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HUMAN RESOURCES FOR HEALTH IN 2030

Human Resource for Health Policy Scoping Report

HRH2030: Human Resources for Health in 2030



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HRH2030 consulted key stakeholders from public and private sector at different levels to find out what policies related to health workers pose challenges in implementation and what policies effectively address health worker needs. On right is City Health Officer of Catbalogan City Dr. Gerarda Tizon. (Photo by RDaquioag/HRH2030)

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Acronyms

AO	Administrative Order
CSC-PRIME	Civil Service Commission Program to Institutionalize Meritocracy and Excellence
DO	Department Order
DOH	Department of Health
DMO	Development Management Officers
DPO	Department Personnel Order
FP	Family Planning
FI+	<i>FOUR</i> mula One Plus for Health
GIDA	Geographically Isolated and Disadvantaged Areas
HHRDB	Health Human Resource Development Bureau
HRH	Human Resource for Health
JO	Job Order
LGU	Local Government Units
MCH	Maternal and Child Health
NTP	National Tuberculosis Program
UHC	Universal Health Care

Executive Summary

HRH2030 conducted the policy scoping activity between June – September 2018, the 3rd and 4th quarters of Year I of the Project. The purpose of the activity was to map out current policies on human resources for health in the Philippines, identify stakeholders in the HRH system, their information needs for decision making on HRH and barriers to effective policy implementation. Data on HRH policies, issues, and priorities were collected through a literature review, key informant interviews, focused group discussions, consultative workshops, and survey.

Two frameworks were used to assess external and internal policy environments: (a) the Health Labor Market Framework, which presents four policy levers for achieving Universal Health Care and (b) the Human Resource Management and Development Framework, which presents 12 functional areas. These frameworks served to define the parameters for analyzing HRH policies.

The policy scoping activity identified 54 policies related to HRH, most of which were DOH Administrative Orders and Republic Acts. Twenty-four of these policies were related to skill mix, HRH competencies and distribution; 23 were related to leadership, governance and performance management concerns; 20 were related to data use and decision-making; and 8 were related to organizational development.

Stakeholders involved in policy development and implementation included the Department of Health, particularly the Health Human Resource Development Bureau, the Regional Health Offices and the Human Resource for Health Network, an inter-agency body composed of both private and public agencies managing the production, migration and employment of the HRH workforce.

The scoping activity identified several policy gaps and issues, most prominent of which were the lack of policies on competency standards and skill mix, effective deployment of HRH, strengthening health leadership and performance management systems, and innovative approaches to coaching, mentoring, supportive supervision, and training. The study team also identified policy gaps in setting data standards and strengthening data sharing. There was no policy to identify a central custodian for Human Resource for Health information. HRMD standards, roles, and functions were also not promoted among national and local governance structures. The implementation of HRH policies showed some weaknesses due to fragmented HRH systems and use of ineffective guidelines. The DOH's policy priorities focused on HRH standards, systems, and methods that support *FOURmula 1+* implementation and the achievement of universal health care.

HRH2030 recommends expanding the policy scoping to analyze policies related to production and performance, to identify appropriate standards for competencies, skills mix, distribution and HR information, and develop policies to set up HR registries and information systems. Policies should also be established to support innovative CMSS approaches and training methodologies such as the use of e-learning platforms. Identification of appropriate HRMD standards and local systems are also important.

Background

This policy scoping report outlines issues and concerns related to the key technical areas of the HRH2030 Philippines Project workplan: health workforce competencies, skills mix, leadership, governance, supervision, information systems, and policy implementation. It notes HRH policy priorities related to the achievement of Universal Health Care and effective implementation of FI+ strategies. The preliminary scoping report also presents recommended next steps to further analyze and develop HRH policies in the country.

Global HRH2030 Strategy

Over 4 million people worldwide lack access to quality health care services.¹ This is due to the huge shortage, imbalanced skill mix, and uneven geographic distribution of health workers. An additional 4.3 million health workers are estimated to be needed worldwide to address these shortfalls and disparities.

In May 2014, the 67th World Health Assembly adopted a resolution (WHA67.24) to develop and craft a new global strategy for human resources for health. The Global Strategy on Human Resources for Health (HRH): Workforce 2030² aims to accelerate progress towards universal health coverage and the UN Sustainable Development Goals by ensuring equitable access to health workers within strengthened health systems. The strategy has four objectives: (1) optimize performance, quality and impact of the health workforce through evidence-informed policies on HRH; (2) align investment in HRH with the current and future needs of the population and of health systems, taking into account labor market dynamics and education policies; (3) build capacity of institutions at sub-national, regional and global levels for effective public policy stewardship, leadership and governance of actions on HRH; and (4) strengthen data on HRH for monitoring and ensure accountability for the implementation of national and regional strategies and the Global Strategy. Key milestones were set to be achieved by 2030.

The Western Pacific Region, of which the Philippines is a part, adopted the Global Strategy on HRH: Workforce 2030. However, a review conducted by the World Health Organization found that, although several initiatives have been started, progress in the delivery of universally accessible quality health services has been inadequate³. Countries still fell short of qualified health workers, maldistribution of workers, and inefficient skills mix. Inappropriate training and education that did not correspond to patient and population needs also continued.

Philippine HRH2030 Program

In the Philippines, current HRH challenges include the lack of integrated HRH organizational policies, fragmented HRH functions of government, lack of evidence-based staffing standards, weak HRH information systems, absence of functional HRH systems, reliance on contract-based health workers, maldistribution of HRH, and inadequate budget items for HRH.⁴ A strong HRH development and management system that fosters a capable, effective, and high performing HRH is critical to support work towards the achievement of Universal Health Care (UHC) and health care reforms under the *FOURmula I* + Strategic Framework.

¹ “Education and Training,” WHO, 2013. <http://www.who.int/hrh/education/en/>

² “Global Strategy on HRH: Workforce 2030,” WHO, 2016.

³ “Implementation of the HRH Strategy in the Western Pacific Region: An Analytical Review,” WHO, 2013.

⁴ “Philippine HRH Masterplan (2005 – 2030),” UP Manila, 2008.

The Philippines adopted the Global Strategy on HRH and USAID supports this endeavor through the Philippine HRH2030 Program. The Program aims to: (a) improve HRH planning and implementation at the primary care level especially for TB and FP/MCH services; (b) strengthen HRH performance management and development with a focus on TB and FP/MCH; (c) improve the use of data for health workforce decision making at central and regional levels. The Program is also expected to provide capacity building to the DOH to strengthen its deployment, training, and management of fit-for-purpose and practice health professionals, as well as help improve access to and quality of family planning (FP), tuberculosis (TB), and maternal and child health (MCH) services for vulnerable sectors.

To reach a broader understanding of the current HRH policy environment, there is a need to review existing HRH policies and determine gaps towards ensuring availability, accessibility, and affordability of the health workforce for UHC. A policy scoping is required to assess the relevance and influence of current HRH policies on the health sector, determine important stakeholders to lead HRH interventions, identify barriers to effective HRH policy implementation, and identify critical information systems for decision making. It is expected that the policy scoping will provide a backdrop to the HRH policy environment, understand the context at which planned HRH interventions are to be executed, identify HRH policy gaps and priorities, and determine the extent to which information is available to make evidence-based decisions.

HRH Policy Framework

The policy team applied two frameworks to the policy scoping activity, to define the health policy environment for HRH.

Health Labor Market Framework

Effective policies to address health worker shortages and maldistribution problems require comprehensive planning of the health workforce based on an analysis of economic forces affecting health workforce supply and demand.⁵ The Health Labor Market Framework reflects the dynamics of these forces and the contribution of four categories of health workforce policies to attain Universal Health Care. The categories of health workforce policies pertain to policies on production, inflows and outflows, policies that address maldistribution and inefficiencies, and policies that regulate the private sector.

The policy team adopted this framework to identify the policy areas that will constitute the HRH policy environment. Figure 1 below presents the Health Labor Market Framework and Policy Levers for Achieving Universal Health Coverage.

Human Resource for Health Management and Development Framework

The policy scoping activity also explored the environment relevant to human resource management. The framework on Human Resource Management and Development (HRMD) within the context of entry, workforce, and exit strategies, presented below in Figure 2, outlined the functional areas for study in the policy scoping. Therefore, the study team collected policies related to talent strategy and workforce planning, capability building and competency management, talent acquisition and placement, organizational development and needs analysis, performance management, succession planning, career management and development, learning

⁵ “The Labour Market for Human Resources for Health in Low and Middle-income Countries,” WHO, 2012.

and capability development, leadership and development, compensation benefit and welfare, incentives and rewards as well as attrition, retention and retirement management.

