Optimizing the Department of Health's Staff Augmentation Programs Towards Improved Health Outcomes
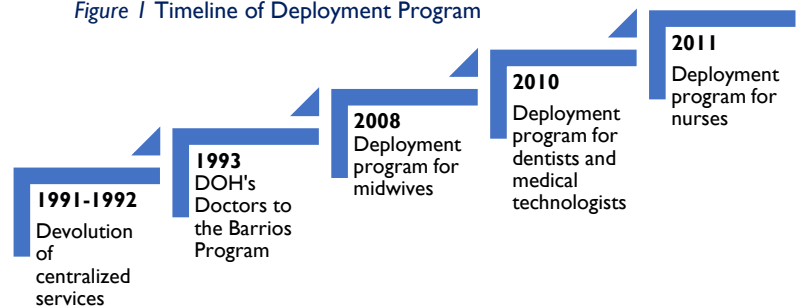
Technical Advisory

Background

The Department of Health's (DOH) Deployment Program was designed to address inequitable distribution of human resources for health (HRH) and shortage issues faced by the health sector since the devolution of government services to the local health governments from 1991-1992 (see Figure 1). While the devolution of centralized services strengthened the Local Government Unit mandate to plan and manage their own health systems, it also left many of unable to cope with their population health needs due to either to their lack of resources or inadequate fiscal capacities. The deployment program demonstrates the national government's attempts to mitigate the service delivery gaps caused by the fragmented distribution of health workforce in the country.

Figure 1 Timeline of Deployment Program

1991-1992
Devolution of centralized services

1993
DOH's Doctors to the Barrios Program

2008
Deployment program for midwives

2010
Deployment program for dentists and medical technologists

2011
Deployment program for nurses

The dearth of studies conducted on the DOH's deployment programs provide opportunities for evaluating the implementation of program and gain insights to optimize its intended outcome on the country's human resources for health management. A rapid review of the DOH's deployment programs was conducted in 2019 with the intention to provide evidence for developing recommendations to improve implementation of future deployment programs. The study does this by reviewing and assessing the program's degree of implementation, access, prioritization of recipient communities and program sustainability with the following specific objectives:

1. To determine and describe the proportion of recipient communities that were poor, marginalized, or indigenous
2. To determine the distribution and mean duration of retention of the deployed HRH
3. To describe the implementation fidelity of the HRH deployment program
4. To measure the changes in health service access in the nine regions
5. To determine the financial and outcome sustainability of the DOH deployment programs

This review is particularly important given imminent changes in the program under Universal Health Care, which includes the development of a National Health Workforce Support System, as well as the recent supreme court ruling which inevitably change the role of the Department of Health in deployment programs.

Methodology

The DOH Deployment Program Study reviewed the deployment programs for doctors, nurses, midwives and medical technicians. One of the main interests of the DOH was to find the extent and manner that national guidelines are implemented in practice at the municipalities, given the decentralized health system. This means that from the regional level downward, local health officials are given more authority in managing the health system. Thus, this study adapted Hasson's Framework for Implementation Fidelity (see Figure 2), a modified version of the original version by Carrol et al. (Carroll *et al.*, 2007; Hasson, 2010), as a framework to compare actual implementation to the basic guidelines given. The modification adds recruitment and context as categories of potential moderators.

Data gathering activities were conducted in selected municipalities of National Capital Region, Central Luzon, Region 4A and 4B, Central Visayas, Eastern Visayas, Davao Region, Socksargen, and BARMM. The study employed a mixed-methods design of records review and key informant interviews who were selected based on were selected based on their availability during the time of the field research. Available administrative and monitoring data collected by the recipient municipalities such as deployed HRH directory, data on retention, and other documentation materials relating to the implementation of the deployment report were reviewed for the records review. KIIs were conducted among deployed HRH (n=20), organic staff (22), and local stakeholders (31) to determine the perceived benefits, satisfaction, implementation fidelity, acceptability and sustainability of outcomes of the deployment program. A majority, or 80%, of the deployed HRH respondents came from the Nurse Deployment Program (NDP) cadre, 15% came from the Doctors to the Barrio (DTTB) cadre, 5% from the midwife program, and no medical technologists were interviewed. The lack of midwives and medical technologists in the field was mainly because of pending budget discussions for the Rural Health Midwives Placement Program (RHMPP) and Rural Health Team Placement Program (RHTPP) at the DOH central office and Department of Budget and Management. Data collected were analyzed quantitatively, through descriptive statistics and time-series analysis, and qualitatively using thematic analysis.

