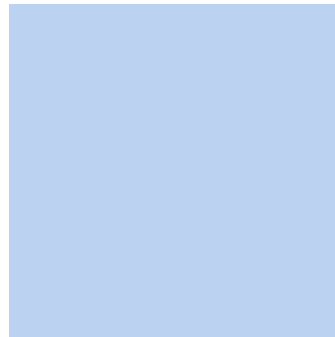




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HUMAN RESOURCES FOR HEALTH IN 2030



FINAL | DECEMBER 2019

2020-2040 Human Resources for Health Master Plan: Strategy Paper

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Cover photo: Dr. Redentor Rabino, one of the first doctors to the barrios in Bongao, Tawi-tawi, conducts the Snellen's test to one of his patients. (Credit: Blue Motus, USAID HRH2030/Philippines)

DISCLAIMER

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Acronyms

AO	Administrative Order (specifically AO 2014-0025)
APO	Accredited professional organizations
BARM	Bangsamoro Autonomous Region in Muslim Mindanao
BHW	Barangay Health Workers
BLAs	Bilateral labor agreements
CFO	Commission on Filipinos Overseas
CHED	Commission on Higher Education
CME	Continuing Medical Education
CO	Central Office
CPG	Clinical Practice Guidelines
CSC	Civil Service Commission
DOH	Department of Health
DOJ	Department of Justice
DPO	Department Personnel Order
DTR	Daily Time Record
DTTB	Doctors to the Barrio
FP	Family Planning
HEIs	Higher education institutions
HHRDB	Health Human Resource and Development Bureau
HRH	Human Resources for Health
HRHMP	Human Resources for Health Masterplan
HRMD	Human Resource Management and Development
IPHO	Integrated Provincial Health Office
IQR	Interquartile Range
KII	Key Informant Interview
LHB	Local Health Board
LDI	Learning and Development Interventions
LI	Local Implementer
LCE	Local chief executives
LGU	Local Government Unit
MNCHN	Maternal, Newborn, Child Health & Nutrition
MOA	Memorandum of Agreement

MOU	Memorandum of Understanding
NC II	National Certificate II
NCR	National Capital Region
NDHRHIS	National Database on Human Resources for Health Information System
NDP	Nurse Deployment Project
NEDA	National Economic Development Authority
OSH	Occupational safety and health standards
PAASCU	Philippine Accrediting Association of Schools, Colleges and Universities
PDOHO	Provincial DOH Office
PHN	Public Health Nurse
PQF	Philippine Qualifications Framework
POEA	Philippine Overseas Employment Administration
PRC	Professional Regulation Commission
PSA	Philippine Statistics Authority
RHU	Rural Health Unit
RO	Regional Office
RPO	Regional Personnel Order
RHMPP	Rural Health Midwives Placement Program
RHTPP	Rural Health Team Placement Program
SD	Standard Deviation
SDG	Sustainable Development Goals
SO	Specific Objective
SPMC	Southern Philippines Medical Center
TB	Tuberculosis
TESDA	Technical Education and Skills Development Agency
TWG	Technical Working Group
UHC	Universal health care
UP SHS	University of the Philippines School of Health Sciences
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

As part of crafting the 2020-2040 Human Resources for Health (HRH) Master Plan, a strategy paper was developed comprising a set of proposed strategies that aim to address the key HRH issues identified in the situation analysis. Major issues facing HRH are the:

- Lack of accurate information to guide planning and policy,
- Inadequate number of health workers in the health sector,
- Inequitable distribution of HRH across levels of care,
- Disjoint between the education and health sectors, an effect of multiple interlinked HRH systems and many HRH stakeholders that operate independently,
- Fragmented HRH governance and unclear accountability mechanisms, and
- Policies that are lacking and/or poorly implemented.

