Provision, Federal refers to the federal or national government, State refers to the state or provincial government, Local refers to city or municipal government. Table adapted from Mountfield and Wong [2005].

The form of decentralization to adopt partly depends on the types of public service to decentralize and other conditioning factors. Arguably, health services are more complex than education services. First, there are more health services than education services. Basic health services comprise personal health care (immunization, dental care, out-patient services) and public health care (TB control, malaria control, HIV/AIDS). Basic education comprises elementary and secondary education, which are relatively easier to standardize. Second, more

types of health expertise are needed, from general practitioners to medical specialists, who are also in shorter supply than teachers. Third, health outcomes and outputs are more difficult to measure than education outcomes, partly because there are more complicated clinical/technical, behavioral and ethical issues involved in measuring health outcomes. Fourth, the health care market is fraught with imperfections, from public goods to externalities and to information asymmetries. Information asymmetry is less of a problem in the education sector. Where they exist, externalities in education are largely inter-personal than inter-jurisdictional, since it is likely that parents would rather have their children finish school where they started.

The major challenge in the public education system not quite found in the public health system is the sheer scale of providing the same service every weekday. Every public school teacher has to give instruction to 40-50 pupils every school day. In contrast, the average public health doctor may not have as many patients in a day. The doctor may also assign to nurses or midwives.

The differences between health services and education services mentioned above suggest that the capacity requirement for local provision is largely financing in the case of education services and technical in the case of health services. Regardless of their initial capacities, however, LGUs can improve their performance if supported by the national government. Thus, the choice between devolution or deconcentration will also depends on the incentive and accountability schemes in place, and whether these can amended to improve the provision of decentralized services. Thus, in case of the Philippines, it may be asked if LGUs have stronger incentives or accountability than the DOH to provide better health services.

## IV. Changes in institutional structures

This section presents the major structural changes in the public health and education sectors since 1991 when the Local Government Code was passed. The focus is on the distribution of functions between the DOH and the LGUs in the case of health, and the assignment of greater responsibilities to regional and other lower-level education officials since 2001. The main features of the School-Based Management initiative of the DepEd are also described.

*Devolution of functions*

The 1987 Philippine Constitution has strong decentralist features. In Article II, Section 25, it is declared a state policy that “The State shall ensure the autonomy of local governments”. This provision was further taken up in Article X where the rights and responsibilities of local governments were expounded. These constitutional provisions were later articulated in the Local

Government Code of 1991 (RA 7160). Among the functions, powers and responsibilities devolved from the national government to local government units under the Code were those concerning the provision and financing of health and education services (Table 2).

**Table 2. Devolved Health and Education Functions based on the Implementing Rules and Regulation of the LGC of 1991**

| Functions | Health | Education |
|---|---|---|
| Provision | 1. Barangays – Health services through the maintenance of barangay health stations<br>2. Municipalities – Implementation of programs and projects on primary health care, maternal and child care, and communicable and non-communicable disease control services; access to secondary and tertiary health services; purchase of medicines, medical supplies, and equipment; construction and maintenance of clinics, health centers, and other health facilities<br>3. Provinces – Health services through hospitals and other tertiary health services;<br>4. Cities – All health services and facilities provided by municipalities and provinces. | 1. Municipalities – Construction and maintenance of school buildings and other facilities for public elementary and secondary schools<br>2. Cities – Support services and facilities for education |
| Financing | 1. Funds for the basic services and facilities shall come from the share of LGUs in the proceeds of national taxes (IRA and national wealth), other local revenues, and transfers from the national government, national government agencies (NGAs) and GOCCs.<br>2. NGAs affected by devolution or the next higher LGU may augment basic services and facilities assigned to a lower LGU | 1. Funds for the basic services and facilities shall come from the share of LGUs in the proceeds of national taxes (IRA and national wealth), other local revenues, and transfers from the national government, national government agencies (NGAs) and GOCCs.<br>2. A province or city, or a municipality within Metro Manila Area, may levy and collect an annual tax of one percent (1%) on the assessed value of real property, which is an addition to the basic real property tax. The proceeds shall exclusively accrue to the special education fund (SEF) and automatically released to the local school boards, in the following manner: (i) in case of provinces, the SEF shall be divided equally between the provincial and municipal school boards; and (ii) the amount can only be used for operation and maintenance of public schools, construction and repair of school buildings, facilities and equipment, educational research, purchase of books and periodicals, and sports development |
| Participation and Accountability | Local Health Board – A LHB is established in each LGU comprising the local chief executive as chair, the local health officer as vice chair, the SP/SB chair of the committee on health, a representative from the NGO or private sector, and the DOH representative. The LHB shall propose to the local Sangguniang an annual health budget, and serve as advisory committee on health matters to the local Sangguniang and other local health agencies. | Local School Board – A LSB is established in each LGU comprising the local chief executive as chair, the local division/city/district superintendent as vice chair, the SP/SB chair of the committee on education, LGU treasurer, representatives from the local Sangguniang Kabataan, president of the PTA, and representative from the local teachers' organization and of the non-academic personnel of local public schools. The LSB shall propose to the local Sangguniang an annual supplementary school budget to be funded from the SEF and other local sources, authorize the local treasurer to disburse funds, and serve as advisory committee on educational matters to the local Sangguniang, and recommend changes in the name of local public schools. The DepEd is mandated to consult the LSB on the appointments of key local education officials. |

Source: Bautista (1993).

In the case of health, the devolved functions included the provision of primary, secondary and tertiary care services, most of the hospitals, health facilities and personnel involved in the delivery of the three levels of care. The estimated DOH budget allocation for the devolved function was nearly one billion pesos or approximately 39 percent of its total budget in 2002. The nearly 46,000 devolved health personnel constituted about 61 percent of the total DOH manpower. The financing of the devolved health functions also became the responsibility of the LGUs. They are suppose to allocate funds for the devolved functions from their substantial incremental share in the internal revenues of the national government and in the proceeds from sale of natural wealth (like mineral resources), and from other locally sourced revenues. An important feature of the Code is that each LGU is mandated to establish a Local Health Board (LHB). Comprising local officials and private sector representatives, the LHB is a mechanism for constituents and service clients to directly influence the local health budget and advise the LGU on health issues and concerns.

The Code also devolved education functions to LGUs, albeit on much lesser extent than in the case of health services. Specifically, the municipalities and cities were given the responsibility of constructing and maintaining school buildings and other facilities. To finance these expenditures, the LGUs are allowed to collect an additional one percent in real property taxes, called the Special Education Fund (SEF), mobilize resources from other sources, or both. The disbursement of the Special Education Fund (SEF) should be based on the annual education budget develop by the Local School Board. Like the LHB, the LSB is also mandated consultative body and venue for direct participation of the private sector representatives in local fiscal affairs.

In a sense, the LGUs were assigned greater health functions than education functions. They were also given greater autonomy to experiment or innovate in their delivery and financing of health services, which has both bad and good consequences. They have less leeway to reconfigure education services, for which however a more secure local financing is provided under the Code.

*Deconcentration of powers and responsibilities*

While DOH devolved more functions than DepEd, the latter however deconcentrated more functions than the former. That is, the sub-national offices of the DepEd are relatively more powerful than those of the DOH. This is evident in the division of responsibilities between the national office and the sub-national offices in the two departments (Table 3).

In the case of DOH, the national headquarter determines the overall health objectives, develops the health plans, programs and projects, sets the health standards and regulations, controls the health budget (for the department), supervises the big specialty hospitals, and monitors overall health outcomes, disease outbreaks and epidemics. As the regional health offices, the Centers for Health Development are primarily assigned to implement national health programs, administer the regional hospitals and medical centers, and support and monitor LGU performance in health. Further, the CHDs are expected to formulate a regional health plan.

In contrast, sub-national offices of DepEd have attained greater powers and responsibilities with the passage of the *Governance of the Basic Education Act of 1991* (RA 9155). Specifically, the regional offices of DepEd are now required to develop their own regional education plan and formulate and execute the corresponding annual regional budget. They are also assigned full management of human resources for education, and the monitoring and evaluation of the education outcomes. More importantly, however, the school heads are now assigned both as instructional leaders and managers. As instructional leaders, the school heads like principals are responsible for implementing the curriculum and accountable for the education outcomes of the school. As manager, they can introduce education programs and improvement plans for the school's physical set up and human resource complement. The national office of DepEd formulates and implements the national education policies, plans, programs and projects. It also tracks and evaluates national learning outcomes, and undertakes the educational R&D activities.