Figure 1: HLMA Framework

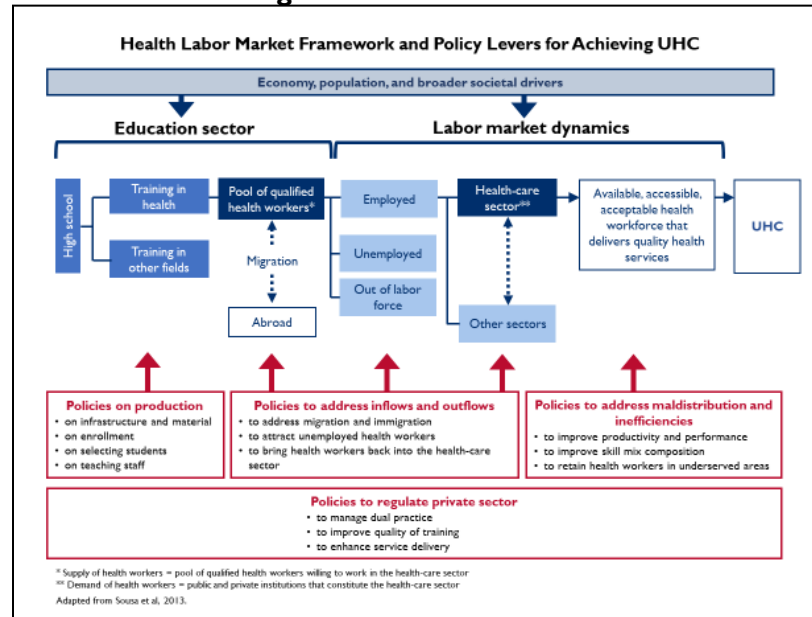
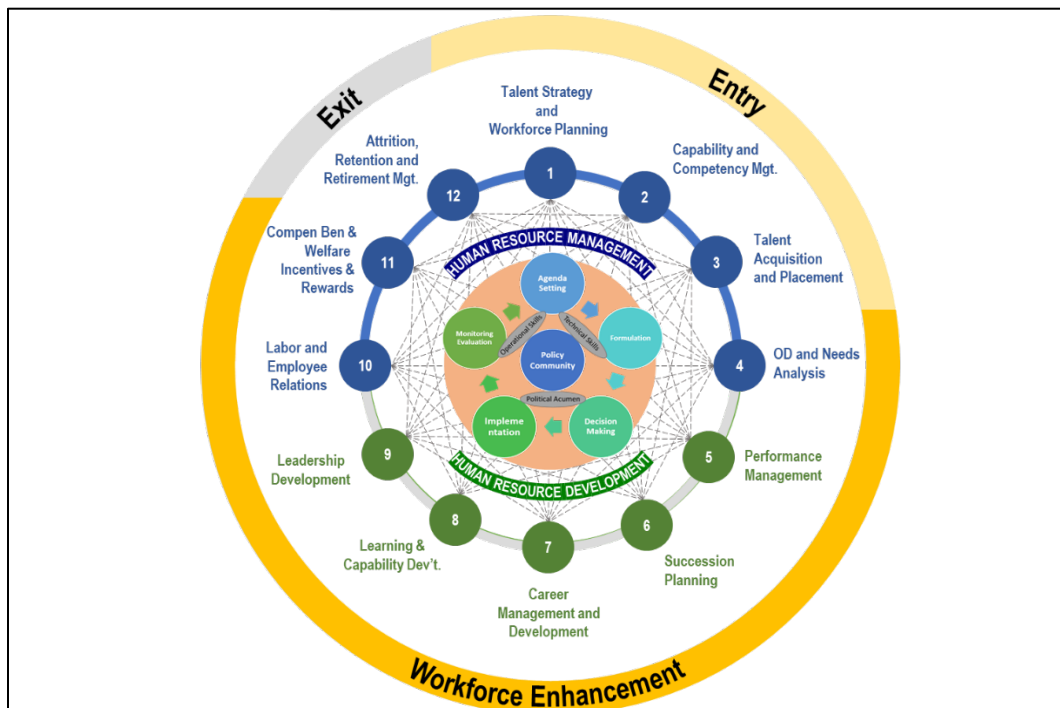


Figure 2: Human Resource for Health Management and Development Framework



Objectives

The objectives of the policy scoping activity are to:

1. Map out current policies on human resources for health in the Philippines
2. Identify stakeholders in HRH system, considering their roles, functions, resources, interests, knowledge, alliances, mandates, powers and importance
3. Identify stakeholder information needs for decision making on HRH
4. Assess accountabilities and barriers to effective policy implementation
5. Identify areas or HRH issues needing qualitative information

Scope

The policy scoping activity aimed to provide a general overview of the current HRH policies in the country, identify who implements them, how these policies are implemented and how information is used to decide on specific HRH concerns. It investigated four general areas: (1) HRH policies related to competencies, skills mix, leadership, governance, supervision and HR information systems; (2) HRH stakeholders active in policy development, implementation and monitoring; (3) HRH policy implementation issues hindering effective execution of HRH programs by mandated institutions; and (4) use of HRH information among decision makers. The policy scoping activity covered HRH concerns at the national, regional, provincial, municipal and barangay levels. It also considered HRH policy priorities of the health sector. Annex I presents the concept note for the conduct of the policy scoping study.

Methodology

The study team used several data gathering techniques in the policy scoping activity. Both qualitative and quantitative information were collected at the national, regional, provincial, municipal, and barangay levels.

Review of literature

The policy team collected literature on HRH policies and legislation from various sources. The literature included HRH laws, administrative issuances and practice acts, implementing rules and regulations, executive orders, DOH issuances, program documents, joint memorandums and circulars, as well as policies from other government agencies. The policy team reviewed and classified the literature according to the three HRH2030 project objectives and two cross cutting components. In addition, copies of HRH studies and researches were also collected. The policy team created an inventory of HRH policies in Excel to consolidate the information.

Key informant interviews

HRH2030 used semi-structured interview guides to conduct key informant interviews at the national, regional, provincial, municipal, and barangay levels. The interview questions aimed to collect information about stakeholders' mandates, roles and functions, resources and participation in the production, management, and regulation of HRH. The policy team conducted 10 interviews with representatives from DOH, HRH Network members, Regional Health Offices, Local Government Units, Academic Institutions and Professional Associations. It included the following types of professionals: DOH National and Regional Directors, Assistant Regional Directors, Technical staff such Training Specialists, Regional National Tuberculosis Program (NTP) and Family Planning (FP) Coordinators, Personnel Administration Division (PAD) Heads and Hospital Chiefs, Provincial and Municipal Health Officers, Program Coordinators, HR Heads, University Deans, Board members of Professional Associations, DOH representatives, Training Specialists, Rural Health Midwives and Barangay Health Workers. Annex 2 presents the guide questions used in key informant interviews, discussions and survey.

Focus Group Discussions

HRH2030 conducted 16 focus group discussions (FGDs) with representatives from the Health Human Resource Development Bureau, League of Private and Government Midwives, Regional Health Offices, Provincial Health Offices, Municipal or City Health Offices and Barangay Health Stations. These FGDs explored the HRH context, issues, and concerns.

Consultative Workshops

Information about HRH issues and priorities were also obtained from three consultative workshops and forums conducted by the DOH to assess readiness of the organization for implementation of the FI+ Strategic Framework. The DOH organized consultative workshops according to FI+ pillars, which were attended by Program Directors and staff. Each bureau or service presented the specific mandate of their office, programs, challenges and plans. The study team noted issues related to HRH that emerged from these workshops and included the data in the analysis.

Survey

HRH2030 conducted a short survey with the HRH Network members to collect information about their organizations, participation in HRH policy development, implementation activities, and data collection. The survey was introduced in the quarterly meeting of the HRH Network and disseminated to members through email.

See Annex 3 for a summary of the data gathering tools and instruments used for data collection and policy analysis.

Limitations of the Study

The following were limitations of the study:

1. Policies reviewed for the scoping study were mostly based on DOH issuances.
2. HRH2030 visited only four out of the nine pilot sites in the regions. This included NCR, Region 3, 4B, and 8. Due to limited time, the other regions were not visited by the policy scoping team.
3. The response rate for the HRH Network member survey was exceptionally low. Only two (2) members of the HRH submitted written responses to the policy survey through the Secretariat. Submitted surveys were from the Philippine Regulatory Commission (PRC) and the Department of Labor and Employment.

Results

This section presents the results of the policy scoping activity. It presents results from the review of HRH policies initially gathered from the DOH. It identifies the stakeholders involved in HRH policy development and implementation through the HRH Network. It describes, in general, how HRH policies are disseminated and cascaded to the Regional Health Offices and Local Government Units. It also provides a general overview of the HRH priorities, policies of the DOH Central Office, as well as the issues and concerns related to competencies, skills mix, leadership, governance, supervision, human resource information system and organizational development.

HRH Policies

HRH2030 collected and reviewed 54 HRH-related policies. Table I presents the type of HRH policies reviewed in the scoping activity. The study team categorized the policies according to the project objectives and identified 24 policies related to competency, skills mix and distribution; 23 policies related to leadership, governance and performance management; and 20 policies related to data use and decision-making. Eight policies were identified to be related to organizational development.

Majority of the HRH policies in the country were mandated by national laws passed by the Senate and administrative issuances released by the DOH. National laws included the Magna Carta of Public Health Workers (Republic Act 7305), Ladderized Education Act of 2014 (RA 10647-2014), Open Distance Learning Act (RA 10650-2014), An Act Institutionalizing the Philippine Qualifications Framework (RA 10968), and the Continuing Professional Development Act of 2016 (RA 10912-2015). Laws that influence how HRH are developed and managed included the Data Privacy Act (RA 10173-2012), Comprehensive TB Elimination Plan Act (RA10767), Responsible Parenthood and Reproductive Health Act (RA10354-2012), and the Local Code of the Philippines (RA 7160).