The starting point of the strategy development were the recommendations from the HRH Network Members from the 2nd HRH Network Meeting. It was supplemented by adapting recommended strategies by the World Health Organization (WHO) and those with evidence from the literature review. The development of the strategies was further guided by the health labor market framework. The initial set of strategies was subjected to a set of criteria. Strategies should:

- Support the UHC law provisions,
- Address persistent HRH issues,
- Build on and reinforce other strategies to create synergistic effects; and
- Contribute to the attainment of national and international policies and commitments.
- Also ensuring that it is guided by the health labour framework for universal health care (UHC).

The strategies were organized around seven strategic objectives. Three objectives focused on improving the recruitment of HRH, developing appropriate competencies, raising HRH productivity and responsiveness, and ultimately retaining HRH. Four objectives aim to strengthen information systems/data, foster sustained intersectoral collaboration and co-development of plans including ensuring the coherence of policies, build the capacity of institutions, and increase the HRH investments. The strategies are suggested to be implemented in combination rather than in single interventions to increase the likelihood of successfully making systemic changes and ensuring that persistent issues are resolved and do not recur.

The interrelationship of the strategies and how these can contribute to improving health system performance, health outcomes, and national long-term goals are summarized through a strategy map in six dimensions: people, processes, financing, learning and growth, partnership and collaboration, and stakeholders.

This report is divided into two main sections. Section I gives details on how the strategies were developed such as the criteria used and framework referred to. Section II lays out the list of strategies per strategic objective with identified facilitating and hindering factors.

Background

Prompted by the passage of the Universal Health Care (UHC) Law in 2018, the 2020-2040 HRH Masterplan (HRHMP) is being crafted and will serve as an overarching document that guides the whole of society and whole of government to meet the HRH component of the UHC goals. The HRHMP addresses the need to improve the country's health outcomes and achieve UHC. To do so, it is critical to have a sufficient number of 'appropriately skilled and motivated, equitably distributed and well supported' health workers in the system.^{1 2}

As stated in the UHC Law, the goal of the national 2020-2040 HRH Master Plan is to provide policies and strategies for the appropriate generation, recruitment, retraining, regulation, retention, and reassessment of the health workforce based on population health needs. The HRH Masterplan provides a picture of the current situation of the HRH sector in the Philippines, which has been presented following the WHO Working Lifespan Strategies. Data and information drawn from published and unpublished studies, policy documents, and other reports are presented about the health workers from entry to the workforce or pre-service (i.e. education and training), in the workforce, and exit out of the workforce. In addition, HRH stakeholders and its policy context were reviewed. The Masterplan will be progressive, technically, economically feasible and sustainable, and will have sufficient details for implementation and operationalization to guide the health sector to achieve better HR management.