**Table 3. Functions of the national and sub-national offices of the Department of Health and the Department of Education**

| Level | Department of Health<br>(per DOH A.O. 2005-0023) | Department of Education<br>(RA 9155) |
|---|---|---|
| National | 1.Formulate national health policies, and national health objectives and strategies<br>2. Promulgate health standards and regulations<br>3. Develop and pursue health human resource development plans<br>4. Monitor health outcomes, undertake disease surveillance and control health emergencies and epidemics<br>5. Conduct health policy research and development<br>6. Supervise specialty hospitals<br>7. Administer national health programs and projects<br>8. Supervise attached agencies | 1. Formulate national educational policies, and a national basic education plan<br>2. Promulgate national educational standards<br>3. Monitor and assess national learning outcomes<br>4. Undertake national educational research and studies<br>5. Enhance the employment status, professional competence, welfare and working conditions of all personnel<br>6. Enhance the total development of learners through local and national programs and/or projects |
| Sub-national | <u>Center for Health Development</u><br>1. Administer regional hospitals, medical centers and sanitaria<br>2. Provide technical assistance to | <u>Regional Office</u><br>1. Define a regional educational policy framework which reflects values, needs and expectations of local communities |

| Level | Department of Health<br>(per DOH A.O. 2005-0023) | Department of Education<br>(RA 9155) |
|---|---|---|
| | LGUs to strengthen their service delivery capacity and management<br>3. Facilitate compliance to accreditation requirements of health facilities, products and services<br>4. Provide venue for inter-agency coordination<br>5. Monitor and evaluate LGU performance in health<br>6. Develop incentive mechanisms for LGUs towards better performance in the delivery of health care | 2. Develop a regional basic education plan, and a regional education standards<br>Monitor, evaluate and assess regional learning outcomes<br>3. Undertake research projects and developing and managing region-wide projects<br>4. Ensure strict compliance with prescribed national criteria for the recruitment, selection and training of all staff in the region<br>5. Fomulate regional education budget with the regional development council<br>6. Determine the organization component of the divisions and districts, and approved the proposed staffing pattern<br>7. Hire, deploy and evaluate all regional education employees<br>8. Evaluate all school division superintendents and assistant division superintendent<br>9. Plan and manage the effective and efficient use of all personnel, physical and fiscal resources of the regional office<br>10. Manage the database and management information system of the region<br>11. Approve the establishment of public and private elementary and high schools and learning centers<br><u>Division Office</u><br>1. Develop and implement division education development plans<br>2. Plan and manage the effective and efficient use of all personnel, physical and fiscal resources of the division office<br>3. Hire, deploy and evaluate all division supervisors and school district supervisors, teaching and non-teaching personnel<br>4. Monitor utilization of funds from the national government and LGUs<br>5. Ensure compliance of quality standards for basic education programs<br>6. Promote awareness of and adherence to accreditation standards<br>7. Supervise the operations of all public and private schools and learning centers<br><u>Schools District Office</u><br>1. Provide professional and instructional advice and support to the school heads and teachers/facilitators<br>2. Curricula supervision<br><u>School Head</u><br>1. Set the mission, vision and objectives of the school<br>2. Create a conducive teaching and learning environment<br>3. Implement the school curriculum and be accountable for higher learning outcomes<br>4. Develop the school education program and school improvement plan |

| Level | Department of Health (per DOH A.O. 2005-0023) | Department of Education (RA 9155) |
|---|---|---|
| | | 5. Offer educational programs, projects and services<br>6. Introduce new and innovative modes of instructions<br>7. Administer and manage all personnel, physical and fiscal resources of the school<br>8. Recommend the staffing complement of the school<br>9. Encourage staff development<br>10. Establish school and community networks<br>11. Accept donations, gifts, bequests and grants for school improvement |

In their review of education decentralization in selected East Asian countries, King and Cordeiro Guerra (2005) provide a more detailed assessment of delineation of decision areas among the national government, local governments and schools in the Philippines in 1998 and 2003. The key decision areas that were retained by school s in 2003 are on instructional matters (mode of grouping students, support activities for students and credentialing). In 2003, the local governments (provinces and cities/municipalities) were found to have greater influence in personnel management (hiring of teachers and principals, career of teachers and principals), in determining teaching methods, and in the allocation to the school of capital expenditures. However, the national government (DepEd Central Office) continues to decide many of the issues concerning instructional mattes (e.g., instruction time, designing program of study, creating abolishing schools), personnel management (fixing the salaries of teachers and principals), and resources (allocation to school of teaching staff and non-salary recurrent expenditures).

*The SBM Initiative*

To push further the education decentralization, the DepEd formally adopted the School Based Management (SBM) approach as one o the priority actions in its Basic Education Sector Reform Agenda (BESRA). Conceptualized in 2005, the BESRA is DepEd's main strategy to "facilitate the implementation of the Philippine Education for All 2015 and to sustain and institutionalize proven effective initiatives." One of these initiatives is the SBM approach, which was successfully piloted under JBIC/WB-supported Third Elementary Education Project (TEEP) and the AusAID-supported Basic Education Assistance to Mindanao (BEAM) Project. Through the SBM approach, the DepEd "aims to enable and empower all schools with their communities to manage their own affairs for improved delivery of education services in a sustainable manner." (DepEd 2008b).

To be installed and institutionalize in all schools in the country, the SBM initiative has several key action points to enable each school contribute to the improvement of education outcomes. Arranged according the different aspects of decentralization (mentioned in the previous section), the specific action points are:

1. Assigning the right functions – The DepEd has developed and disseminated from the central office to the field offices the SBM Framework and Standards (Appendix 2) and the roles and responsibilities of the sub-national offices of DepEd. It is also finalizing the SBM Manual and Guideline that will provide detailed operational guidelines to all offices.
2. Ensuring adequate capacity – By 2010, the DepEd is targeting that all schools/school clusters will all have plantilla positions for a full-fledge school head. Each school head will also be ensured to fulfill certain competencies before they are hired or promoted. A start-up capacity building program shall be conducted to orient education officials at the regional and division levels, and of school-level officials on the preparation of school improvement process (SIP), annual investment plan (AIP) and on SBM implementation and monitoring. A study will be undertaken to improve the equity of the allocation DepEd's budget for MOOE for all public schools. A set of guidelines is also prepared to facilitate the direct release of MOOE to schools. The guidelines will also be disseminated to all public schools. Cooperation among schools in sharing learning initiatives shall be encouraged.
3. Setting the proper incentives and accountability – To speed up their acquisition of needed capacities to advance their SBM implementation, the schools can also apply for an SBM on a competitive basis. Each grant ranges from 10,000 pesos to 50,000 pesos. The funds for the SBM grants come from the regular DepEd budget and from AusAID-supported Project SPHERE and the Government of Spain. To strengthen partnerships with the local community, the DepEd will push for the improve representation of schools in the local school boards (LSBs). A School Governing Council (SGC) shall also be established in each school to act as the policy-making body for the SIP.
4. Monitoring and evaluating performance - The use of SBM grants will be monitored through the school-based financial management system that will be installed in all recipient schools. Functionality indicators will also be used to monitor the performance of the DepEd representatives to the LSBs. A Student Tracking System will be installed to monitor student absences, lags in performance or other difficulties encountered in school so that school authorities can address these problems at once. To monitor progress with SBM, a baseline assessment shall also be undertaken.

For SY 2007-08, the DepEd targeted to adopt the SBM Framework and Standards in all divisions. By the end of the current school year, it aims to have at least 80 percent of all elementary and secondary schools to advance to the mature level of SBM practice. By 2010, at least 80 percent of all students at the elementary and secondary level are attending schools with mature level of SBM practice. In adopting and institutionalizing SBM in the country, the DepEd

follows other countries like El Salvador, Guatemala and Honduras that have successfully adopted the same initiative.

## V. Performance under decentralization

The gains from decentralization should manifest in terms of improved outcomes in the long run, outputs in the medium run, and inputs and processes in the short run. Thus, the health decentralization started nearly 17 years ago should start to yield some health outcomes. In contrast, the education decentralization started in 2001 could only reliably show some changes in inputs and processes. Nonetheless, both education outcome and output indicators are discussed here, not to assess the impact of education decentralization, but to identify the trends in these indicators and the emerging issues they suggest that such decentralization must confront.

*Outcomes*

In general, some of the widely used outcome indicators for health and education have been improving since 1980 (Table 4). In the case of health, the rates of improvements in infant mortality rate (IMR) and under-5 mortality rates (U5MR) are faster under the decentralization period (1991-present) than before it. For instance, IMR dropped by 31 percent between 1980 and 1990 and by 49 percent between 1990 and 2006. The U5MR also improved dramatically, falling by 53 percent during the period 1990-2006. Life expectancy at birth also rose steadily, from 61 years in 1980 to 66 years in 1990, and to around 70 years in 2006.

**Table 4. Selected health and education outcome indicators, 1980-2006**

| Indicators | 1980 | 1985 | 1990/ 1989* | 1995/ 1994* | 2000 | 2006/ 2003* |
|---|---|---|---|---|---|---|
| Health outcomes | | | | | | |
| Infant mortality rate | 65 | 55 | 45 | 36 | 30 | 23 |
| Under-5 mortality rate | 81 | 74 | 66 | 51 | 40 | 31 |
| Life expectancy at birth | 60 | 63 | 65 | 67 | 69 | 70 |
| Education outcomes | | | | | | |
| Simple literacy rate | | | | 93.9 | 92.3 | 93.4 |
| Functional literacy rate | | | 75.4 | 83.8 | | 84.1 |

*For education outcomes. Sources: Health outcome data for 1980-1990 from Lieberman, Capuno and Minh [1990], 2006 data for IMR and U5MR from Family Planning Survey. 2006 data for life expectancy at birth from http://www.indexmundi.com/philippines/life_expectancy_at_birth.html. Education outcome indicators from 2005 Philippine Statistical Yearbook.