Types of Policies	Number
Administrative Orders	12
Republic Acts	9
Implementing Rules & Regulations	7
Program documents	3
Manuals	3
Memorandum circulars	3
Department orders	3
Strategic plans	3
Omnibus Policies	2
Executive orders	2
Budget circulars	2
University policy	1
Quality procedure	1
Memorandum Order	1
Joint Circular	1
Executive Order	1
Department Personnel Orders	1

DOH Administrative Orders, which generally provide an overview of current DOH policy directions and sectoral goals such as the Strategic Framework and Implementing Guidelines of FI+ for Health and the Philippine Health Agenda, have only recently recognized the critical role of the HRH in instituting health sector reforms and now include an HRH component. Specific issuances on HRH include the Establishment of the DOH Academy, Deployment Program and PHA Deployment, Competency-based HRH Management and Development Systems, Installation of HRHMD Systems within the SDN, and National Database on HRHIS.

Overall, HRH policies governing the health sector provide a broad framework in raising professional competencies of health workers, such as the Continuing Professional Development Act, the Philippine Qualifications Framework and the Ladderized Educational Act. Likewise, the law also promotes the well-being of health workers, their working conditions and terms of employment through the Magna Carta of Public Health Workers. Implementing rules and regulations (IRR), which provide critical guidance for policy implementation, often accompanied national laws while guidelines often accompanied administrative issuances. The IRR or guidelines designated the implementing agencies responsible for enforcing the law or described how the policy was to be implemented. Memorandums, joint circulars, and executive orders supplemented these national policies with procedures based on specific mandates of the implementing agencies. Program manuals and other documents served to provide tools for detailed implementation of the policies. However, mechanisms to operationalize the policies and provide adequate and sustained funding seemed to be inadequate to effectively carry out its implementation.

Review of HRH policies also indicated a lack of consistency and strategic coherence in linking critical policies between the education and labor sectors to effectively use these as leverage towards achieving UHC goals. Because different government agencies oversee different components of the whole HRH system, policies were often developed based on specific

mandates of these agencies and separately from other HRH policies formed by other organizations. With no common goals to work on and no framework to guide the development of HRH policies, divergent policy strategies may negate achievement of HRH development goals within the health sector.

Human resource management and development functions, especially within the DOH, are lodged in two separate units, the Personnel Administrative Division (PAD) under the Administration and Finance Management Team and the Health Human Resource Development (HHRDB) Bureau which is under the Health Policy and Systems Development Team. Having two separate structures for HRH seems to serve as a deterrent to effective coordination of HRMD efforts and provision of strategic direction within the agency and the health sector. In effect, HRMD functions conducted by both units are siloed, and a comprehensive policy on HRH standards and procedures that integrate and systematize HRH functions is absent. Several weaknesses were identified in the use of organizational development approaches, performance management systems, standards for compensation, benefits and welfare, incentives and rewards, as well as in procedures for career management and development.

HRH Policy Stakeholders

There are three major key stakeholders involved in the development, implementation and monitoring of HRH policies in the Philippines. These stakeholders are the DOH, the Human Resources for Health (HRH) Network and the Local Government Units (LGUs).

Department of Health

The DOH is the principal health agency in the Philippines.⁶ It is responsible for ensuring access to basic public health services to all Filipinos through the provision of quality health care and regulation of providers of health goods and services. Its vision is to be a global leader for attaining better health outcomes, competitive and responsive health care system, including equitable health financing. Its mission is to guarantee equitable, sustainable, and quality health to all Filipinos, especially the poor. It also aims to lead the quest for excellence in health.

DOH Central Office

The DOH is mandated to develop national plans, technical standards and guidelines on health.⁷ It is the regulator of all health services and products as well as a provider of tertiary health services and technical assistance to health providers and stakeholders. The central office is headed by the Secretary of Health who chairs the Executive Committee and Undersecretaries who head a cluster of offices organized into Teams. There are 7 teams: Health Regulation, Health Policy and Systems Development, Administration and Financial Management, Procurement and Supply Management, Field Implementation and Coordination, Health Facilities and Infrastructure Development, and the Public Health Services. Each Central Office Bureau or Service is headed by a Director and Division Chiefs. The Health Human Resource Development Bureau (HHRDB) is under the Health Policy and Systems Development Team. Figure 3 below presents the organizational structure of the HHRDB.

The HHRDB has 47 *plantilla* positions composed of the Director, four Division Chiefs, one Administrative Officer and 41 Technical and Administrative staff.⁸ The four divisions plus the administrative unit: Planning and Standards, Learning and Development, Career Development and Management, Personnel Administration Division.

⁶ Department of Health; <https://www.doh.gov.ph/about-us>

⁷ Ibid; <https://www.doh.gov.ph/profile>

⁸ HHRDB Organizational Chart, DOH; <https://www.doh.gov.ph/orgchart-hhrdb>

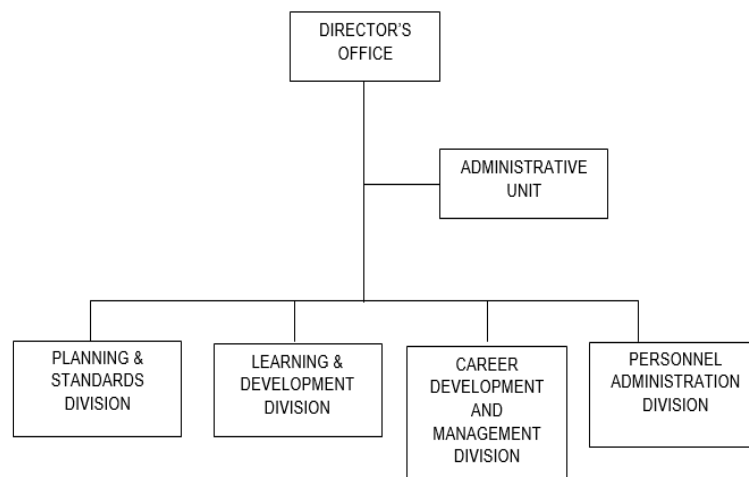
The Planning and Standards Division is responsible for the development of HRH policies, plans, programs, projects, standards, and systems responsive to health trends and needs. It maintains an HRHIS and monitors standards on HRH. It conducts research on HRH for development and management as well as convenes and coordinates with advisory bodies for HRH concerns.

The Learning and Development Division is responsible for identifying the training needs of specific HRH cadres in the health sector. It develops, coordinate, facilitates and implements learning and development programs or interventions for HRH. It monitors and evaluates learning and development programs or interventions.

The Career and Development Management Division develops, implements and monitors plans and programs on the recruitment, selection, deployment and utilization of HRH. It institutes career management and development systems in the health sector and manages licensure of specific HRH categories assigned.

The Personnel Administration Division (PAD) used to be part of the HHRDB but is currently under the Administration and Financial Management Team. It is responsible for formulating and implementing policies, standards, and guidelines in matters pertaining to internal personnel recruitment, selection, and placement. It develops and administers employees' compensation, incentives and other benefits. It is also responsible for implementing and monitoring employee performance and efficiency through performance appraisal systems. The PAD also advises employees related to personnel management and welfare services, and processes appointments, leave applications, separation from the service and other concerns. It manages the grievance machinery and employee incentives and rewards systems.

Figure 3: HHRDB Organizational Structure



Regional Health Offices

The DOH has 17 Regional Health Offices headed by the Regional Director and Assistant Regional Director. It is composed of a Legal Division, Planning Division, Health Promotions Division and Communications and Information Technology Division. The Regional Health Offices implement and monitor national health policies issued by the Department of Health. They coordinate with different regional stakeholders in the implementation of national health policies.

The Regional Health Offices work in partnership with the devolved Provincial Health Offices and Municipal/City Health Offices through the Provincial Department of Health Office (PDOHO), who represents the DOH at the local level. The PDOHO is composed of Development Management Officers (DMOs) who are retained DOH personnel assigned to specific areas. The DMOs represent the DOH in Provincial and Municipal Local Health Boards. They assist the DOH in implementing national health policies and provide technical assistance to Local Government Units to adopt national health policies through the development of local legislations or health programs. The PDOHO is also responsible for disease surveillance, training coordination, data collection and reporting on local health implementation.

Human Resource for Health (HRH) Network

On October 25, 2006, the DOH led the creation of the HRH Network.⁹ This is a multi-sectoral network composed of various government and non-governmental organizations. It aims to address and respond to HRH concerns and problems in the Philippines. The HRH Network aims to facilitate the implementation of the HRH Master plan, provide policy directions and develop HRH programs, harmonize existing HRH policies and programs, develop and maintain an integrated HRH database, and advocate HRH development and management in the country.