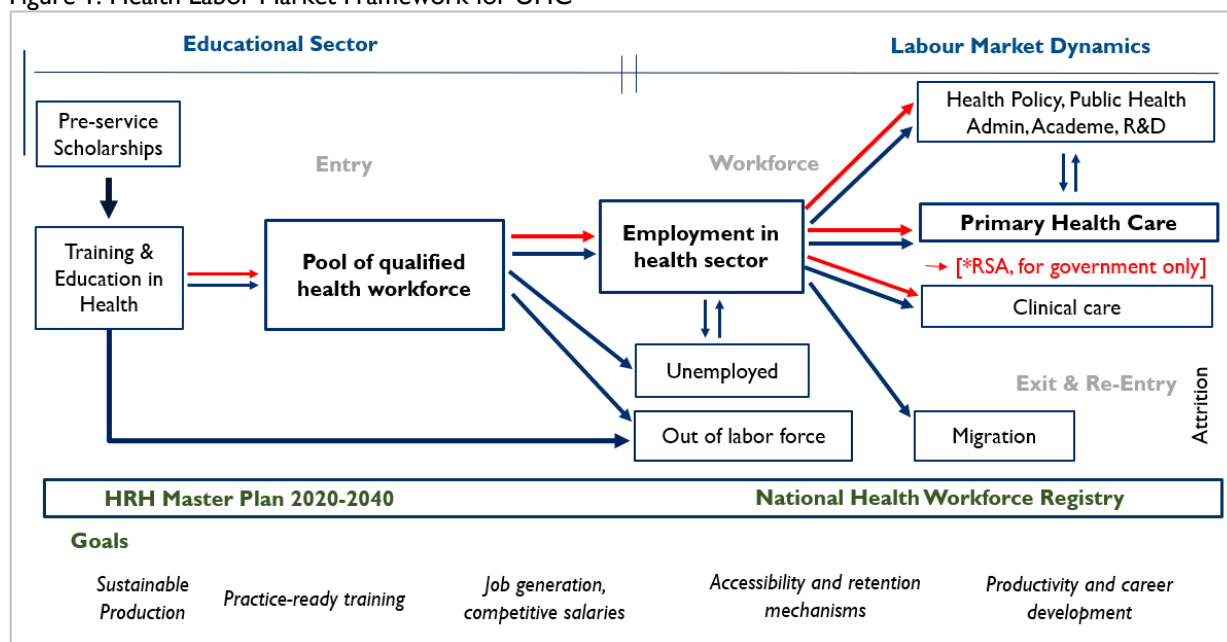
Methodology

The HRH Master Plan blueprint was developed by conducting two major activities – a situation analysis (SA) and strategy development. In the situation analysis, the key issues faced by the Philippines' HRH sector and that must be addressed in the Masterplan were identified. These issues were determined through a document and literature review consisting of legislations, policy documents, published studies and unpublished data. Secondary analysis of data from many agencies (e.g. Commission on Higher Education [CHED], Professional Regulation Commission [PRC], Philippine Overseas Employment Administration [POEA], Commission on Filipinos Overseas [CFO], Health Human Resource Development Bureau [HHRDB]) corroborated these issues and identified additional ones. The results of the SA were presented to the HRH Network and validated in their second quarterly meeting. Additional inputs obtained during the validation was subjected to content analysis and incorporated in the SA report.

For the strategy development, the HRH Network members were asked to identify strategies for the issues they validated. The strategies were summarized and compared with the literature on HRH strategies on recruitment, productivity, and retention. Where there was a World Health Organization (WHO) recommended HRH-related strategy for an issue identified in the SA, this was adapted. Otherwise the strategies recommended by the HRH Network members were used. Another round of review of literature, this time focusing on the available evidence for each strategy, was undertaken. To validate the proposed strategies and set priorities, three regional consultations were held with participants coming from regions per island group.

The HLMA framework (Figure 1), which was adapted to include the HRH-related provisions of the UHC law guided both activities.

Figure I. Health Labor Market Framework for UHC



Criteria in identifying strategies of the HRH Masterplan

Strategies that have been identified for the HRH Masterplan are distinguished between transformative and enabling i.e. cross-cutting strategies. These satisfied the following criteria and expected to be implemented at the health system, facility or institutional, and individual levels:

- Supports the UHC law provisions: expand scholarships, reorient curriculum to PHC, permanent employment, practice ready training, return service agreements, workforce registry and support system
- Addresses persistent HRH issues in order to create system changes and the effects of the core problem
- Builds on and reinforces other strategies to create synergistic effects
- Contributes to attainment of national and international policies and commitments

The criteria were determined based on the a) need to respond to the current driver of change, like the UHC law in the health sector and the HRH sector; b) need to resolve persistent issues facing the HRH sector; c) prevailing wisdom that strategies should be bundled; and d) commitments of the health sector to national and international health goals.