Likewise, the education outcomes indicators have risen since 1989. The simple literacy rate has remained high at over 90 percent since 1990. However, this simple measure may gloss over the fact that some Filipinos may not be functionally literate. Indeed, the functional literacy

rate is consistently well below the simple literacy rate since 1989. In 1003, for example, only 84 percent of the all Filipinos aged 10 or older were functionally literate, although about 93 percent of them were literate.

Though the overall health gains look substantial, they cannot be fully credited to the fiscal decentralization program, considering that living standards rose through the years and that the government adopted other favorable policies (like trade liberalization and deregulation) during the period. It may be said perhaps that health decentralization helped sustain the overall trends established before 1991. However, even this assessment should be qualified since disparities in health outcomes stayed wide, if not become, wider during the decentralization period.

Based on figures reported in the 2007 *Philippine Statistical Yearbook*, the National Capital Region (NCR) was largely consistent in having the lowest IMR and U5MR among the regions over the period 1990-2003. At the bottom of the regional ranking in the same indicators were the Autonomous Region of Muslim Mindanao (ARMM) and the Eastern Visayas Region, which are also among the poorest in the country. As measure of regional disparity in health, the standard deviation of IMR was 8.33 in 1990 and then rose up to 10.84 in 1998, before it fell to 7.46 in 2003. The same pattern is observed in the case of U5MR.

*Outputs and innovations*

Based on DOH figures, there are some significant achievements in health outputs in recent years. For instance, the number children who are 9-11 months old with complete immunization grew from 1.35 million in 2000 to 1.815 million in 2004. Also, there were 1.528 million pregnant women who were given shots of TT2 Plus vaccines in 2004, or about 400 thousand more than in 2000. Of course, these were the joint achievements of the DOH and the LGUs, since the vaccines and medical supplies normally come from the DOH while the LGUs provide the personnel and other logistics for these health activities.

While all Filipino children and mothers are targeted in these public health programs, the poor remain relatively underserved despite the decentralization. In 1998, only about 60 of the children in poorest wealth quintile had full basic immunization coverage (BCG, measles, DPT) compared to about 87 percent in the richest wealth quintile. The disparity stayed as wide in 2003 (Gwatkin et al. 2007).

One of the expected gains from decentralization is the greater experimentation and innovation in the provision of local public services (Oates 1972, p. 12). Indeed, there have been several innovative practices documented since the devolution of health functions in 1992. Some of the early ones are documented in Pineda (1998) (see Appendix 1). Some of these innovations

are intended to enhance access to health services in remote barangays by constructing satellite clinics, strategically deploying health personnel, and tapping the private sector and individual volunteers. Other innovations tried to augment or secure additional funds for health, from both internal and external sources.

There have been various health innovations since then, some of them have won Galing Pook Awards (for exemplary or trailblazing programs). Among the recent GP awardees for health are the *PhilHealth Plus* of Pasay City, the *La Union Medical Center Economic Enterprise for Sustainability and Development Program* of La Union, the *Harnessing synergy in Integrated Population , Health and Environmental Programming* of Concepcion, Iloilo, and the *Effective Partnership towards an AIDS-Free Zamboanga City* of Zamboanga City (Table 5). While the social recognition that goes with the awards provided the added incentive, the primary motivations for LGUs to undertake these innovations were the various challenges facing them. Ably addressed by talented and inspired local leaders, these challenges include severe fiscal constraints, low quality of services, and increasing demand for services.

Interestingly, among the GP awardees are a number of local innovations in education services (Table 5). This goes to show that some LGUs have strong preferences for education despite the fact that it is not their main responsibility. The innovative local education programs are the *Project JOSIE* of Bulacan, *Functional Literacy Towards Economic Growth* of M'lang, Cotabato, and the *Mobile Teaching Program* of Ifugao. Particularly relevant to DepEd, the innovative education program of Naga City may serve as a model for a closer engagement with the local school board. Under the city's *Reinventing the Naga City School Board*, more sectoral representatives were invited to become LSB members. A consequence of the program is that local educational plans are tied closely to the budget, and additional private sponsors were tapped to upgrade elementary schools in depressed areas.

Possibly more LGUs than have vied for the GP awards and such schemes had innovations. Unfortunately, their exact number cannot be determined from the available data, although the innovative LGUs seem a minority. The total number of GP awards applicants and nominees between 2002 and 2004 include 28 out of the 79 provinces, 42 out of the 117 cities, and 49 out of the 1,499 municipalities. Many of the applicants and nominees also applied in several years. Thus, it is likely that a substantial number of LGUs did not initiate similar innovations.

**Table 5. Selected Galing Pook Award winners for innovative health and education services**

| Health Services | Education Services |
|---|---|
| Pasay City (*PhilHealth Plus*)<br>• PhilHealth Plus is an expanded health insurance package that provides uniform in-patient and out-patient benefits; more indigent households and individually paying members were covered; and health facilities were upgraded to Sentrong Sigla | Bulacan (*Joint Systems Improvement in Education Project*)<br>• Project JOSIE is an attempt to improve learning competencies of grade school children involving parents as partner educators, and supported through legislations and budget allocations, and formal |

| Health Services | Education Services |
|---|---|
| standards.<br>La Union (*La Union Medical Center*)<br>• The La Union Medical Center was converted into a public-private economic enterprise to recover cost and enhance revenue and at the same time provide improved hospital services by charging prices based on the ability to pay of patients, with the poor paying in kind.<br>Concepcion, Iloilo (*Harnessing Synergy in Integrated Population, Health and Environmental Programming*)<br>• The HSIPHEP program simultaneously promoted family planning and coastal resource management among municipal fisherfolks.<br>Negros Oriental (*Inter-LGU-NGO Partnership in the Delivery of Health Services*)<br>• This innovation involved the cooperation of the province of Negros Occidental, several component LGUs, private sector organization such as NGOs and medical professional groups, to strengthen hospital service delivery and financing capacity, referral systems and inter-local health zones.<br>Zamboanga City (*Effective Partnership towards an AIDS-Free Zamboanga City*)<br>• A comprehensive strategy was developed and implemented by the city government and an NGO to increase public awareness and knowledge of STDs/AIDS/HIVs, access to and utilization of appropriate health services, and institutionalization of surveillance and monitoring of AIDS/HIV incidence. | support institutions.<br>Naga City (*Reinventing the Naga City School Board*)<br>• This program sought to empower the Local School Board by expanding the membership to include representatives from more sectors, preparing and financing the local educational plan, and promote private-sector sponsorship of elementary schools in depressed areas.<br>M'lang, Cotabato (*Functional Literacy Towards Economic Growth*)<br>• This program sought to improve the literacy and standards of living of the indigenous communities of B'laans and Manobos through social enhancement activities and livelihood projects.<br>Ifugao (*Mobile Teaching Program*)<br>• Instead of building additional schools in remote areas, the provincial government of Ifugao designed a mobile teaching program whereby teachers and trained and equipped to go around the province and provide education services to target school children following a special curriculum developed for the purpose. |

Sources: Galing Pook Foundation (2001, 2002, 2006).

Also, it is widely noted that the range of quality of devolved health services is rather wide. From one end, there are places like Makati City and Marikina City are able to provide free hospitalization and other medical support to the poor and old among their constituents. At the end, there are places where health facilities are dilapidated and ill-equipped, without adequate supply of drugs, or *san*s medical doctors, nurses or medical technologists. In a revealing survey commissioned by the World Bank in 2001, it was found that most people in rural areas would rather go directly to a higher-level health facility (a district or provincial hospital) and bypass the one nearest them (usually a barangay health station or rural health unit). This suggests the inferior quality of most frontline health services even under the devolution.

Whenever an opportunity arises, it behooves the DepEd to encourage LGU initiatives in education to narrow down the generally low and wide regional wide variations in education achievement tests. The disparities in achievement tests can be reduced through more inputs, such as financial and technical support from parents, LGUs and other stakeholders. Besides, these stakeholders can exert influence or moral suasion on school officials to improve the welfare and performance of the student, teachers and others school staff.

The need to improve the overall performance of elementary and secondary students in achievements tests has been underscored repeatedly. This is understandable. The mean percentage scores of grade school pupils have been consistently below 60 in mathematics, reading comprehension (later English) and Science, although they have improved during the three consecutive school years since 2002-03 (Table 6). Worse, the mean percentage scores of fourth year high school students in the same subjects were even lower.

**Table 6. Mean Percentage Scores in National Achievement Tests, SY 2002-03, SY 2003-04, and SY 2004-05**

| School Year | National Achievement Test for Elementary Students* | | | National Achievement Test Fourth Year Students** | | |
|---|---|---|---|---|---|---|
| | Mathematics | Reading Comprehension/ English | Science | Mathematics | English | Science |
| 2002-03 | 44.84 | 41.80 | 43.98 | | | |
| 2003-04 | 59.45 | 49.92 | 52.59 | 46.20 | 50.08 | 36.80 |
| 2004-05 | 59.10 | 59.15 | 54.12 | 50.70 | 51.33 | 39.49 |

*The test was given to 1.67 million Grade Four students in SY 2002-03, to 1.63 million Grade Five students in SY 2003-04 and to 1.60 million Grade Six students in SY 2004-05. The test was given to 0.965 million Fourth Year students in SY 2003-04 and to 1.03 million Fourth Year students in SY 2004-05. Source: 2007 Philippine Statistical Yearbook.