The HRH Network was formally established through a Memorandum of Understanding among member agencies. The DOH serves as the HRH Network's chairman, with the HHRDB serving as its secretariat. The HRH Network is organized into 3 Technical Working Groups (TWG) on entry, workforce, and exit policies. The TWG on Entry is concerned with production of HRH and is mostly composed of agencies mandated for higher education, professional regulations, technical skills development, and professional associations. The TWG on Workforce is composed of agencies concerned with employing and financing HRH for delivery of services. The TWG on Exit is concerned with HRH exiting the country to work abroad or returning to the country from working abroad. Table 3 presents the list of agencies under each TWG.

Table 3: List of Agencies Working Under each HRH Network TWGs

TWG on Entry	TWG on Workforce	TWG on Exit
Commission on Higher Education (CHED)	Department of Health (DOH)	Philippine Overseas Employment Administration (POEA)
Professional Regulatory Commission (PRC)	Department of Labor and Employment (DOLE)	Overseas Workers' Welfare Administration (OWWA)
Technical Education Skills Development Authority (TESDA)	Occupational Safety and Health Center (OSHC)	Commission on Filipinos Overseas (CFO)
Association of Deans of the Colleges of Nursing (ADCN)	Department of Interior and Local Government (DILG)	Public Services Labor Independent Confederation
Association of Philippine Medical Colleges Foundation	National Economic and Development Authority (NEDA)	National Reintegration Center for OFWs
Institute of Labor Studies	University of the Philippines Manila	Bureau of Immigration
	Civil Service Commission (CSC)	
	Department of Budget and Management (DBM)	
	Philippine Nurses Association	

While the HRH Network has achieved many positive results, such as conducting capacity building activities and hosting HRH forums, the network also encountered challenges. Members of the HRH Network often raised issues regarding the legality of the network, with only a

⁹ HRH Network, <https://www.doh.gov.ph/Health-Program/human-resource-for-health-network>

Memorandum of Understanding serving as basis for its creation and the DOH acting as a Secretariat to coordinate activities. As a result, the HRH Network members could only work within their respective mandates, which inhibited development of inter-sectoral policies and actions to address HRH concerns. Inter-agency policy agreements of the HRH Network signed by heads of agencies were also subject to internal changes of the member agencies, especially when new heads of agencies were not supportive of the policy agreements and organizational policies changed. This resulted to a discord on HRH policies by cooperating agencies. It was also difficult to expect funding support from HRH Network members since the agencies were not authorized to support HRH Network activities through their respective budget allocations from the General Appropriations Fund.

The Department of Health attempted to secure a mandate for the HRH Network through a proposed HRH Network Bill. However, this proposed legislation did not generate support from legislators and the bill was not passed into law. Activities of the HRH Network are currently supported by the DOH through the HHRDB, who provides both technical and financial support to the committee. The Department of Health through the HHRDB continues to seek appropriate policy instruments that will provide the necessary mandate and funding to the HRH Network to achieve its objectives. HHRDB is exploring whether an Executive Order from the President would provide the necessary authority for the HRH Network.

Local Government Units

In line with the implementation of the Local Government Code (LGC) of 1991 (RA 7160), the management of health service from the province down to barangays were devolved to the Local Government Units (LGUs). At the Provincial level, the Provincial Health Office, Provincial Hospital and District Health Offices were devolved under the administration of the Provincial Governor. Municipal Health Offices and Barangay Health Stations were placed under the administration of the Municipal Mayors.

The Provincial Health Office integrates both the public health and hospital services at the province level. It is headed by the Provincial Health Officer, with an Assistant Provincial Health Officer who takes charge of the Provincial Hospital. The District Hospitals are part of the Provincial Health Office, headed by a District Hospital Chief. It provides clinical services to communities within the jurisdiction of the province. The Municipal Health Office provides public health services and is considered as a primary health care level. It is composed of a Municipal Health Officer, Public Health Nurse, Rural Health Midwives, Sanitary Engineer or Inspector and the Public Health Dentist. The Municipal Health Office manages satellite health clinics at the barangay level, called Barangay Health Stations. This facility is manned by a Rural Health Midwife assisted by Community Health Volunteers called *Barangay Health Workers*.

Budgets for running these facilities are incorporated into the Internal Revenue Allocations (IRA) of their respective Local Government Units. Forty-five (45) percent of the LGU IRA is allocated for Personnel Services (PS) while the rest of the budget is allocated for Maintenance and Other Operating Expenses (MOOE). Payment for salaries and benefits of locally hired health personnel, purchase of equipment, supplies and medicines, conduct of local health activities as well as capital outlay for building, refurbishing and maintaining health facilities are charged against the IRA of the LGUs.

The Local Government Code of 1991 also mandated the creation of a Local Health Board at the province and municipal level. These committees are headed by the Local Chief Executives and

representatives from the Provincial/Municipal Health Offices and the National DOH, represented by the Provincial DOH Representative. The committees discuss, deliberate on and recommend the approval of local health ordinances and budgets to the *Sangguniang Panlalawigan or Pambayan* (Local Legislative Councils). LGUs through their local health boards or by the authority of their Local Chief Executives can approve or veto the adoption of national health policies for implementation at the localities. Being a devolved entity, LGUs have their own policies on HRH.

HRH Policy Implementation

The policy scoping activity looked at the potential barriers to effective implementation of HRH policies. The study team reviewed seven dimensions of policy implementation¹⁰: policy formulation and dissemination, social, political and economic context of the policy, leadership for policy implementation, stakeholder involvement, implementation planning and resource mobilization, operations and services, feedback on progress and results. The study team interviewed both policy makers and implementers to provide their insights into the dimensions of HRH policy implementation.

Examination of policy implementation dimensions covered the national, regional, provincial, municipal/city and barangay levels. The study team conducted site visits to four regions – Region 3, 4B, 8 and the National Capital Region, one Provincial Health Office, one Municipal Health Office, one City Health Offices and one Barangay Health Station to look at local policy/program implementation. To investigate the various dimensions of policy implementation, the study team primarily examined the operations of the deployment program. We also solicited insights on local operations from FP and NTP program implementers and with staff who were not involved in the deployment program.

Policy formulation and dissemination. Development of the Deployment Program was largely driven by the DOH Central Office. After approval, the HHRDB disseminated the implementation guidelines to the RHOs through the Human Resource (HR) Training Specialist, who subsequently organized plans for program implementation with other concerned units at the regional level. The RHO developed a regional order detailing how the national guidelines were to be implemented and identifying roles of each regional units. The DMOs were held responsible for disseminating the guidelines to the Local Government Units. Each year, the HHRDB issues guidelines on the use of funds allocated for HRH deployment to the Regional Health Offices.

Social, political and economic context. The DOH Central Office selected geographically isolated and disadvantaged areas (GIDA) for implementation from the list of GIDA submitted by the regions. The selected sites, however, also included urban areas which were not classified as GIDA (e.g. National Capital Region). Interviews also indicated strong pressures from local politicians in the selection of areas for deployment. Because the deployment of HRH made tangible services available at primary health care levels at no cost to the LGUs, Local Chief Executives (LCE) often requested DMOs and, occasionally, Regional Directors to deploy HRH in their health facilities. To accommodate these requests, HRH were sometimes deployed to areas that were not included in the list of priority GIDA issued by the National DOH Office.

¹⁰ The USAID: Health Policy Initiative Task Order I. “Taking the Pulse of Policy: The Policy Implementation Assessment Tool,” 2010.

Stakeholder involvement in policy implementation. Several stakeholders were involved in the implementation of the deployment program, including HHRDB, RHOs, the HR Training Specialists, DMOs, and LGUs. At the Central level, the HHRDB coordinated with DOH units to consult and collect data for the development of the deployment guidelines, which were subsequently implemented by the RHO. The HR Training Specialist coordinated the program with other regional units and oriented newly hired applicants. The PAD managed recruitment and selection of HRH applicants while the DMOs supervised the deployed HRH, and HHRDB handled overall program monitoring.

Implementation of the deployment program was conducted in partnership with the Local Government Units who accepted the deployed HRH to serve in their respective health facilities. However, because government salaried staff cannot be deployed in private facilities, the program did not engage the participation of private providers nor private sector organizations in the deployment program. Only public health agencies were involved in the implementation of the program as stakeholders.

Leadership for policy implementation. Implementation of the Deployment Program at the regional level was led by the HR Training Specialist and the DMO. Role of the HR Training Specialist in the program centered on the dissemination of policy guidelines on deployment to the regional staff, program monitoring, recruitment and orientation of deployed HRH. The actual deployment of HRH to LGUs, coordination with LGUs in the implementation of the program and field monitoring of deployed HRH in health facilities was managed by the DMOs who acted as their supervisors. Therefore, negotiation with LGUs regarding work conditions, allowances, and management of deployed HRH performance was undertaken by the DMOs.

DOH leadership seemed to be inadequate in negotiating and arranging for logistical support to deployed HRH, ensuring good working conditions, appropriate workloads and work hours, obtaining shares in PHIC reimbursements for services rendered by deployed HRH, capacity building and meaningful contribution to primary health care goals and objectives, including the formulation of strategies to retain deployed HRH at local levels.

According to key informants, the absence of clear work standards and support systems was one of the main reasons that DOH representatives were unable to negotiate appropriate HRH technical and logistical support from LGUs. Unlike the DTTB Program, where travel and other allowances are specified in the MOU, the deployed nurses, midwives and other HRH did not have any MOUs to indicate logistical support from LGUs such as travel to GIDA and other allowances. In absence of these specific provisions, DOH Representatives were not clear about HRH logistical support systems necessary for deployed HRH to carry out their tasks and ensure good work conditions for them at the locality.