The suggested strategies from the 2nd Quarterly Meeting of the HRH Network were the starting point in the development of the HRH Masterplan's strategies (Appendix I). These were complemented by recommended strategies and actions from WHO and WB reports on retention, recruitment, and productivity; the WHO Global Workforce Strategy, and the report of the High Commission on Health Employment and Economic Growth (HCEE) on Working for Health and Growth.³

Key HRH Issues

The initial task in updating the HRH Masterplan is to undertake a situation analysis (SA) of HRH in the Philippines, which has been completed. The key issues identified in the SA are the following:

- Lack of accurate HRH information to guide planning and policy. The currently available data on the number of health workers in the country is not up to date and comes from multiple sources and does not accurately reflect the actual numbers. The estimate of the total number of health workers for instance, is based on the number renewing their

professional regulation commission (PRC) license. There are disparate information systems so that the number of workers in the health sector comes from the National Database on Human Resources for Health Information System (NDHRHIS), an information system operated by the DOH. Other HRH-related data such as on production and migration are housed by other agencies. There is no data on health workers that are out of work or unemployed. There is no single source of HRH related data and information. There is a lack of support and structure for HRH information management.

- Inadequate number of health workers in the health sector. This is based on various estimates despite the large number of active health workers in the workforce according to PRC data. For instance, there are 869,974 health professionals who renewed their PRC identification cards in 2018. However, there is a gap of about 25 HRH per 10,000 population in 2018 when compared to the WHO estimate of 44.5 per 10,000 population needed to achieve coverage of sustainable development goals (SDGs). Estimates from the Department of Health (DOH) also point to a shortage of 9,287 health workers in health facilities. This caused in part by fewer number of graduates in the health sciences due to high attrition rates; the limited number of decent jobs in the health sector; unclear career paths of health workers; the inadequate support for health workers' health, safety, and well-being; and the increasing demand for Filipino health workers in overseas destination countries. For health workers who decide to work abroad, some of the pull factors include higher salaries, the prospect of better social, economic, and professional opportunities abroad, and the presence of relatives in the destination country. Factors that facilitate the move to other countries are also present. For instance, some receiving countries have visa provisions that allow family members to join the migrating health worker. The effect of temporary and permanent health worker migration has been on the quality and quantity of workers left in the country. A growing phenomenon is for health workers, particularly nurses, to work in non-health sectors.
- Inequitable distribution of HRH across levels of care. Closely linked to the inadequacy of workers in the health sector is inequitable distribution as is evident in the HRH density across the country e.g. Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) has <1% of the total human resources in the country. The results of the workload indicator of staffing need (WISN) study indicated varying degrees of surpluses, shortages, and normal workloads in various levels of care and cadres. Factors affecting the maldistribution of health workers include the inadequate remuneration in low income class municipalities; disparities in salary between private and public, national and local; and the inability of some LGUs to absorb health workers such as those who are deployed. In addition, the poor working conditions and the characteristics of the place of assignment can affect retention. These include poor health infrastructure, inadequate health system and social support, limited training opportunities, the limited employment and educational opportunities and hospital facilities for family members, the relative isolation, etc. Many health workers study in urban areas, creating a bias in terms of place of employment.

The growing local and international demand exerts pressure to address the poor wages and poor working conditions facing health workers in the country. Domestic demand drivers include geographically isolated and disadvantaged areas (GIDA) as these are priority areas. Demand for health care is growing as shown by health expenditures, and a growing population group of 65 years old and above. Abroad, the demand for Filipino HRH is continuous. For health workers, better wages, the prospect of professional growth, and the opportunity to improve their socio-economic standing abroad on the other hand, are pull factors.