A closer look at the regions reveals some interesting results. First, the NCR consistently performed below the national average. Second, the economically disadvantaged Eastern Visayas Region did better than average in all counts. While these results may suggest that educational excellence is possible even with meager resources, the general pattern though in the case of the rest of the regions is that the richer regions generally registered higher mean percentage scores than the destitute regions.

*Access*

Under decentralization, users should have better access to health services because presumably the local leaders would know where the need for such services is dire. Many LGUs upgraded their health facilities, and some established health facilities to serve their constituents in remote areas. For example, the provincial governments of Negros Occidental and Negros Occidental agreed to co-finance the construction and operation of new health clinics in the mountains the serve jointly the households living near their political borders.

Moreover, some survey results show that public health facilities get their share of service users, especially the poor. In 2003, the poorest households were more likely than the richest

households to visit public health facilities for treatment of childhood illnesses like fever, diarrhea and acute respiratory infection. The richest households sought treatment in private health facilities. (Gwatkin et al. 2007)

Besides ensuring physical access to health services, LGUs usually extend financial assistance to their needy or sick constituents. Beginning in 1997, the LGUs were also required to enroll the indigent families among their constituents in the national health insurance program. Specifically, the LGUs are mandated to pay part of the premium contributions of each enrolled family. However due to the financial burden of enrollment, few LGUs participated in the social health insurance program.

Despite the accessibility of local health facilities, many people skip these because of their poor quality. Moreover, there are indirect costs of treatment that are not covered by health insurance like drugs purchased from private pharmacies, transportation and food expenses, and lost income that discouraged sick people, especially the poor, from seeking treatment. Some evidence of this can be gleaned from the results of the 2003 National Demographic and Health Survey. For example, pregnant women from the lowest wealth quintile were less likely than those in the top wealth quintile to seek antenatal care, give birth in a medical facility or attended to by a medically trained person during delivery.

The overall access to education services can be inferred from the net participation rate, which is the proportion of the enrollees to the population of the same age range. A high net participation rate would indicate that most school-age children are in fact attending school. The net participation rate for elementary education was high (above 95%) from SY 1997-98 to SY 2001-02 (Table 7). Since then, however, the rate declined steadily. By the SY 2005-06, only about three in four children aged 7-11 years old were in school. In comparison, the net participation rate for secondary education is low and declining in recent years as well. By the SY 2005-06, less than one in two young teenagers (13-16 years old) was in school.

**Table 7. Net participation rate and cohort survival rate in public and private elementary and secondary schools, SY 1997-1998 to SY 2005-2006**

| School Year | Net participation rate | | Cohort survival rate | |
|---|---|---|---|---|
| | Elementary | Secondary | Elementary | Secondary |
| In percent | | | | |
| 1997-98 | 95.09 | 64.04 | 68.68 | 71.40 |
| 1998-99 | 95.73 | 65.22 | 69.75 | 71.25 |
| 1999-00 | 96.95 | 65.43 | 69.29 | 71.02 |
| 2000-01 | 96.80 | 66.10 | 67.18 | 73.05 |
| 2001-02 | 97.02 | 73.44 | 67.13 | 73.16 |
| 2002-03 | 90.29 | 58.33 | 69.80 | 65.84 |
| 2003-04 | 81.72 | 47.03 | 63.57 | 60.41 |
| 2004-05 | 76.06 | 42.50 | 64.87 | 61.33 |

| | | | | |
|---|---|---|---|---|
| 2005-06 | 73.51 | 44.50 | 62.58 | 54.99 |

Source: 2007 Philippine Statistical Yearbook.

Another problem confronting education authorities is that less than three in four of those who started their primary or secondary schooling stayed long enough to finish elementary or high school, respectively (Table 7). The problem is particularly acute in the poor regions like ARMM and Central Mindanao and Eastern Visayas. The cohort survival rates for the levels of education have also been deteriorating in recent years.

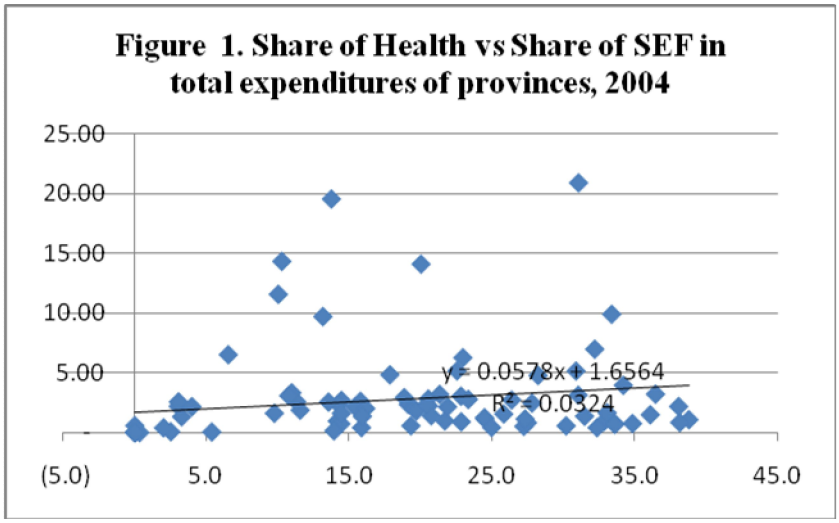
*Financing*

Since 1991, the LGUs have been financing more and more the health and education expenditures in the country. According to NSCB figures, the share of LGUs in the total health spending (from all sources) grew from 4.3 percent in 1992 to 19.3 percent in 2000. In 2004, the share was lower than in previous years but still substantial at 14.4 percent. In contrast, the share of the national government fell somewhat steadily from 30.6 percent in 1992 to 15.9 percent in 2004. The LGU education spending also grew in relative size. From under five percent in 1991, the share of the LGUs in the total public budget for education hovered between around eight and six percent thereafter up to 2005 (Manasan, Cuenca and Villanueva 2007).

The increase in LGU outlays for education and health services is expected. As mandated in the LGC of 1991, LGUs have been using up their Special Education Funds (SEF) from their additional real property tax collections. According to BLGF figures, the total amount of SEF was about 1.41 billion pesos in 2001 and 1.67 billion pesos in 2004, or a little over four percent of the total expenditures of provinces in each year. In comparison, the share of health in the total expenditures of provinces in both years was about 20 percent. The higher LGU allocation for health perhaps only reflects the fact that more health than education responsibilities were assigned to LGUs under the Code.

It can be seen in Figure 1 that there is wider variation in the share of health spending than of education spending across provinces in 2004. In health, the spread was 0.3 percent (Tawi Tawi) to 36.5 percent (La Union), with an average hovering at 17.4 percent. In education, the majority of the provinces allocated less than five percent on SEF. The exceptional provinces with about 20-percent allocation for education were Laguna and Bataan.

The wide disparity in local health spending is an expected consequence of fiscal autonomy granted to LGUs under the Code. Differences in local preferences and needs for the types and amount of public spending, in fiscal and organizational capacities, and in other institutional factors all influence local budget decisions. These determinants of local public spending have been investigated in previous studies.




First, the nature of the devolved health functions, the available fiscal resources for the devolved expenditure responsibilities, and specially the mismatch between the two factors were found to be the most critical factors explaining local health spending, at least during the early years of decentralization (Diokno 1994, Manasan 1995, Capuno and Solon 1996). The type and scale of health spending was and continues determine local health spending because much of the devolved functions are recurrent spending. Thus, much of local health spending goes to facility-based health care and on personnel services. Imbalances in the distribution of devolved health functions and share in the internal revenues across LGUs also influenced the health outlays in the few years after 1991 (Capuno 2001). For example, the cities had greater health spending than is needed to finance their share of devolved health functions because of their higher average IRA share. Some provinces were forced to cut down on their health spending, despite their avowed preference for this service, because of their deficient IRA share.

Second, health externalities and spillovers are also found to influence LGU expenditures. There are cases where cities spend less on health because a provincial or a national-retained hospital is located within its jurisdiction. In Quezon City alone, for example, the four big specialty hospitals effectively cater more to the needs of the cit residents than to the needs of the average Filipino living outside Metro Manila, who are supposed to be their target clients. Some evidence of the negative effect of such free-riding opportunity on local health spending is found in study of sample of LGUs (Capuno and Solon 1996).

Third, the DOH's own local interventions – fiscal transfers and regulation - also influence local health spending. In the 1990s, the DOH tried matching grant mechanisms to secure local budget support for health programs. Under the Comprehensive Health Care Agreement, the DOH matched each peso that the LGU allocate to the devolved health functions with a higher amount and additional support for the LGUs to promote locally the national health programs. The DOH also provided grants to upgrade the quality of devolved health facilities that have passed the

initial licensing standards. Local health facilities that were accredited under the Sentrong Sigla Movement were given cash incentives and technical support. The SSM was successful in eliciting the wide participation of LGUs. To sustain this program, the SSM standards were incorporated into the accreditation standards for health facilities of the Philippine Health Insurance Corporation. Other DOH programs like immunization, TB and malaria control, and maternal and child care are also locally administered in tandem with the devolved health personnel. In addition to the time of the health personnel, logistic support (for transportation and social mobilization) is provided by the LGUs to these national health programs.