Implementation planning and resource mobilization. The DOH issued implementation guidelines for the deployment program (Administrative Order 2014-0025), specifying implementing structures, how to select priority areas for deployment, deployment of HRH to DOH and LGU hospitals and to public health facilities, pre-recruitment procedures, recruitment and selection, the application process, pre-deployment and deployment procedures. An updated version of the guideline was issued in 2018 specifying qualification and salary standards per type of HRH and their possible tasks and functions. Fund allocations were based on the number and type of HRH assigned to each region. However, with the budget cuts made in 2018 for Regional Health Office

allocations, most of the Regional Health Offices feared that lesser HRH will be deployed for the succeeding years.

The guidelines included requirements for continuing education and capacity building as well as monitoring and evaluation. The policy guidelines also suggested HRH retention strategies for LGUs and specified roles of the HHRDB, Regional Health Offices, recipient hospitals and LGUs, and deployed HRH. In addition, the guidelines included procedures for logistical support, funding source, budget utilization and other special provisions which were also indicated in the guidelines. Other fund support aside from salaries were highly dependent on the support and availability of funds from the Local Government Units.

The scoping activity identified five major planning/resource mobilization barriers to the implementation of the deployment program.

1. *Lack of benefits and allowances for deployed HRH.* Because of their status as job order employees, deployed HRH were afforded only basic salaries with no other benefits. In addition, nurse deployed personnel and other HRH, except for deployed doctors, did not have any travel and transportation allowances to support field visits to GIDA. Expenses for these visits were shouldered by individual HRH out of their own pockets. No formal arrangements on LGU support to HRH were included in the deployment plan. Only the “Doctor to the Barrios Program” had a memorandum of agreement with LGUs that included provision of specific benefits and allowances for the doctor, which were chargeable against the budget of the LGUs.
2. *Inability of the deployed HRH to receive continuing education and capacity building.* Despite provisions in the guidelines, the deployed HRH were not provided with any continuing education and training. Based on the Commission of Audit (COA) rules and regulations, only activities of regular and permanent employees can be supported with an official budget. Since the deployed HRH held temporary “job order” positions, government budgets could not cover expenses for travel to trainings and payment for training fees. In view of this, any expenditures afforded to deployed HRH ran the risk of being disallowed by financial audits from the COA. As a result of these policy contradictions, the DOH Regional Health Offices and LGUs could not send the deployed HRH for training on any health programs. This greatly hampered capacity building and services of deployed HRH, most of whom were new graduates and did not have any previous experience in public health programs.
3. *Lack of sustainable local funding sources to retain services of deployed HRH.* LGUs often complained of reaching their Personnel Service (PS) cap as a reason for their inability to absorb deployed HRH into the local health system. Internal Revenue Allocations (IRA) provided by the Department of Budget and Management were often not enough to support hiring of additional personnel since this fund was dependent on income and population classifications. With GIDA having low income levels and low IRA, they were often not qualified to retain HRH and unable to provide standard salaries.
4. *Limited operations and services.* Since many of the deployed HRH were unable to avail of trainings on standard procedures and protocols of public health programs, their services were very limited. Untrained HRH were rarely assigned to service provisions involving clinical examinations, immunizations, or treatment. Instead, most of the deployed HRH were mobilized to gather statistics and collect and consolidate data for health reports. Their skills as nurses or midwives, for example, could not be maximized to expand availability and

access to much needed health services in GIDA communities. In this manner, the purpose of the deployment program was defeated.

5. *Unequal salary standards.* The wide disparities between the salaries of the LGU health staff and deployed HRH also tended to distort the roles of the LGU health staff and deployed HRH in the provision of public health services. Salary standards for LGU health staff were dependent on the income classification of their municipality/city and the Internal Revenue Allocation (IRA) received by LGUs from the government. The lower the income classification of the municipality or city meant a much lower amount of IRA for Personnel Services and Maintenance and Other Operating Expenses (MOOE) by the LGUs. Thus, many of the local LGU health staff received lower salaries. On the other hand, salaries of deployed HRH followed much higher national wage standards since this was one of the incentives of the program to attract HRH applicants. Given higher salaries from the national government, many LGU health staff were discouraged by the arrangement and refused to deal with HRH deployed personnel.

The planning/resource mobilization issues mentioned above partially stem from a lack of operational guidelines and local mechanisms by which HRH concerns may be addressed and managed by the Regional Health Offices. In consultation with the Bureau of Local Health Systems Development, the Philippine Health Insurance Corporation, Commission on Audit or Department of Interior and Local Government, feedback could have been provided and amendments to the guidelines worked out to strengthen operational support for deployed HRH.

Feedback on progress and results. Under the deployment order, the Regional Health Offices (RHOs) were responsible for monitoring and evaluating the performance of deployed HRH. The RHOs were expected to monitor deployed HRH twice a year and submit a monitoring report to the HHRDB, which includes an evaluation of the deployed HRH's performance, factors that hindered utilization of their services, their contribution to UHC and possibility of renewal. The RHO was responsible for monitoring compliance to the guidelines by the recipient hospitals or LGUs. However, the guidelines did not indicate any sanctions to non-complying LGUs. Scoping indicated that monitoring was not regularly conducted by the RHOs nor by the Central Office due to lack of personnel to undertake the activity. Evaluation of HRH deployed personnel relied on written reports from the LGUs and RHOs at the end of the contract term.

Retention of the deployed HRH was one of the main concerns on deployment program. The program was conceptualized as a temporary measure to address HRH shortages and maldistribution in GIDA. However, results of the deployment program showed that LGUs rarely retained deployed HRH by offering permanent *plantilla* positions in their facilities. None of the LGUs took any effort to allocate local budget to retain deployed HRH. Instead, as a practice, LGUs became dependent on the DOH to provide them with additional personnel through the deployment program. RHOs observed that LGUs continued to re-hire HRH who had previously served in their areas through the deployment program. Contracts of these deployed HRH get renewed yearly to continue his or her service. With the absence of LGU efforts to retain deployed HRH or sustain the program, shortage of HRH will continue and further affect provision of basic services to critical areas.

National HRH Policy Priorities

The Department of Health (DOH) recently completed the *FOURmula One for Health (FI+)* which serves as the Department's policy thrust under the administration of the current Secretary of Health, Secretary Francisco T. Duque III from 2017 - 2022. The FI+ serves as a guide for DOH Offices, attached agencies, partners and other stakeholders in prioritizing areas for provision of health services and financing support.¹¹ The FI+ framework has 5 strategic pillars namely: Financing, Service Delivery, Regulations, Governance, and Performance Accountability. Objectives and key interventions are outlined for each pillar, indicating priorities for action. The policy also outlines in broad terms the implementing guidelines to be supplemented by the National Objectives for Health which will provide specific objectives, targets and strategies for each pillar.

The Department also initiated a proposed bill on UHC which is expected to “protect and promote the right to health of every Filipino” and ensure access to a “comprehensive set of health services” that are affordable. The proposed bill provides for all Filipinos an “automatic inclusion” in the National Health Security Program and are thus “entitled to all benefits prescribed.” The proposed bill includes a specific chapter on Human Resources for Health which provides for a competitive compensation package, PhilHealth reimbursement for professional services, secure available *plantilla* items, return of service, publicly-funded health professional education, curriculum with primary health care and outcomes orientation, and integrated HRH data.

Given the current policy thrust and expectation for the passage of the Universal Health Care, the DOH identified numerous health and HRH policy priorities:

General Health Priorities

1. Ensuring the availability of HRH in every health facility
2. Developing appropriate production of HRH
3. Generating good regulatory policies on health
4. Strengthening of the supply chain and procurement
5. Developing guidelines on service delivery by Primary Health Care networks
6. Standardizing Clinical Practice Guidelines (CPGs)
7. Establishing systems and operational structures for the Return Service Agreement
8. Strengthening the HRH Network's strategic contribution to health goals, through efficient funding, building capacities for research and as a viable venue or forum for strategic HRH thinking
9. Reviewing and integrating performance management functions to policy directions
10. Building capacities of Program Managers and the HHRDB to develop national and sector-wide policies
11. Re-structuring DOH for firefighting and strategic management
12. Establishing the National Health Worker Account

Human Resource for Health Policy Priorities:

1. Mandatory return service for human resources for health
2. Redistribution of the Health Workforce
3. Improvement of HRH working conditions
4. Strengthening leadership and management capacities

¹¹ “Administrative Order 2018-0014: Strategic Framework and Implementing Guidelines for *FOURmula One Plus for Health*,” DOH, 2018.

5. Strengthening human resource data and information systems

In relation to these priorities, key HRH interventions would need to contribute to the achievement of FI+ and Universal Health Care goals. Critical to the crafting of HRH policies is information about current HRH and assessment of HRH situations. Policy environments would also need to enable the development of evidence for innovative approaches to solving issues and concerns on HRH.