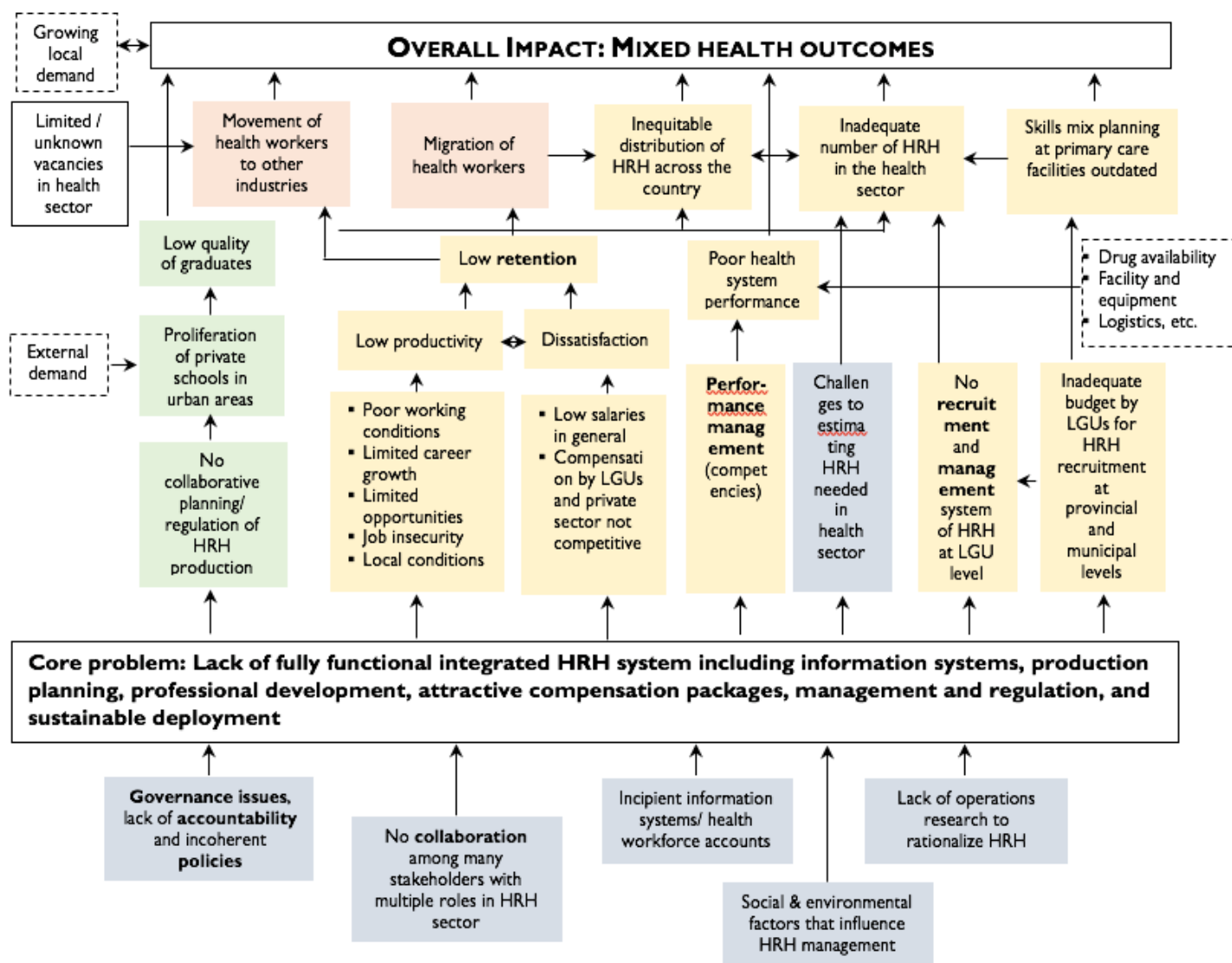
- Multiple interlinked HRH systems that are not fully functional and stakeholders that operate independently. An effect is the disjoint between the education and the health sectors. While this has been acknowledged (e.g. the HRH Network as a mechanism for discussing issues and decision making, data sharing, among others), accelerated action is required to have fully functional integrated HRH systems and policies. For example, there is a lack of collaborative planning in the production of HRH. There are too many schools in urban areas which is a business response to external demand without regard to the quality of the graduates being produced. There is no information coming from the health sector to inform the production of health workers for the country. Representatives from the education sector value the remittance from health workers working abroad, which while important, disregards the population health needs of the country, particularly in rural areas. There is weak regulatory capacity, and limited accountability and responsiveness of the education sector's accreditation system to health priorities.
- Fragmented HRH governance and unclear accountability mechanisms. The DOH is responsible for the recruitment of health workers at the national level, the Deployment program, and for DOH retained hospitals. On the other hand, LGUs