Fourth, there are findings that local spending on social services is sensitive to some measure of needs of the local population. As reported in the 1997 Philippine Human Development Report (p. 64), the per capita expenditures of provinces on social services in 1994, which included health and education, were at least positively correlated with human development indicators (life expectancy, functional literacy rate and average family income).

Last, some anecdotal studies also underscore that "politics" influence local fiscal decisions. There are reports that found many LGUs were unwilling to provide the so-called Magna Carta benefits of the devolved health workers because of the political pressures exerted by those in the local bureaucracy that were not entitled to the same. The procurement of drugs and medical supplies in some places are rigged by corrupt officials. In Pangasinan, it is reported that some municipalities do not support the health programs of the then Governor Agbayani because they belong to a rival congressional district.

The partial review of the empirical studies points out to a number of determinants of local health spending. Since many of these are already dated, new ones are clearly needed to understand the persistent health inequalities. More importantly, these studies should also identify the policy variables that can be manipulated to improve health service delivery by different types of LGUs.

## VI. Review of relevant health policies

One of the DOH's main functions is to monitor and assess health outcomes based on the national health objectives. To improve the health outcomes, it formulates the necessary policies strategies and then undertakes the appropriate programs, projects and activities. A critical step here is the design and implementation of the right policies to influence the provision and financing of the devolved health functions. Under the LGC of 1991, the LGUs have autonomous control over the devolved health functions, subject only to the oversight of the DOH. Because LGUs have different preferences, capacities and conditioning environment, the level and quality of local health services are likely to be widely disparate. There are reasons to believe that a local

population will desire a very low level of health services. And it is also not socially warranted, since it may lead to disease outbreaks or epidemics that can spread to other areas. Over the years, the DOH has tried several approaches to influence the outlays for and the quality of health services, both through supply-side and demand-side interventions.

*Securing LGU health financing*

Applying one of the tenets of fiscal decentralization in health, the incremental finance should have been adequate for the devolved health functions for each LGU. However, there was a mismatch between the so-called costs of devolved health functions (CDHF), which are based on the DOH budget in 1991, and the incremental IRA shares of LGUs. According to DOH estimates, provinces got 23 percent of the IRA and 59 percent of the CDHF, and the municipalities received 34 percent of the IRA and 38 percent of the CDHF. In contrast, the cities shares in the IRA and CDHF were 23 percent and 3 percent, respectively. The barangays also got 20 percent of the IRA and only a negligible share in the CDHF. The inequitable distribution of the fiscal burden of decentralization left many provinces and municipalities financially adequate to maintain the same level of health services in their localities as did the DOH before 1991. This provided an opportunity for some LGUs to rationalize their health budget allocations. In many places, however, the budget reduction entailed the non-payment of recurrent spending (like salaries of the devolved health workers and drug procurement) and therefore the provision of health services. The DOH tried several approaches to secure the LGU financing for health.

First, as a stop-gap measure, the DOH supplemented the funds of the poor LGUs unable to support their CDHF. This measure proved necessary to arrest the deterioration in health service delivery, for which the DOH as decentralization advocate was likely to be blamed. This measure was only temporary because the DOH had neither the funds nor organizational capacity to sustain it.

Second, the DOH adopted matching grant mechanism to secure a province-wide commitment to finance the devolved health functions. Instead of dealing with each LGU, the DOH with the CHCA enters into a memorandum of agreement with all the LGUs (except barangays) in the province. In practice, however, only the firm commitment of the provincial government was secured. While the DOH was able to sign up many provincial governors, it mistook such commitment as binding with the component municipalities and cities as well. Since the DOH also the lacked the capacity to monitor and enforce compliance, the CHCA was later discontinued.

Third, the DOH pushed for legislations to protect and promote the welfare of the devolved health personnel and to secure local commitment to the national health insurance program. Under the Magna Carta for Health Workers of 1992, all health personnel should

receive allowances on top of their salaries. This should make the effective government income of the devolved health personnel at par with those retained by the DOH. However, the burden of financing the so-called Magna Carta benefits was passed on to the LGUs, which considered the law as another "unfunded mandate" and an infringement on their fiscal autonomy. Moreover, even the richer LGUs hesitated to grant the Magna Carta benefits to avoid demoralizing the organic local government personnel (who are not entitled to such benefits).

Another legislative measure was the National Health Insurance Act of 1995. A key feature of the NHIP is that LGUs should co-finance with the national government the premium contributions of indigent households among their constituents that are enrolled with NHIP. The sharing schedule is progressive, wherein a low-income LGU initially pays only ten percent of the insurance premium. Despite its progressive feature, the so-called Sponsored Program initially attracted few LGUs, from only two in 1997 to 891 (or about half of all provinces, cities and municipalities) in 2002. The poor LGUs were unable to participate because of limited health budget, which they still have to allocate on the devolved services as well.

Fourth, the DOH – building on its past experience with health decentralization – has recently articulated a more coherent devolution strategy where it treats LGUs as equal partners. Under the Health Sector Reform Agenda (now called *Four*mula One for Health) DOH supports the LGUs to produce their own Province-wide Investment Plan for Health (PIPH) which now becomes the basis for DOH support to the LGUs. Through the PIPH process, the LGUs within a province will asses their current health situations, identify their strengths and weaknesses, develop detailed investment plans, and secure individual commitments. For its part, the DOH will know local health priorities and then tailor fit its assistance accordingly. Where the LGUs and the DOH come to a common understanding, they sign a service level agreement to specify their respective responsibilities and the monitoring and enforcement mechanisms to ensure compliance. While several PIPHs have been "approved" by DOH, their execution has only started within the last two years.

*Improving the quality of local health services*

One of the unintended though predictable consequence of devolution is the wide disparities in the quality of devolved health services. Several reasons account for this. It could be that local political leaders do not prefer or appreciate the value of health services. It could also be that they lack the incentive to improve the quality or are not accountable for substandard services. The local health officials could be overworked, demoralized or incompetent. To raise the quality of local health services, the DOH tried several approaches, from regulation to yardstick competition to demand-driven schemes. These approaches achieve varying successes.

First, the DOH sets the licensing standards for all public and private health facilities. Every year, the DOH requires all health facilities to renew their licenses to operate. While most hospitals go through the licensing process, many fulfill only the paper requirements. This is because the DOH lack fields personnel to actually visit and inspect the medical facilities. Moreover, the criteria used are mostly based on inputs like number of beds and the presence of absence of certain medical equipments and medical professionals. Outputs and performance indicators like in-patient and out-patient visits, and the health condition of the discharged patient are not given enough weight.

Second, the DOH also tried to promote yardstick competition among the devolved health facilities. The Sentrong Sigla Movement is a certification program wherein health facilities that satisfy stricter criteria than those imposed for licensing are qualified to receive an award. The award consists of a seal of excellence (Sentrong Sigla signage) to all, and cash awards and public recognition to the best among the qualifiers. The idea behind the SSM is first to raise the minimum service standard through incentives and then to encourage best practices through inter-LGU competition. To raise further the service standards, the SSM criteria were revised to include output indicators. The SSM was fairly successful in eliciting LGU participation.

To sustain the program, the SSM criteria were later incorporated into the accreditation criteria for hospitals and clinics used by the Philippine Health Insurance Corporation (PhilHealth). As the administering agency for the national health insurance program, the PhilHealth accredits health facilities that may file for insurance reimbursements for services rendered to PhilHealth members. Because of the added income from insurance reimbursement, the health facilities have the incentive to upgrade the quality of their services.

In recent years, the PhilHealth also adopted the capitation program. Under this program, the PhilHealth pays on a capitation basis any LGU that have enrolled their indigent constituents with PhilHealth. Under the terms of the service contract agreed between the PhilHealth and LGU, the former pays P300 per insured person per year to the latter in exchange for outpatient care services rendered to the insured members in the rural health units of the LGU. The expectation here is that the effective quality of the accredited rural health unit will be monitored the service users.

Fifth, the DOH also directly fielded critical health personnel in LGUs that are unable to fill up their plantilla positions. The Doctors to the Barrios (DTTB) program was initiated in response to the inability of the LGUs t hire physicians due to low pay scales, remoteness of their location or peace and order problems. Under the DTTB program, the DOH hires the doctors and deploys them to the hardship areas. The concerned LGUs in turn provide the accommodations and supplemental allowances. After their two-yea tour of duty, the deployed doctors either choose to be absorbed in the local bureaucracy or purse further studies with DOH sponsorship.

The DTTB program has been successful in meeting the needs of LGUs for physicians. However, very few of these doctors chose to stay in their assigned LGUs after two years.

Sixth, the DOH also tried social advocacy to drum up support for increased local health financing or improved quality of health services. In the formulation of the PIPH, local non-health officials were either consulted or directly involved. The local chief executives (mayors or governors) were often the chairs of the local PIPH committees, whose members often included the chairs of the committee on health of the local Sangguniang, the local budget officers, and planning and development officers. In the process, the participating non-health officials gained a better understanding of health issues and concerns, and developed better rapport with the local health officials. Other members of the local health boards were also participated in the PIPH planning.