The following section describes the HRH policies related to each of the three HRH2030 Program Objectives and the Organizational Development as a cross-cutting concern. The sub-sections present an enumeration and general description of these policies and a discussion of HRH policy issues and concerns arising from these policies.

Competencies, Skills Mix and HRH Distribution

A total of 24 policies related to competencies, skills mix and HRH distribution were reviewed. Most of the policies relate to deployment programs, proposed working conditions of health workers, continuing professional development, human resource for health management and development systems, and HRH procurement of consultants. Key among these policies serving as an overarching framework were as follows:

The Philippine Qualification Framework (Republic Act 10968). This policy was initially drafted as Executive Order 83 and approved by President Benigno Aquino III in 2011. The policy was developed in response to the gaps between the education and labor sectors, which resulted in a mismatch of job skills. The policy was signed into law by President Rodrigo Duterte on January 16, 2018 as Republic Act 10968, institutionalizing the Philippine Qualification Framework (PQF) and establishing the PQF National Coordinating Council with appropriation of funds.

The PQF is a “quality assured national system for the development, recognition, and award of qualifications based on standards of knowledge, skills, and values acquired through different methods by the learner or worker¹²”. It presents an 8-level qualification descriptor and standards for qualification outcomes. It outlines the knowledge, skills and values of each level, the application, degree of independence and type of qualification to be obtained. The PQF aims to develop national standards and learning outcomes for education and training. It supports the development and maintenance of systems that allow individuals to access and attain qualifications through the different education and training systems as well as access employment after each training. The policy also aims to ensure that the PQF meets international qualification standards to support national and international mobility of workers.

Given the PQF and its aim to support employees to access qualifications that are aligned with industry standards, the policy provides justification for the DOH to establish an accreditation or certification system that will allow health workers to acquire specific skills through non-formal education and be recognized to possess these skills through certification. Defining the competency levels and standards for all cadres in the health sector is a critical factor in completing the HR system. The DOH had started to define competency levels and standards of human resource for health management and development. However, this initiative is yet to be completed and put in the context of current FI+ and UHC policy directions.

¹² <https://www.thecorpusjuris.com/legislative/republic-acts/ra-no-10968.php>

The Deployment Program. Under EO 102, series 1999, functions of the Department of Health were re-directed, mandating the agency to ensure equity, access, and quality of health care services. In line with this mandate, the HHRDB set forth to develop programs and policies that would strengthen equity, access, and quality of health care services. The Deployment Program was one such program that distributed several types of HRH such as doctors to the *barrios*, physician augmentation, dentists, nurses, medical technologists, UHC implementers, pharmacists, family health associates, public health associates and midwives. See Section on HRH Policy Implementation for information about the Deployment Program.

Magna Carta of Public Health Workers. One of the main concerns of health workers since 1991, when basic health services were devolved to the local government units through the passage of the Local Government Code, has been the benefits afforded to them by law. Republic Act 7305, or the Magna Carta of Public Health Workers, was meant to protect health workers and set their working conditions when devolved to the local government units. However, 25 years after the Magna Carta was passed, several concerns raised by locally-paid health workers regarding compensation, working conditions and benefits, such as hours of work, night shift differentials, hazard pays and subsistence allowance remain unresolved. Recognizing the absence of effective mechanisms to address these grievances among HRH, the DOH has resolved to review these concerns in line with strengthening HRH for UHC.

The policy scoping activity identified several policy gaps in HRH competencies, skill mix and distribution, as follows:

1. *Absence of policies on HRH skills mix standards.* At present, there are no policies on skills mix and information is inadequate to define appropriate standards for skills mix at the primary health care level. Instead, primary health care facilities are traditionally managed by teams composed of a rural health physician, public health nurse, dentist, sanitary engineer/inspector, and rural health midwives. Each category of health worker is assigned a specific ratio to population, which serves as a standard to determine the number of health workers needed at the primary health care level. However, with the changes in disease burdens, health needs of the population, direction of the health care systems toward UHC and challenges in migration, compensation and distribution besetting the HRH, there is a need to identify appropriate standards for skills mix at the primary health care level.
2. *Absence of adequate technical competency standards.* Technical competencies for health staff providing primary health services are defined in the DOH national programs. However, these competencies leave gaps in the knowledge, skills and attitudes of health workers, particularly in competencies that require cross-cutting knowledge, skills and attitudes, such as change management, patient experience, and supportive supervision. There is no clear policy on what competencies to meet or how to stay competent through continuing professional development for health workers. HRH competency standards and frameworks need to be established.
3. *Maldistribution of health workers.* The human resources for health situation in the country indicates a shortage of HRH, especially in GIDAs, in part due to migration. The government implements a deployment program to support LGUs who have limited capacity to complete recommended HRH in their localities. However, the effectiveness of its implementation and impact on health outcomes need to be assessed. The strategic

importance of the deployment policy would need to be reconsidered in the light of meeting Universal Health Care goals.

4. *Inability of Local Government Units (LGUs) to provide and compensate HRH.* Interviews on the deployment program among DOH regional staff revealed that many LGUs are not able to provide the Magna Carta benefits to public health workers as mandated by law. LGUs and health workers often have different interpretations of the law and LGUs point to the lack of funds as the main reason for not providing these benefits. LGUs also reason that the law does not actually mandate the provision of these benefits but rather, its provisions are subject to the availability of local funds. Payments and benefits to health workers remain below standards due to limited budgets. The reasons why these benefits are not provided by the LGUs needs to be further investigated.

The availability of national assistance through the deployment program seems to demotivate rather than motivate LGUs to retain and offer permanent *plantilla* positions to these HRH. According to LGUs, hiring of new HRH is hindered by their Personnel Service Cap limitations. At present, there is no current policy which will compel or encourage LGUs to fill out local *plantilla* positions or hire new HRH.

HRH Leadership, Governance and Performance Management

The study team identified 23 policies from DOH issuances related to leadership, governance and performance management. However, only a limited number of these policies provide a clear framework on HRH leadership, governance, and performance management for local HRH. These were the DOH Academy and the Ladderized Education Act. Policies related to Coaching, Mentoring and Supportive Supervision (CMSS), building leadership capacities of HRH and indicators for effective performance management were inadequate.

DOH Academy. The DOH Academy was created to serve as the primary training arm of the agency, which was expected to exercise stewardship in providing learning and development interventions that were relevant, rational, and effectively responded to the needs of the health sector. Administrative Order 2015-0042 entitled “Guidelines for the establishment of the DOH Academy was issued on October 2, 2015, aimed at recommending policies and guidelines for the establishment of the DOH Academy. Specifically, it aimed to define the organizational structure and prescribe operational guidelines in the development, implementation, management, monitoring and evaluation learning and development interventions (LDI) in LGUs and health-related sectors.

However, the DOH Academy did not seem to operate efficiently and was unable to effectively gain the buy in of academic institutions to provide LDI to LGUs and health-related sectors. Two (2) assessments conducted in 2015 by Dr. van den Borne of EPOS Management (European Union)¹³ and 2016 by Dr. Eufemia Yap,¹⁴ an independent consultant, provided several suggestions on how best the DOH Academy may be organized. Dr. Van de Borne recommended immediate and intermediate actions for the DOH to move the DOH Academy forward. Some immediate actions recommended relate to assessing the legal feasibility of the DOH Academy, determining the functionality of the HHRDB divisions to take on the role

¹³ Francine van de Borne, “Final Report: The Provision of Technical Support to the HRH Technical Working Group for the Establishment of the DOH Academy.” 2015.

¹⁴ Eufemia Yap, initial report on the DOH Academy assessment. 2016.

required, and holding consultations with DOH units and senior management to agree on purpose, priorities, structure and location of the Academy. Some suggestions for intermediate actions include a systematic review of all in-service trainings to align these with formative learning principles, negotiation with Higher Education Institutions (HEI) to adopt transformative education approaches and forge new partnerships with them, train DOH on transformative education, and establish user friendly e-learning systems. Dr. Yap proposed values and framework for the DOH Academy, mechanisms for partnerships with HEIs and strategies to reduce training days of each HRH Cadre by 50%.

Ladderized Education Act of 2014. Republic Act 10647 institutionalized a ladderized approach to educating health workers by interfacing technical-vocational education and higher-level education. This approach aims to open opportunities for the career and educational progression of health workers by facilitating their entry and exit into the education system as well as entry and exit to job platforms to earn income. The Act mandates the Philippine Qualification Framework National Coordinating Committee (PQF-NCC) to implement a unified PQF system that provides access and progression to educational and job opportunities through a ladderized system. The mandate of the Act also includes the development of qualification and credit transfer systems in the ladderized degree programs. It also allows the Committee to design harmonized guidelines and equivalency competency courses, synchronize standards, upgrade curriculum design per discipline and adopt a strategic implementation scheme. The responsibility for identifying priority disciplines where the ladderized system will be applied was left to the PQF NCC to decide. The Act also mandated other agencies to support the establishment of the ladderized education through grants and scholarships. Higher Education Institutions (HEIs) with similar curricula were also encouraged to avail of the system.

A very limited number of academic institutions provide ladderized education. The University of the Philippines Health Science Institute at Palo, Leyte is one such institution that provides a ladderized curriculum for health cadres in local communities. However, opportunities to establish ladderized education may not have not been maximized in other parts of the country.