have the responsibility of staffing field health facilities. Frequently mentioned in the regional consultations is the political and bureaucratic interference in HRH processes and management. For example, the recruitment process is non-transparent with those having connections to those in power being favored. Health workers that are locally recruited are not always adequately compensated, provided benefits or given security of tenure, which can be traced to the personnel services cap mandated in the Local Government Code (LGC), and the income of municipalities and provinces. Additionally, local chief executives (LCEs) may not prioritize health during their tenure to the detriment of health workers and health care provision in the locality. The private sector, while guided by the policies, standards, and programs established by the DOH, operates independently. Temporarily or permanently migrating HRH are governed by a different set of agencies and policies. In general, there is poor HRH management as shown in the unclear job descriptions of health workers; inadequate supervision in clinical, public health, and health systems administration; and the variable capacity of local health systems in HRH management and development. HRH governance consists of complex interactions and further illustrates the lack of coordination among stakeholders.

A related issue is the lack and/or poor implementation of policies. At present, there is variable implementation of policies. There are several policy gaps and issues, most prominent of which are 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. Additionally, there are policy gaps in setting data standards and strengthening data sharing. There is no policy to identify a central custodian for human resource for health information. Human resource management and development (HRMD) standards, roles, and functions are 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. There is a lack of consistency and strategic coherence in linking critical policies between the education, labor, and other sectors. Policies emanating from non-health sectors also impact the HRH sector.

The abovementioned key issues have been classified as either a cause or an effect of the core problem of the HRH sector in the Philippines. They can be seen in totality in the problem tree (Figure 2). A problem tree is planning tool that maps causes and effects arising from a core problem. In 2019, the core problem identified is the lack of a fully functional integrated HRH system including information systems, production planning, professional development, attractive compensation packages, management and regulation, and sustainable deployment. The multiple effects, causes, and the core problem itself will be addressed in the Masterplan. To facilitate the identification of appropriate strategies that will resolve the persistent issues of the HRH sector, the effects and causes of the core problem has been further categorized using the WHO Working Lifespan Strategy.