Seventh, the DOH has been promoting capacity-building training programs for the devolved health personnel. Some of the training programs were meant to make the devolved health workers more competent with their assigned tasks. Most of the training programs however are designed to enable the devolved health workers implement the national health programs like TB control, malaria control and maternal and child health care. Sometimes though these national training programs take too much of the time of the devolved personnel that local service delivery is sacrificed. On the other hand, the devolved health workers sometime treat these out-of-town trainings as breaks from work which they otherwise would not get from their LGUs.

Last, the DOH also pushed for inter-LGU cooperation in health to take advantage of economies of scale in service delivery, the benefits of a working hospital referral system, and to contain negative interjurisdictional spillovers and health risks. Since the late 1990s, many LGUs have formed their own Inter-Local Health Zones (ILHZs). Members of an ILHZ are expected to share in the cost of certain health services or jointly-used hospitals or clinics, share resources or critical health personnel, and coordinate their health plans. Several ILHZs have gained national prominence for innovative health programs like in Sogod Bay, Southern Leyte where the ILHZ operated a revolving drug fund. However, many ILHZs cease to be functional when new local chief executives are elected into office.

## VII. Lessons and implications for education

This section presents a summary of the relevant lessons learned from the country's experience with health decentralization. The focus is on the DOH's policies to ensure the adequate, timely and sustainable provision quality health services under decentralization. From each, the implication to education decentralization is also drawn out.

But first, the desirability of devolving education services to LGUs needs to reviewed. Based on economic theory, there are more plausible reasons to devolve education services than health services. As mentioned in Section III, education services are less technically complex than health services, which should it easier for average local chief executive to manage them. Also, education externality is more interpersonal and less interjurisdictional, unlike health externality that easily crosses borders. Hence, the LGU is likely to internalize the cost and benefits of education services. Moreover, the degree of information asymmetry between teachers and parents is lesser than that between doctors and patients. In the case of basic education, the parents of school children can verify the school lessons and exam results, but few of them can interpret clinical laboratory results.

Finally, schoolchildren seldom transfer schools before they finish, while sick patients can be referred to health facilities elsewhere for more complicated treatment. Since the service clients of schools are less mobile than the clients of health facilities, they are more likely to credit the LGU that provides them. Hence, a local chief executive is more likely to provide education services than health services, if given the choice. A proof to this is the establishment of colleges or universities in some of the richer cities in the country. The Pamantasan ng Makati and Pamantasan ng Lungsod ng Maynila are cases in point.

Of course, the theoretical reasons for devolving education services are not sufficient. Actual evidence of the advantages of education devolution must be presented. The Philippine evidence regarding LGU financing of education services are limited. In their comparative assessment of education decentralization in Bangladesh, Indonesia and the Philippines, Behrman, Deolalikar and Soon [2002] conclude that the evidence so far on the effects of decentralization on the efficiency of education services are inconclusive, partly because of the dearth of suitable data. Further, they argued that education decentralization in the selected countries were not really undertaken to improve the efficiency, but rather to address some other fiscal difficulties and as part of wide-raging government reforms. In the case of the Philippines, the assignment of education financing function to LGUs was a part of the Local Government Code, rather than integral component of education decentralization reform, which came in later.

Notwithstanding the limited evidence of the advantage education devolution, the following lessons from health devolution should help inform the policy debate in education reform.

*First, a big bang approach to devolution does not always work.* The whole process of transferring health functions, services and personnel to LGUs was completed in almost a year only. The advantage of the big bang approach was that resistance to reform was pre-empted. The disadvantage was that legitimate concerns and issues were not articulated and studied. No preparations were made to anticipate and address transition problems. Not all LGUs were ready

to absorb the devolved functions. Not all health personnel knew what to expect once devolved to LGUs. The lack of information, advocacy and social mobilization created confusion and poor coordination.

Thus, if education services are devolved, the whole process should be well planned. This will involved information and education campaign targeted to parents and school children, advocacy targeted to LGUs and other local stakeholders, and a lot of convincing on the part of the school staff. A staggered implementation may be desirable, depending on the readiness of the LGUs to absorb their additional responsibilities. However, the roll-out cannot be too protracted lest resistance to reform will gather momentum.

However, the schedule of SBM roll out seems to be too fast. According to plan, by the end of the current school year (SY 2008-09) already some 80 percent of all public primary and secondary school will have advanced to mature level of SBM standard. This means that, among other things, the LGU will have institutionalized a multi-year budgeting for SEF. For LGUs to do this, they should have the technical capacity to forecast their revenues, make the political commitment to tie their future income to education and have the DBM/COA authority to make such allocation. Very few LGUs would have the requisite technical, political and financial capacity to do so. Even if it were possible, it will hard to convince LGUs to make such a commitment when they know that education remains the primary responsibility of the national government. Besides, very few even made the same effort to finance their devolved health services.

*Second, finance should follow function to each LGU*. This means that each LGU should get adequate incremental fiscal resources to finance its share in the devolved function. Also, each LGU should be made to understand that they get the incremental resources because of the devolved functions. This should avoid the past situation where the mismatch in the allocation of IRA and costs of devolved functions left many provinces and municipalities unable to sustain their health financing. This should also disabuse the minds of the local officials from thinking that they can have incremental IRA shares and refuse additional expenditure responsibilities. A corollary to this lesson is that the LGUs should not be assigned any unfunded mandates.

A first step towards ensuring this if education were to be devolved is already done by DepEd. Among the key activities in the SBM initiative is the estimation and direct transfer of MOOE budget to each school or school cluster. These estimates will provide the basis for the required incremental resources needed by individual LGUs were they to manage the school themselves. The additional financing should be distinct from other transfers due them. This does not mean necessarily mean however that LGUs should be tied to spending their incremental resources on education alone. They should be still be given the freedom to determine exactly how to spend their additional funds for education.

*Third, the welfare of the devolved personnel should be protected.* The working condition, career paths, job description, and the prospects for professional development of the local health workers effectively and largely changed for the worse after 1991. This is because in the local bureaucracy the salary scales are lower, prospects for promotion and professional training are limited, and the local chief executive may not understand or appreciate health services. For many devolved health workers, the DOH unfairly changed the implicit terms of their employment contracts. The failed implementation of the Magna Carta for Health Workers only further dampened their morale. The DOH should have planned for the transition of its personnel to the local bureaucracy to ensure that the original terms of their employment contracts with the DOH are respected or approximated in their new posts.

Protecting the welfare the devolved personnel might involve some changes in civil service and audit rules. It was feared, for example, that some of the health positions were "politicized", that is, politics rather than merit determined who will occupy the positions. This view was partly the cause of misunderstanding between LCEs and the devolved health workers. On the one hand, the LCEs had the view that it was part of their work to "control" health services and personnel. On the other hand, the public health physicians had the view that they alone could decide on health matters. Such misunderstanding could be avoided in the case of education if the teachers, school heads are made aware of their prerogatives, responsibilities and accountabilities to the LGU under devolution. The DepEd may have to provide supplemental funds to the low-income LGUs to ensure that the devolved school staff will get the same salary levels as before.

*Fourth, the systems of political and bureaucratic accountability should be improved.* While the Local Health Board was designed as venue for public participation in health planning, many of them were not constituted or continued to function. Hence, they failed to provide the check and balance necessary to steer health service delivery and financing in the public's favor. Further, health is hardly a local election issue, since no benchmarks were set to assess local government performance in health to guide voters. Also, election laws and the system of recall and referendum built into the LGC are only a blunt accountability instruments.

To improve bureaucratic accountability when education is devolved, the Local School Boards should be organized and made functional. Already, this is being pursued under the SBM initiative. If successful, then the functional LSB can help ensure that health plans suit the local needs, and are budgeted and implemented. To improve political accountability, teachers should be absolved of their election duties. This is to avoid conflict of interest. Through social advocacy, the DepEd can also ensure that voters and candidates will take education as a local election issue.

Another accountability issue that the DepEd may want to reconsider is the establishment of a School Governing Council in addition to making the Local School Boards more functional.

Since the SGC and the LSB will have common members and both chaired by the LCE, one may become redundant in practice. Instead, the DepEd in cooperation with the DILG may want to issue a joint circular to expand (i) the LSB membership to include those in the SGC who are not yet LSB members, and (ii) the functions of the LSB to include those of the SGC.

Also, the DepEd has to decide the accountability of the school principal to the LGUs that provides the SEF under the SBM initiative. Ideally, the LSB should have some say in the hiring, promotion, retention, retirement or dismissal of the school head. This will ensure that local needs and concerns are met and addressed by the school. To avoid abuse, however, an objective system of LSB evaluation of the school head should be adopted. The results of the evaluation will carry some weight in the overall assessment of the school head's performance.

Finally, the DepEd has to consider that when SBM is adopted and institutionalized, the system of incentives and accountability changes as well from being project-based to bureaucracy-based. It is pointed out that pilot project are never successfully adopted in the bureaucracy because the regular employees were never given the opportunity to "own" the project. It may be argued, however, bureaucrats will not have the same sense of ownership as project managers in the sense that their salaries will depend on the success of the pilot projects. In contrast, project managers of donor-funded projects internalize the outcomes of their pilot initiatives, and, therefore are more driven to assure success. Thus, what may be necessary to ensure the successful institutionalization of these pilot initiatives is to align the incentives of the bureaucrats more closely with the outcome of the institutionalization, rather than simply getting involved in the design and implementation of the pilot projects.