Figure 2 Conceptual Framework
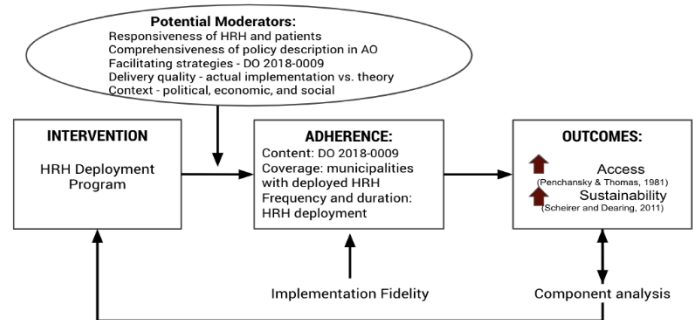
Findings & Recommendations

Following analysis of the DOH Deployment Program study results, the following recommendations were developed for strengthening and fulfilling the intended outcomes of the DOH Deployment Program. These recommendations reflect the current state of the DOH deployment program and do not take into account impending future changes due to Universal Health Care and the recent Supreme Court ruling on the computation of the Internal Revenue Allotment (IRA) for LGUs[1].

Strategic Area: Prioritization of recipient communities

Findings. Results found that **only a small proportion of the recipient municipalities belonged to 5th/6th class municipalities and GIDA despite the AO being explicit on prioritizing such areas**. The interviews and document review conducted at the sample sites revealed that only 22.2% of sites were considered poor and 44.44%. were considered GIDA barangays[2]. This finding however runs counter to organic staff and deployed HRH respondents' perception of catering to marginalized patients and indigenous communities within their regions. Both deployed HRH and organic staff respondents strongly agreed that they serve patients who are poor, marginalized,

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[1] Referred to as the Mandanas Case
[2] Sample sites were cross validated against Philippine Health Insurance Corporation (PHIC) 2010 Inventory to ascertain their municipal classifications.

and/or indigenous, giving a median score of 5[3]. All interviewed deployed HRH also mentioned attending to the medical needs of indigenous people, the poor, and those in distant or GIDA areas.

Recommendations:

- Develop policies that encourage implementing agencies and stakeholders to prioritize deployment candidates coming from underserved communities. More efforts in reaching these priority deployment candidates need to be consistently undertaken among those who have recently graduated and more senior HRH, who may want to return to work in their hometowns or be closer to family. Immediate steps can be undertaken in improving the pre-recruitment process by building the capacities of recipient communities, specifically LCEs and Health Officers in determining HRH needs and subsequently drafting HRH requests and fulfilling requirements for staff augmentation.

- Institutionalize tools and approaches to strengthen the DOH's and LGU's capacity to determine the equitable allocation of deployed HRH. This ensures that HRH deployment and augmentation are pursued according to health needs, burden of disease, equity, and population demands.

Strategic Area: Retention

Findings. **Deployed HRH showed high job satisfaction** mainly due to fulfillment of their desire to serve and competitive salaries, although the lack of job security and other bureaucratic setbacks influenced their decision to leave after the end of contract. The deployed HRH also reported high satisfaction with the facilities, colleagues, communities to which they are deployed and treatment they received from the local staff and the patients at the RHUs they served. Likewise, the local staff are also highly satisfied with the presence and performance of the deployed HRH. They described the deployed HRH as be hard-working, responsible, and great contributions to their health centers.