Figure 2. The HRH problem tree in 2019

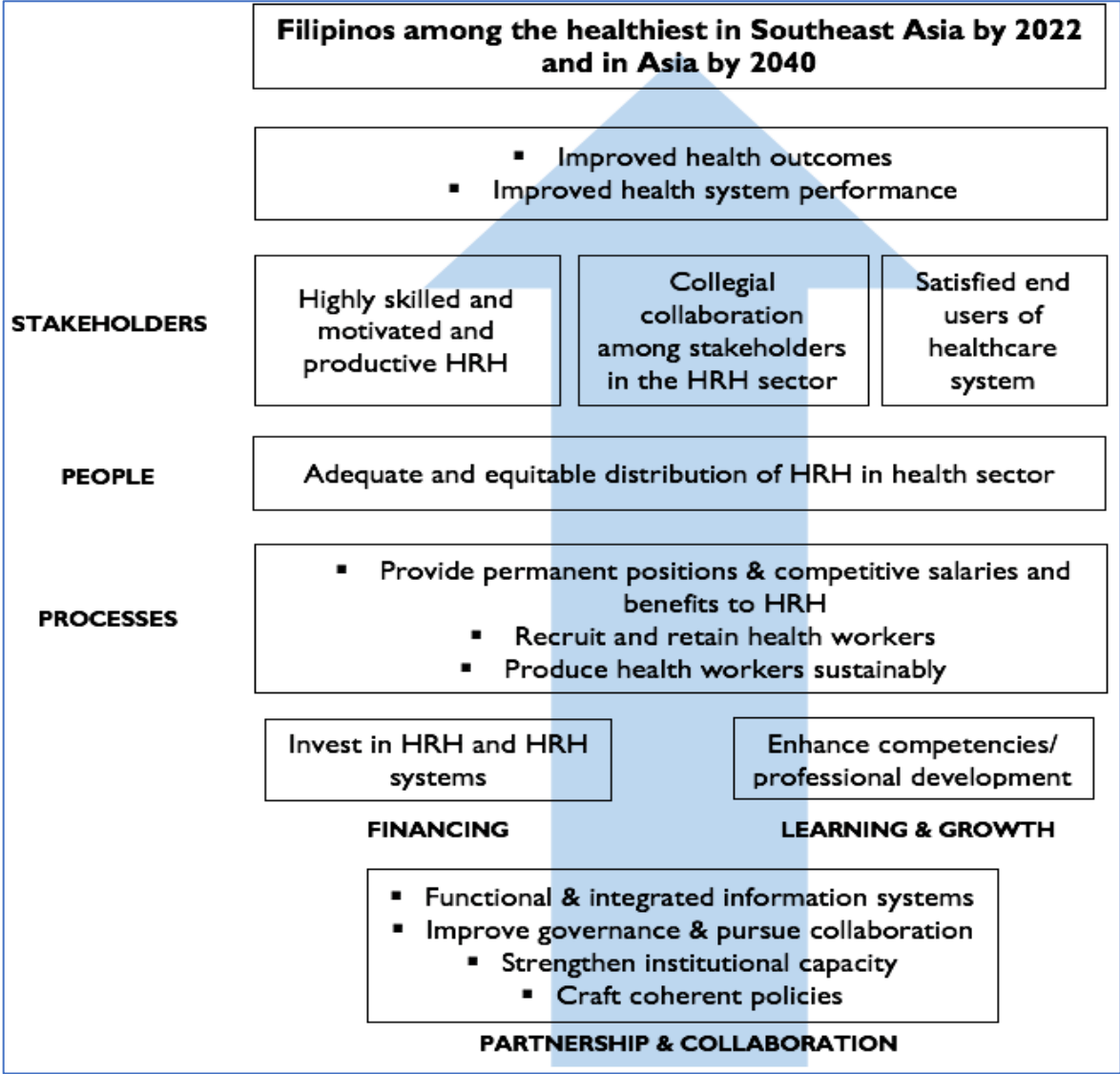


Strategy map

To better understand how the proposed strategies, interrelate and combine to achieve the goal of the Masterplan as well as contribute to national goals, a strategy map is laid out (Figure 2). The strategies are summarized according to the four dimensions of the Balanced Scorecard which is commonly used when applied to the private sector: customer, internal processes, financing, learning and growth or organizational capacity. Since the strategies are for the HRH sector, two of the dimensions of the Balanced Scorecard have been adapted to people (customer) and processes (internal processes) while keeping financing and learning and growth. In addition, stakeholders, and partnership and collaboration have been added and used as organizing elements due to the sector's multi-sectoral nature. Financing, partnerships and fostering learning and growth will facilitate the necessary processes that will lead to adequate and equitable distribution of HRH. This will in turn impact positively on the stakeholders of the HRH sector ultimately leading to improved health outcomes.

The 2020-2040 HRH Masterplan’s draft strategy map proposes that by addressing the key issues confronting the HRH sector with a mix of transformative and enabling strategies, the availability and distribution of health workers in the Philippines can be rationalized, leading to an improvement in the health system performance and improved health outcomes. In the short and medium-term, the Masterplan aims to address the provisions of the UHC law such as expansion of scholarships, return service agreement (RSA), and re-orienting curriculum, through recruitment, retention and productivity strategies. The long-term impact or goal of the HRH Masterplan is improved health outcomes, thereby contributing to the vision of Filipinos as one of the healthiest in Southeast Asia by 2022 and one of the healthiest in Asia by 2040 as stated in the DOH’s National Objectives for Health and consistent with the goal of Filipinos having long and healthy lives according to NEDA’s AmBisyon Natin 2040. The improved health outcomes will also contribute to the accomplishment of the Philippines’ commitment to the UN SDGs and the WHO Global Strategy Workforce.