*Fifth, a system of monitoring and evaluation should be in place before the devolution rolls out*. One of the unfortunate consequences of the devolution was the fragmentation of the health information and surveillance system. Under the devolution, many local health personnel do not file, complete nor send their health reports regularly to the DOH. They submit their reports to their local chief executives, many of whom neither have the time or technical appreciation of health data. Hence, the DOH did not have a complete and timely basis for its planning.

Again, the DepEd by implementing the SBM initiative is already putting in place a monitoring system that will be useful as well under the devolution. The monitoring system will include a scheme for tracking the sources and uses of school funds, and for tracking student performance. The only remaining concern here of course is that the local monitoring systems will continue to be linked up from the local to the national level.

*Sixth, first be strategic, then tactical.* When LGC was implemented, the central office of the DOH encountered its own adjustment problems. The DOH was not prepared to articulate and

perform its new role under decentralization. Considering that the devolution was a major organizational change for it, the DOH organized only organized ad hoc unit – the Local Government Assistance and Monitoring Service (LGAMS) – rather than empower it regional units to deal with issues and problems concerning the LGUs in the early years of the devolution. Moreover, the DOH central office continued to administer the vertical health programs (for communicable diseases, expanded program for immunization, maternal and child health, etc) and the so-called retained hospitals (mostly regional hospitals, medical centers and specialty hospitals). Notwithstanding the need for fire-fighting responses to emerging problems arising from a big bang implementation, such responses would have been more effective if guided by a strategy.

Finally, such a strategy was crystallized during the term of President Joseph Estrada. The Health Sector Reform Agenda (HSRA) outlines the major goals and activities of the DOH in five reform areas, namely: DOH-retained hospitals, public health programs, health regulation, social health insurance and local health systems. The gist of the approach is to simultaneously pursue the different activities under these reform areas initially in the so-called convergence sites, which are provinces selected on the basis of their health needs, capacities and political commitment to pursue the reforms in partnership with the DOH. It was under the HSRA that the ILHZs were first defined and then advocated.

With the Basic Education Reform Agenda (BESRA), the DepEd has already made the first step in being strategic. All that the DepEd needs is to build on its previous experience to adapt the BESRA to a devolved setting.

*Seventh, bottom-up planning is better than top-down planning*. With its several failures to enlist the full cooperation of the LGUs in implementing its own health plans, the DOH soon DOH soon realized that a better way is to listen to the LGUs first before making any plans. Towards this, the DOH re-engineered itself by strengthening its regional offices that will directly deal with the LGUs. Then it encouraged and supported the LGUs to formulate their respective province-wide investment plans. These plans then become the basis of DOH's interventions in the localities. Consequently, the DOH is able to elicit greater participation and support from the LGUs, especially in the so-called convergence sites.

Bottom-up planning is one approach that DepEd is yet to institutionalize. The school budget planning that the Local School Boards do is limited to the SEF. The rest of the school budget is determined at the regional and central level. However, if education is devolved, it would mean that LGUs will shoulder a bigger share of the total education budget. To hit the national education targets, the DepEd should be at least concerned about the LGU outlays for education. The DepEd may even need to adopt bottom-up planning to ensure that national and local education outlays are consistent, complementary or synergistic.

Another reason why bottom-up planning may be necessary in DepEd even under the present situation is that there might be wide variations across schools and in their environment to warrant various SBM configurations. For example, local partners may be proactive of technically competent in some areas, which would warrant advancing them at once to mature level of SBM standard. In some areas, the school principal may have to devote a considerable amount of time winning over the LGU officials or other stakeholders, although the school may advance already in other aspects of SBM activities. This suggest that the baseline assessment of the SBM initiatives should include information and analysis of the school environment, including the proclivities and abilities of target partners, before any SBM initiatives can de drawn up for each school.

*Eighth, the appropriate role is that of a steward, not a general.* Unlike before 1991 when the DOH can expect all health personnel from the central office down to barangay health station to follow all its administrative orders and directives, the DOH now understands that it can only guide and try to influence local health systems. While the DOH helps LGUs make informed decisions, it also accepts that LGUs are "free to fail" under autonomy.

By making the schools developed their own school improvement process and annual investment plans under the SBM initiative, the DepEd in a way already exercises stewardship. This experience should prepare it to adopt a more "hands off" approach to managing devolved education functions in the future. The good consequence of this approach will be the local best practices in education service delivery and financing that will germinate under devolution. The bad consequence of course will be the deterioration in education quality in some places.

*Ninth, leverage grants and minimize use of not unconditional transfers*. After several attempts, the DOH finally found two effective ways to improve local health services. The first is to leverage its own resources for greater local resource commitment or improved performance. Instead of providing unconditional transfers which only encouraged LGUs to continually depend on the DOH, the DOH is now shifting to a contractual mode when it deals with LGU. For example, it enters into a service level agreement with the LGU when it provides resources to implement a component of the PIPH. The agreement specifies the rights and responsibilities of the DOH and LGU and the performance benchmarks used to measure compliance. Unlike before when it unconditionally provided drugs, medicines and other support to LGUs, the current approach would encourage LGUs to become responsible providers of health services.

The DepEd is providing performance-based grants to the schools under the SBM initiative. Under the SBM grants scheme, the school of made to compete for grants by submitting proposals. As an extension to this scheme, the DepEd may want to leverage the SBM grants for greater SEF commitment to support the school plans as approved by the Local School Board.

This will enable the DepEd to develop the proper instrument to influence LGU fiscal behavior (concerning mobilizing and allocating funds for education).

*Tenth, promote minimum service standards more than best practices*. As another way to promote the quality of local health services, the DOH both tried to implement minimum service standards and to encourage best practices. Promoting best practices of course encourage innovations in service delivery and financing. Replicating the best practices in other areas however proved to be difficult partly because it is hard to standardize the practice so that they can be adopted elsewhere. In contrast, minimum service standards are more easily and widely enforced. This is what happened in the case of the Sentrong Sigla Movement. The Sentrong Sigla seal of quality proved to be enough incentive to many LGUs to upgrade their health facilities. In practice, however, the best among the SS certified facilities are also awarded and given cash gifts. Nonetheless, its unique design both raises minimum service quality and promotes outstanding practices.

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## Appendix 1. Early Innovations in Health Services in Selected Cities

| Health issue/ concern | Specific strategy | City | Main features |
|---|---|---|---|
| Insufficient number of barangay health stations | Conduct outreach activities in rural barangays | Gingoog (Gingoog Total Integrated Develop-ment Approach) | - Provides both health/ medical, infrastructure and other services to barrages<br>- Outreach activities conducted one or twice a month<br>- contributed to building people's participation in local governance<br>- Uses regular agency budgets and taps resources form local community |
| | Use of barangay halls and rooms of private homes for BHS | Cotabato | -Provide BHS to every barangay to widen access to health services, by using existing barangay halls or spaces in homes of concerned citizens as health stations |
| Inadequate number of health personnel | Mobilization of health volunteers | Cotabato | -Activated 100 volunteer health workers, mostly trained *hilots*, to assist the midwives in the BHSs<br>-Gives a token of appreciation worth P500 every December to each volunteer |
| | | Naga | - Trained 400 first responders and emergency technician volunteers, for the City's rescue and emergency medical assistance program |
| | Organization of Women's Group | Olongapo | - Taps the 6,000-strong members of the Balikatan Ladies of Olongapo Movement for the City's cleanliness drive and other barangay projects; members also serve as volunteer health workers without pay in city hospitals, during immunization drive, and in organizing and conducting health classes |
| | | Lapu-Lapu | -Taps the 410-strong members of local "mother support groups" for health advocacy activities such as feeding the children during nutrition month |
| | | Surigao | -Taps the 12,000-strong members of the Primary Health Care Federated Women's Club as health volunteers involved in the operation and maintenance of BHSs and feeding centers, keeping health records, and in the conduct of health information and education campaigns |
| | Involvement of private companies/ medical practitioners | Lapu-Lapu | - Asked private companies and institutions to adopt and to provide for the health needs of barrages<br>- Involves the private medical practitioners from the Mactan Doctors Organization and nurse-volunteer from the Mactan Community Hospital in its immunization program;<br>- In 1998, about 50 doctors and 100 nurses give free medical services to barangay people |
| | Hiring of temporary/ part-time health personnel | Cotabato | -To station one midwife in every barangay, hire casual midwives and charged their salaries against the 20 percent Development Fund |
| | | Puerto Princesa | - Hired 5 doctors on contractual basis for its Satellite Clinics Project, which is financed by its 20 percent Development Fund<br>- Each doctor is paid P10,000 per month for a work that requires him/her to say in his/her assigned clinic two days a week<br>- Schedules of the doctors in the satellite clinics are synchronized to maximize their availability |