The **reported reasons for job dissatisfaction appeared to relate more to practical and daily concerns such as expenses, getting along with community, and living far from their family**. These reasons provide a wider perspective to barriers to retention, as these findings differ from the results of 2012 study of DTTBs, which cited lack of support from LGUs, concerns on changes in compensation upon absorption, family issues, and career advancement as main factors impeding retention (Ruppel et al., 2012).

All cadres except doctors were reported to almost always renew their contract. **Nurses and midwives were more commonly absorbed by the LGU compared to doctors and medical technologists perhaps due to the recipient communities limited resources to absorb the salary of physician**. The trend may also be due to the difference in the nature of professional growth as physicians who often move on to further residency training, while field experience is often more valued for the other cadres. The same can be said of medical technologists who may prefer urban areas whey they are more likely to find completely equipped facilities, which is a strong requirement for them to fulfill their work. While the deployed HRH, organic staff, and local implementers are working harmoniously to serve the community, the long-term goal of the deployment program was seen to be still out-of-reach. Retention remains an issue as there were only few reported deployed HRH who remained in service in the same community they were initially deployed to and the lack of documentation made it difficult to say otherwise.

Recommendations:

- Alternative and more actionable strategies for retention such as the provision of non-financial incentives can be explored to address the limited financial capacities of the LGUs. Policies that allow for flexible work arrangements, assistance in finding favorable accommodation, and social support in adjusting to the local community can also encourage retention.

- The use of development impact bonds to transition HRH from DOH to LGU support may be explored in the future, in view of the recent Supreme Court ruling on LGU IRAs. Meanwhile, policy implications to establish mechanisms to develop and implement strategies for transitioning deployed HRH from the DOH to LGU support should be studied to ensure appropriate accountability mechanisms are established. An example is on

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[3] using Likert scale of 1 to 5

financing the salaries of deployed HRH via cost-sharing arrangements between central office and the LGU for a certain period. The use of development impact bonds, which are a performance-based investment instrument intended to finance development programs in low resource countries, may also be explored as another viable strategy for financing.

- Rich community networks may also be tapped in designing non-financial incentives to ease the smooth integration of the deployed HRH into the local community. Social support and strong ties in the community can reinforce the desire among those who are already inclined to settle.
- Increasing training opportunities may also encourage retention among deployed HRH. Networks among educational institutions or professional societies may be tapped in order to design training opportunities to entice deployed HRH to stay in their deployed area, continuously update their skills, and/or aid in career progression for employment at the rural area. Training opportunities need not be limited to certificate courses but can include master's programs (for different types of medical professionals), priority in and access to residency opportunities, sponsorship to scientific conferences, and access to journals.

Strategic Area: Implementation Fidelity

Findings. In terms of the overall deployment program, **while implementation guidelines were available for each phase of the program, implementation variations between the regions were still observed**. Political influence, specifically during the recruitment and selection phases was commonly noted across multiple areas. Monitoring, evaluation, and retention phases were neglected as evidenced by the limited availability and quality of data in these areas. For instance, in some regions some documents were not standardized (e.g. evaluation forms) or did not even exist at all (e.g. retention reports). Moreover, **the goal of retention remained unfulfilled due to the budget constraints faced by LGUs**[4]. Therefore, current efforts implemented by deployed HRH within their health centers are unsustainable as they are likely to be replaced after their contracts. Nonetheless, local stakeholders were supportive of such efforts and also reported initiating programs for the development of the deployed HRH.

Recommendations:
- A strengthened system for monitoring and evaluation through both policy and action to be implemented by point persons, managers, and the local health boards to ensure consistent compliance on the ground. Strengthened compliance may further be encouraged through the issuance of prescribed monitoring forms. Making monitoring data accessible online allows for regular, consistent and comprehensive program reviews rather than occasional specialized studies. Strengthening transparency and accountability measures also safeguards the program from political influence and increasing involvement of the local politicians in the direct management of the HRH Deployment Program.
- Reinforce implementation processes through redesigned orientations that are more comprehensive, with stronger emphasis on safety and security measures, current local health system activities and programs, and local environment. Linking attendance to salaries may ensure orientation attendance at each level. A checklist to determine LGU receptiveness to and actual need for HRH should be explored as an approach for determining deployed HRH allocation.
- Document best practices and develop case studies to share insights and practical approaches for effective implementation and consistent monitoring of the deployment program. Likewise, the advantages and disadvantages of different deployment program implementation and monitoring arrangements in the different regions and local contexts can also be assessed.