The policy scoping assessment identified several HRH policy gaps in leadership, governance and performance management among HRH as follows:

1. *Lack of mandate to strengthen HRH leadership capacities.* With the advent of the UHC bill, competencies of health managers would need to be raised to manage increased demand for health care services. However, after reviewing the training materials, the study team determined that the DOH has not put in place effective trainings on management and leadership for HRH in health care. There is a need to evaluate training approaches used to build competencies of HRH managers and leaders, especially among HRH at primary health care levels. Competencies of health workers need to be assessed to identify gaps in leadership and management skills. Policies are needed to support and sustain capacity building for leadership, governance and supportive supervision.
2. *Lack of policies to enable e-learning and other training methodologies.* The main training methodology used in building capacities of HRH was face-to-face interactions between trainers and trainees. Health workers were often called to seminars or workshops for several days to train on specific health programs. However, this methodology required time away from the health facilities resulting in a disruption of health services due to the absence of doctors, nurses or midwives. The use of e-learning approaches in building the capacities of HRH is expected to provide a platform that will enable health workers

to gain new knowledge and skills but at the same time continue to provide health services in their respective localities. To support this initiative, policies to enable e-learning needs to be established to ensure that this approach is supported by the DOH and Local Chief Executives.

Recognizing that e-learning alone may not be enough to build capacities of local HRH as health managers, opportunities to practice leadership or apply leadership skills may improve learning. Policies will be needed to formulate more effective leadership modules and include immersion and integration approaches to learning.

3. *Need for an enabling policy to support Coaching, Mentoring, and Supportive Supervision (CMSS) innovations.* Service Delivery Networks were expected to be the main structure to deliver health services under UHC. Current CMSS approaches need to be reviewed to determine how the provision of CMSS will now be re-configured or structured to ensure continued technical support in building service capacities of different HRH under the SDN. As such, there is a need to assess CMSS systems with the end in view of making it functional under a SDN set-up.

4. *Lack of standards for performance management.* As the most recent pillar that was added to the DOH's FI+ Strategic Framework of the DOH, performance management is now recognized as a critical factor in attaining UHC. Traditional ways of evaluating performance of HRH need to be reviewed. New performance indicators and performance management systems would need to be put in place to ensure that HRH commit to FI+ strategic goals.

Human Resource Information System (HRIS)

A total of 20 policies related to health resource information system were reviewed. However, only three of these policies had guidelines explicit to information systems. These were the Data Privacy Act of 2012 (RA 10173), the National Database of Human Resource for Health Information System and the DOH Information System Strategic Plan 2018 – 2020.

Data Privacy Act. The Philippine Data Privacy Act, passed in 2012 (RA 10173), has comprehensive and strict legislation about “protecting the fundamental right of privacy of communication while ensuring the free flow of information to promote innovation and growth.” It applies to the processing of all types of personal information and to any person involved in the processing of personal data. The Act includes data controllers and processors who use equipment located in the Philippines or maintain offices in the country. The law allows for “the processing of personal data, subject to compliance with the requirements of the Act and other laws allowing disclosure of information to the public and adherence to the principles of transparency, legitimate purpose and proportionality.”

The Act also requires informed consent prior to the collection of all personal data, including automated processing of personal data. The extent and purpose of processing personal data is to be fully disclosed to the individual. Consent is to be given freely and recorded. Consent is also required for sharing of information to other affiliates and mother companies. It should also be covered by an agreement to protect the rights of the data subject and subject to review by the National Privacy Commission.

The law also requires the establishment of a data privacy and technical security program for any entities involved in data processing. This program outlines the development, implementation and review of data collection procedures as well as measures to safeguard personal data of subjects. The law also requires a notification to be issued in all “personal data breaches,” Companies are obligated to notify the National Privacy Commission for any breaches. Penalties under the law include imprisonment and a fine, including a private right to action for damages. Implications of the Data Privacy act to the creation of HR information systems will need to be studied.

Philippines eHealth Strategic Framework and Plan (2017). The eHealth plan served as the DOH's strategic framework in the application of information communications technology to support health sector reforms and other critical health programs. In several of the National Objectives for Health Plans, the use of ICTs was seen to be a strategic approach to improve health services and achieve goals of the DOH towards Universal Health Care. International commitments of the DOH also promoted the use of eHealth services to reach vulnerable populations and communities.

In line with these, the DOH developed the Philippine Health Information System Strategic Plan, which presented its vision, mission, objectives, priority focus and strategies in implementing eHealth for greater efficiency in health care, workforce productivity and optimize use of resources. The DOH coordinated with the Department of Science and Technology (DOST) in working towards the implementation of the eHealth roadmap. The partnership created a Joint DOH-DOST National Governance Steering Committee and Technical Working Group on eHealth.

Guided by the eGovernment Master Plan of “linking government data center and databases to create a secure network for government information systems and harmonize information technology systems in the public sector,” the joint undertaking established and implemented the Philippine Health Information Exchange (PHIE) platform for secure electronic access and efficient exchange of information. This platform facilitates PhilHealth reimbursements and data access and exchange of health data. This plan provides for an impetus to the creation of an HRIS and the interoperability of such a system to other information systems.

National Database of Human Resource for Health Information System (NDHRHIS). The NDHRHIS was initially established to keep a permanent registry of all licensed hospitals. With the new classification of hospitals and other health facilities, hospitals are now required to establish non-medical support units, which include an Information Management Unit (IMUs). All IMUs are required to submit information to the DOH through the Health Facilities and Services Regulatory Bureau (HFSRB) for purposes of research, standards setting, improvement of access and quality of health care services.

In line with this mandate, the HHRDB as the system owner, utilizes the NDHRIS to facilitate the collection of data on HRH from the hospitals and other health facilities, as mandated by the AO 2015-0017. It is used to produce statistical reports for HRH planning, management, policy development and research. The NDHRHIS is also used to generate information on the current distribution and skill mix of HRH for deployment purposes. The DOH-HHRDB is the current system administrator of the NDHRHIS. Mode of data collection is done through an on-line and manual registration and encoding. An annual inventory of NDHRHIS facility users is conducted by the HHRDB to monitor and evaluate facility users in reference with the total number of facilities registered under the HFSRB.

Current policies seem to indicate lack of guidelines, standards and integrated systems to strengthen Human Resource Information Systems (HRIS). Although the presence of a governing body on eHealth would push forth the use of ICT to improve efficiency of services in government, HRH data standards, data sharing and interoperability of current information systems do not seem to be in place. There is lack of clear HRH registries, data collection systems and data sharing mechanisms among DOH units.

Integrated Database System for the Human Resources for Health. In line with the goal of harmonizing the policy and coordinating the action of different agencies, accredited professional organizations, academic institutions, and non-government organizations in the HRH Network, a Memorandum of Agreement on data sharing was formulated. Seven agencies: DOH, POEA, CFO, National Reintegration Center for OFWs, TESDA, CHED and PRC agreed to create an integrated database system on HRH to “capture, process, store and report vital information on HRH” that covers production, utilization, deployment, migration, re-entry and retirement at the national level. Terms and conditions related to the roles and responsibilities of agencies, accessibility, security and confidentiality, data storage retention, ownership of data, copyright and license were agreed on. However, members expressed difficulties in data sharing due to differences in data standards, limitations from the data privacy act and inoperability of information systems among HRH Network members.

The scoping activity identified several policy gaps in Human Resource Information Systems:

1. *Lack of data standards for HRH.* Current information systems used by different organizations to collect HRH data within the health sector seemed to lack common standards on data.
2. *Need to map and identify barriers to data sharing and data use.* Barriers to data sharing and data use need to be determined so that the development of policy interventions can facilitate information exchange. Data integration and discussion also need to be considered in the light of the new data privacy act.
3. *Lack of a national custodian for HRH.* There is no central repository of HRH data in the health sector and no designated custodian to manage and coordinate data use for HRH at the national level. In addition, the governance structure on HRIS needs to be assessed to identify who oversees formal decision making on HRIS, institutions in charge of particular HRH mandated committees on HRIS, barriers to governance as it relates to data privacy and sharing of information.
4. *Lack of standards for data quality.* There is a need to review and assess factors which affect data quality in the collection of information about HRH. In addition, policy gaps related to data quality standards and procedures to ensure data quality and procedures on how to validate these standards need to be determined.
5. *Lack of data sharing agreements with critical agencies.* There is a need to coordinate with the PHIC data systems to identify critical HRH information needs and arrangements for data sharing with the DOH. In addition, there is a need to explore the possibility of the Philippine Regulatory Commission (PRC) sharing their data on licensed HRH to the DOH.

Organizational Development

The study team reviewed eight policies related to organizational development. Most of the policies presented changes in structures, implementing arrangements and functions of government programs and units. However, how these changes were to happen and what organizational development processes the agency would undertake to execute the changes were only implied in the policies. Only two policies provided some guidelines on human resource management and implementation of performance accountabilities:

Civil Service Commission PRIME-HRM. The Program to Institutionalize Meritocracy and Excellence in Human Resource Management (PRIME-HRM) provided a framework in capacitating government agencies in the performance of their human resource management functions. The policy aimed to institute a system of merit and recognition of excellence in public service human resource management through incentives, capacity building, and continuing development. The program covered all national and local government agencies including government owned and controlled corporations and state universities. It also covered all regional offices and Human Resource Management Officers, heads of agencies and rank and file employees.