| Health issue/ concern | Specific strategy | City | Main features |
|---|---|---|---|
| Lack of Emergency medical assistance | Emergency Rescue Naga (ERN) | Naga | - Initiated the ERN under its Disaster Preparedness program in April 1991, led by Naga City Hospital personnel<br>- Provides emergency medical assistance, rescue services and transport to a hospital, and also medical back-up assistance to events and conducts regular training on Disaster Preparedness and Management to ERN volunteers and other groups<br>-City government's expenditures for 1997 was P150,000<br>-For 1996, ERN responded to 2,257 emergency and transport cases, or an average of 6.2 trips per day; proved critical during when super typhoon Rosing hit Naga in 1996<br>- Awarded the Galing Pook Award in 1994, Disaster Management Award in 1995 and1996, and the Alay Buhay Award in 1996 |
| | Satellite Clinics | Puerto Princesa | -Built and operates 5 strategically located satellite clinics to serve far-flung rural barrages with no access to health service, to handle both emergency cases and simple illnesses and to provide transport for serious and complicated cases; equipped with 4-5 beds<br>-Each clinic has two midwives, a radio operator, a driver and a utility man; a doctor visits two days a week<br>- For 1997, the total budget for the clinics is P6.2 million pesos<br>- From 1993-97, the clinics served an average of 47,000 patients per year<br>- Winner of the Galing Pook Award in 1996 |
| Financial constraints and augmentation | Barangay funds for health | Olongapo | -Requires its barrages to allocate 5 percent of their IRAs to health and welfare, from which budgets for drugs for barangays are drawn |
| | | Cotabato | - Barangay finance the medicines |
| | | Lapu-Lapu | - Barangay provide the allowances for barangay health workers (which range for P400 to P1500 per month per worker, depending on the budget) |
| | 20 Percent Development Fund | Cotabato City | -Source of funds for temporary health personnel |
| | | Puerto Princesa | -Source of funds for satellite clinics |
| | Contributions | Surigao | -Members of the Barangay Environmental and Sanitation Implementation Group contribute their labor while the city government provides funds for construction of health stations and feeding center<br>-The city's PHC Federated Women's Club obtained P1.5 million of the construction of its training center from a senator's Countrywide Development Fund |
| | | Butuan | - Under the share-a-food project, well-to-do families sponsor malnourished children for three months |
| | | Lapu-Lapu | - Private companies and congressmen contribute for the milk-feeding of children; a food manufacturer regularly gives noodle's for children's feeding and supplies to barrages |

Source: Pineda [1998].

## Appendix 2. SBM Framework and Standards

| SBM Dimension | Level 1 (Standard) | Level II (Progressive) | Level III (Mature) |
|---|---|---|---|
| School Leadership | School Head (SH) is designated.<br><br>SH is trained on basic competencies on instructional leadership (e.g., National Educators Academy of the Philippines (NEAP) – SMILE)<br><br>SH is trained in SBM and LSB responsibilities.<br><br>SH initiates: (i) organizing stakeholders, (ii) installing appropriate SBM systems (e.g., school improvement planning, budgeting, and resource management, staffing, performance monitoring and reporting)<br><br>SH performs fund management duties (e.g., accounting/ bookkeeping functions) | SH performance greater responsibility and accountability in school management<br><br>SH exercises instructional leadership and management functions<br><br>SH pursues continuing professional development<br><br>SH as a resource on SBM (e.g., acts as mentor/coach)<br><br>SH cooperates with organized stakeholders<br><br>SH manages SBM system<br><br>SH is relieved of accounting/ bookkeeping functions and devotes more attention to instructional leadership and supervision | SH is fully accountable to stakeholders for school performance<br><br>SH significantly influences student learning outcomes<br><br>SH promotes/shares SBM experiences and leading practices to other schools<br><br>SH creates critical mass of SBM champions<br><br>SH has effective working relationship with LSB and SGC<br><br>SH innovates and institutionalizes continuous school improvement process<br><br>SH acts as fund manager and devotes more attention to instructional leadership and supervision |
| Internal stakeholders participation (teachers, parents, students) | Students are made aware of their rights and responsibilities as primary stakeholders<br><br>Teachers are trained on curriculum, content and pedagogy<br><br>Parents assume responsibilities as partners in learning process<br><br>Students, teachers and parents are adequately oriented on SBM<br><br>Students, teachers, and parents understand their respective roles and responsibilities on SBM, and are organized for participation in SBM process | Students exercise their rights and fulfills their responsibilities as primary stakeholders<br><br>Teachers improve teaching effectiveness<br><br>Teachers mentor peers<br><br>Teachers pursue continuing professional development<br><br>Parents co-manage and co-monitor learning process<br><br>Students, teachers and parents support SBM<br><br>Organized stakeholders introduce and co-implement programs | Students engage themselves in school leading and management<br><br>Students are held accountable for their performance<br><br>Teachers are co-leaders/co-managers of schools<br><br>Teachers hold themselves accountable for school performance<br><br>Parents are also held accountable for the performance and achievement of their children<br><br>Students, teachers and parents champion SBM |

| SBM Dimension | Level 1 (Standard) | Level II (Progressive) | Level III (Mature) |
|---|---|---|---|
| | | supporting school-wide improvement process | Organized stakeholders pro-actively engage themselves in school governance and continuous school-wide improvement process |
| External stakeholders participation (alumni, parents of alumni, local leaders, retired teachers, youth leaders/ Sangguniang Kabataan | External stakeholders are organized and made aware of their rights and responsibilities as education stakeholders<br><br>Local government stakeholders are oriented into a functional LSB (e.g., school building and facilities, extension classes, and sports development)<br><br>Community leaders/ People's organizations (POs)/ Non-government organizations (NGOs) are oriented, organized, and mobilized to support SBM (e.g., school community partnerships at least within the classroom or selected intervention like Adopt a School Program)<br><br>External stakeholders understand their respective roles and responsibilities on SBM; and are organized for participation in SBM process | Organized external stakeholders exercise their rights and responsibilities as education stakeholders<br><br>Local government stakeholders are enabled (thru capacity development interventions on resource planning and management for an expanded LSB functions (e.g., support educational subsidies, Instructional Materials and Textbooks (IMTEX), teachers and school personnel welfare and development)<br><br>Community leaders/ POs/NGOs are enabled (through capacity development interventions, resource programming ,planning and management) for expanded and school-wide support (e.g., Every Child A Reader Program, Institutionalized remedial class support, health and nutrition)<br><br>Organized external stakeholders support implementation of school-wide improvement process | Organized stakeholders engage themselves in school governance and school-wide improvement process<br><br>Local government stakeholders are fully enabled to institutionalize expanded LSB functions thru multi-year supplemental lump-sum budget allocation for SBM (e.g., PS, MOOE, CO)<br><br>Community leaders/ POs/ NGOs are fully enabled to provide institutionalized support to community-wide programs to continuously improve learning outcomes (including ALS)<br><br>Organized stakeholders introduce and co-implement programs supporting the school-wide improvement process<br><br>Organized stakeholders champion SBM<br><br>Organized stakeholders help create a community environment that support basic education |
| School Improvement Process | School conducts assessments of SBM practice using assessment tool<br><br>School Governing Council (SGC) is organized<br><br>SGC members are oriented and trained on | Periodic assessment of SBM practice using assessment tools<br><br>SGC supports continuous school improvement process<br><br>SGC members are performing their | Institutionalized assessment of SBM practice using assessment tool<br><br>SGC demands and champions continuous school improvement process |

| SBM Dimension | Level 1 (Standard) | Level II (Progressive) | Level III (Mature) |
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| | SBM and school governance – they are made aware of their duties and responsibilities<br><br>SIP/AIP needs and priorities are systematically identified (through situation analysis) within the context of existing conditions, circumstances and available resources<br><br>SIP/AIP emphasizes improvement of educational outcomes<br><br>Stakeholders are informed, consulted, and engaged in SIP/AIP formulation, implementation, and monitoring and evaluation<br><br>SIP/AIP implementation is regularly tracked and reported with necessary corrective measures undertaken<br><br>Best practices are identified, documented and shared among peers<br><br>Resources and funds (MOOE) are linked to SIP/AIP targets and allocated to meet minimum educational cost requirements (e.g., per capita per student) | respective duties and responsibilities<br><br>Participatory and knowledge-based SIP/AIP development and implementation are responsive to community needs and performance feedback<br><br>SIP/AIP meets divisional/ regional/ national performance standards on learning outcomes<br><br>Stakeholders are informed, consulted, and engaged in SIP/AIP formulation, implementation, and monitoring and evaluation and are satisfied with school performance<br><br>SIP/AIP implementation is benchmarked (with leading practices)and undertakes innovations and improvements<br><br>Best practices are replicated<br><br>Resources and funds are augmented with LSB and community contributions and allocated to meet desired educational outcomes | SGC members are held accountable for school performance<br><br>SIP/AIP formulation and implementation involve full sustained engagement of stakeholders<br><br>SIP/AIP surpasses national/ regional/ divisional performance standards; division/ region/ national plans and programs are based on SIPs/AIPs<br><br>Stakeholders are informed consulted, and engaged in SIP/AIP formulation, implementation, and monitoring and evaluation and are jointly accountable for school performance<br><br>SIP/AIP implementation is geared towards achieving exemplary performance and institutionalized benchmarking and continuous improvement process<br><br>Best practices are institutionalized<br><br>Resources and funds are sustained by LGU and community partners through supplemental budget and community equity |