Strategic Area: Access

Findings. **Deployed HRH and organic staff reported high satisfaction in working with each other, within the community, with their colleagues, at facilities assigned, and with patients, indicating high**

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[4] The retention goals is the absorption of the deployed HRH as a permanent local staff in the LGU

cultural acceptability between deployed HRH and their area. They were also generally accessible to their patients despite their full workday. Lastly, deployed HRH were involved in partnerships and programs in the community with minimal organizational support from local government units (LGUs) for HRH activities.

Initiatives undertaken by deployed HRH during their deployment were well-accepted by their host communities although these usually received sparing administrative and financial support from their respective LGUs. Responses from the local stakeholders indicate that the sustainability of the deployment program outcomes will need more robust organizational and fiscal support from the LGUs and technical guidance from the DOH regional offices. New programs, policies, and practices established with regional offices that provide support for the deployed HRH in the RHU were also rarely present. Deployed **HRH reported that they are stretched to a full capacity of working eight hours each day due to the volume of patients and time spent with each patient**. While this means that they can accommodate and become available to all patients, these conditions may lead to feeling overworked and burnout. However, it is possible that good relationships with colleagues and community might mitigate this.

Recommendations:
- The use of national staffing standards and/or Workload Indicators of Staffing Needs (WISN) provides an effective approach for considering access to health workforce, determining staffing needs of the facility, and planning staff augmentation.
- Developing policies that ensure an evidence-based planning for staff augmentation can be explored to encourage the DOH and LGUs to plan according to such staffing standards and needs results.

Strategic Area: Sustainability

Findings. Overall, deployed HRH, local stakeholders, and organic staff **are aware of community partnerships conducted in their RHUs.** Many of these partnerships are carried out on a need-basis, but some are held on a regular basis (some are yearly). Most of these partnerships are initiated by the organizations who approach the RHUs and LGUs and offer their cooperation. **Very few are initiated by the HRH themselves, such as medical missions and school health lectures.** More than half of the local stakeholders also reported that they lack new programs, policies, and practices established with regional offices that provide support for the deployed HRH in the RHU.

In terms of financial and administrative support, **most deployed HRH and local stakeholders feel that they are rarely supported by the DOH regional offices and LGU**s. In previous partnerships, the LGUs provided **assistance mainly in the form of coordination and lending personnel to work on partner activities**. Some local stakeholders reported receiving supplies and technical support.

Throughout their assignment, the deployed HRH initiated programs that may continue beyond the duration of their assignment, as an intended outcome of the program's sustainability, **are health clubs, campaigns on dengue and measles, program-specific task forces (TB task force, diabetes task force), mental health and LGBT awareness, anti-smoking campaigns, school lecture series, and even fertility awareness and family planning education**. Other DOH programs reported to be implemented in the community are TB-related activities, deworming, and healthy lifestyle. **One deployed HRH respondent cited involvement in creation of ordinances on health sanitation and creating a local water sanitation and hygiene committee.**

Recommendations:
- Policy revisions that emphasize deployed HRH's partnership within the community can help address local stakeholders' perception of how the current deployment programs are misaligned with the needs of the community. Creating a stronger link between deployed HRH program planning and local health objectives, identification of legal frameworks (such ordinances), or other measures of community ownership and buy-in could support sustainability of deployed HRH programs.
- Review and revitalize current support systems to improve available support systems for deployed HRH and local stakeholders. This is critical for sustainability of impact of programs as deployed HRH, and their programs, need to operate in an enabling environment.