The Program has three components namely:

1. *Comprehensive HRM Assistance, Review and Monitoring (CHARM)*, which is a “detailed appraisal of human resource management systems and standards, management of human resource records, other systems and programs and the competence of HRMOs.”
2. *Continuing Assistance and Review for Excellent Human Resource Management (CARE-HRM)*, is a program that assists agencies to implement recommendations based on their CARE-HRM report.
3. *Special Program for Evaluation and Assessment as Required/Requested (SPEAR)*. This is an assessment conducted by the CSC on specific areas of the agency’s HRM based on request. The evaluation may be conducted on regular assessment periods or separate from it. There is usually a Memorandum of Agreement between the agency and CSC to conduct the evaluation.

The CSC has three levels of accreditation – Level I (regulated), Level II (accredited) and Level 3 (deregulated) and confers two types of recognition to agencies – Center for Excellence in HRM and Seal of Excellence in HRM, for agencies who comply to the HR management programs and systems and manifest exemplary practices. A Certifying Board assesses and recommends the agencies for specific recognitions.

Policy Scoping activities revealed that many of the HR units of government, especially among LGUs interviewed, used the PRIME-HRM as a policy standard for HRM practices. They endeavored to implement the program and complied with its requirements. At the DOH level, PRIME-HRM accreditation is being pursued by the Central Office. However, policy scoping in selected regional areas did not seem to have related HRHMD systems development activities in pursuit of the accreditation nor capacity building for HRMOs.

The LGU HR Units interviewed made efforts to reach the highest level of accreditation and recognition by the CSC through the PRIME-HRM Program. Bataan Province is an example of an LGU who had achieved Level II accreditation and worked towards achieving Level III. See Box 1.

Box 1: Bataan Province PRIME-HRM

The Province of Bataan was one of the Local Government Units visited by the Policy Scoping Team to provide insights on local policy implementation of HRH policies and practices. The following are highlights of the unique practices found in the province:

1. The province has a vision to keep their population healthy. This vision is included in their development and implementation plan.
2. The Governor and Mayor are both advocates of good health, have internalized the right to health principles, and have a clear understanding of both health outcomes and health systems. The Governor has clear health goals for the province and strategies to achieve them. He also has an appreciation of what the province can contribute to national economic development goals and the role health plays in this plan.
3. Both the HR units of the Province and the City comply and have applied for full accreditation of their HR systems with the Civil Service Commission. Documentations required are complete and approved by the Governor and Mayor.
4. Provincial and City goals on health are appreciated and implemented by the Provincial and City Health Offices. The City Health Office has a set standard on the number of minutes (15 minutes per patient) that health workers should devote to a patient. This standard is a written policy of the City which primary health care units comply to.
5. Both the Province and the City have received recognition for their achievements in health (e.g. Hall of Famer for Tobacco Control). They are motivated by the prestige given and the monetary incentives received by the province. The local government supports and invests in health programs of the locality through the allocation of appropriate budgets. Health is a priority of the province and city.

FOURmula One Plus for Health. An additional pillar on Performance Accountability was included in the Strategic Framework and Implementation Guidelines of the *FOURmula One Plus for Health* policy. This pillar was expected to “drive better execution of policies and programs in the DOH while ensuring responsibility to all stakeholders. Key interventions of the pillar include the: (a) institutionalization of transparency and accountability measures at all levels of the DOH and health sector and (b) shift to outcome-based management approach, which would require regular monitoring and performance reviews and improvement of mechanisms that link performance to incentives.

A concern raised in the adoption of Performance Accountability as a strategy for the FI+ for Health is the identification of appropriate performance standards and indicators for health workers that will ensure their commitments to the policy goals. An assessment of current performance accountability approaches, methodologies and tools was deemed critical by a key informant to ensure that performance accountability processes and measures are improved to achieve FI+ objectives.

Recommendations:

Based on the results of the policy scoping activity, the following actions are recommended:

For the DOH to:

1. Develop an HRH strategic plan that will map out its vision, mission, specific targets, strategies and indicators to ensure availability and accessibility of HRH, build competencies of the health workforce, apply appropriate skills mix and distribution as well as establish HRHMD and information systems in the health sector;
2. Develop appropriate quantitative and qualitative measures that will determine real-time availability, vacancy, distribution, and characteristics of HRH workforce, and use that data in decision-making and strategic planning for UHC and FI+;
3. Craft a policy that will define competency standards for HRH, especially at primary health care levels and Service Delivery Networks. Establish mechanisms to build and continue to build capacities of the HRH, provide supportive supervision, execute appropriate performance evaluation and assessment of HRH level of competency and performance. Include mechanisms for ladderized education, as necessary in GIDA, retention strategies, and continuing professional development;
4. Formulate a policy supporting the use of e-learning platforms to upscale competencies of the health workforce and facilitate learning and development of HRH, especially at LGU level;
5. Work with the Civil Service Commission to design an appraisal of HRHMD at the LGU level and propose standards to update/enhance HRHMD systems through the PRIME-HRH program. These standards may include recommendations for appropriate HRH recruitment procedures, workload distribution, fund allocations and standardized compensation, promotion procedures as well as retirement benefits;
6. Evaluate current DOH HRHMD systems, update and expand the roles and functions of national and regional HRH units based on a comprehensive HRH framework in line with the UHC and FI+ implementation.

For the HRH Network to:

1. Seek an appropriate policy instrument that will strengthen the HRH Network's mandate as a viable venue in proposing strategic HRH policies and standards, HRH information systems, learning and development programs for the HRH workforce;
2. Participate in the development of technical competency standards and practice guidelines for health cadres based on good professional practices;
3. Review, revise and align agency regulatory policies on HRH towards the goal of meeting HRH production requirements, appropriate distribution of HRH to GIDA, retention of HRH workforce and enhanced participation of the private sector in public health services;

4. Participate in strengthening mechanisms for more effective coordination of licensing, certification, accreditation and information technology systems towards the goal of meeting HRH capacities and requirements for UHC and FI+ implementation in the country;

For the Regional Health Offices to:

1. Expand roles and functions of the Regional HR Training Division and PAD to include other functions on HRHMD and strengthen regional HRH systems;
2. In line with the management of HRH deployed:
 - 2.1. Collect information related to LGU HRH policies and systems, HRH budget, workload of health staff, vacant HRH plantilla positions at hospitals and health centers, targeted poor as evidence for planning of deployment strategies;
 - 2.2. Develop regional policies on local support for HRH deployed personnel at GIDA, including the development of service level agreements through a MOA with LGUs;
 - 2.3. Develop a learning and development package for HRH deployed staff with CPD accreditation and higher-level courses;
 - 2.4. Work with LGUs to develop retention schemes and incentive systems for HRH deployed staff using national budgets as a leverage;
3. Orient Provincial DOH Representatives on HRH policies, functions and systems to guide deployment implementation.

For the Local Government Units to:

1. Establish a clear HRHMD system based on the CSC PRIME-HRH Program;
2. Establish competency-based activity standards for the HRH workforce in primary health care level health facilities.

Next Steps:

Following from the results of the policy scoping activity, the HRH2030 shall:

- I. Expand policy scoping activities to include an inventory of HRH policies on:
 - I.1 HLMA Policy Levers:
 - a. HRH production (e.g. policies related to enrollment, selection of students, teaching staff);
 - b. Migration and immigration of HRH (e.g. policies related to entry and exit of HRH, return policies related to HRH who worked outside the country);
 - c. Policies that regulate the private sector (e.g. policies related to professional practice, dual practice, service delivery, quality of education and training of HRH);
 - d. Policies that address maldistribution and inefficiencies (e.g. policies related to productivity and performance of HRH, skill mix composition, and distribution.

I.2. DOH HRHMD policies:

- a. Talent strategy and workforce planning
- b. Capability and competency management
- c. Talent acquisition and placement
- d. OD and need analysis
- e. Performance management
- f. Succession planning
- g. Career management and development
- h. Learning and capability development
- i. Leadership development
- j. Labor and employee relations
- k. Compensation benefit and welfare incentives and awards
- l. Attrition, retention and retirement management

I.3. HRMD policies from the Civil Service Commission (e.g. PRIME-HRM);

I.4. HRMD policies from selected health facilities and hospitals (e.g. LGUs).

- 2. Identify policies that: (a) were not implemented, (b) support or strengthen HRH leverage towards achievement of Universal Health Care, (c) support or strengthen HRHMD systems, (d) irrelevant or needs to be rescinded;
- 3. Identify and analyze specific HRH priority policy issues and gaps related to the three Objective areas to sustain and institutionalize effective interventions on:
 - a. Competencies, skills mix, and distribution
 - b. E-learning
 - c. Human Resource Information System (HRIS)
- 4. Develop policy briefs on specific HRH policy agenda that support the use of tested HRH methodologies, approaches, interventions and systems to improve HRH workforce expected to advance Universal Health Care in the country.

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