Figure 3. Strategy map of 2020-2040 HRH Masterplan



Proposed strategies of the 2020-2040 HRH Masterplan

To improve the likelihood of achieving the strategic objectives, studies have found that it is best to not implement strategies as single interventions but as a combination of contextually relevant recommendations, especially for recruitment and retention, taking into

account potential complementarities.^{4 5 6} The proposed strategies that are being recommended have been found to work with varying levels of success based on evidence, like the systematic and literature reviews that have been carried out. In many cases, these are espoused by the WHO. Where there was insufficient evidence, such as on strengthening institutional capacity in the health sector, reviews in other sectors were used.

Transformative strategies

Transformative strategies will consist of strategies that will address the pressing issues that were identified in the first HRH Masterplan in 2005 that continues to challenge the HRH sector at present. These are the effects of the core problem comprising of the broad categories of inadequate HRH in the health sector and inequitable distribution of HRH in the country. Other effects of the core problem that are contributory factors to the inadequacy and inequitable distribution of HRH are migration and movement of health workers to other industries, low retention, low productivity, worker dissatisfaction, poor working conditions, inadequate remuneration, among others. Recruitment, retention, and productivity are known strategies that in combination can effectively address these issues. However, among the strategies enumerated below, there is no single strategy that is focused solely on retention. While improving wages and working conditions as well as developing career paths can go a long way in improving the retention of health workers, this can be further improved if the process begins prior to entry into the workforce i.e. as students. Students who have a rural background or exposed to rural topics or conditions are more likely to return and serve in rural communities upon completion of their studies.⁷

Strategic Objective I

Install systems that will improve **recruitment** of HRH fit for practice and fit for work to sustainably **produce** and deploy HRH and to promote greater HRH **retention** in the health sector leading to adequate and equitable HRH distribution vis-à-vis local health needs

Proposed strategy	Evidence	Hindering/ facilitating factors
Establish targeted admission practices in education institutions	A rural background increases the likelihood of graduates returning to practice in rural communities. ^{8 9 10 11} A Cochrane review found that 'it appears to be the single factor most strongly associated with rural practice'. ¹²	Facilitating factor would be if this is going to be in public HEIs. Not feasible if private HEIs since difficult to regulate. Other hindering factors include the need to coordinate with school officials and family.
Educate and train future HRH in or near their places of origin	A systematic review found that scaling up education and training and deployment to underserved areas, particularly poor remote/underserved communities have increased midwives and nurses in those areas. ¹³	A facilitating factor is that CARAGA and Region IVA have experience doing this. Barriers include availability of funds, policy support, political support, the availability of schools in the area, the lack of experts, and the willingness of people to teach in GIDA areas. Alternative learning maybe limited by connectivity issues.
Re-orient curriculum to PHC and integrate public health, rural health courses/ topics, and rural exposure/immersion	A systematic review mentioned that admission selection criteria and targeted curricular activities may be able to address the	A facilitating factor is that this has been done before although the practice needs strengthening. Hindering factors include political will, budget, and structure. Additionally, private schools might resist.

Proposed strategy	Evidence	Hindering/ facilitating factors
	<p>shortage of primary care physicians ¹⁴</p> <p>A literature review found that the inclusion of rotations in remote/ underserved areas and remote/underserved area's health issues in curricula increases the interest of health professions to work in remote/underserved areas. ¹⁵</p>	
Expand scholarships with enforceable return service agreements (RSA) that also offers incentives	<p>Two reviews found that compulsory service in remote/underserved area increases healthcare workers in remote/ underserved areas. ¹⁶</p> <p>An overview of systematic reviews, a systematic review, and a literature review found that financial incentives such as linking educational loans with service requirements, service option educational loans, loan repayment programs, and direct financial incentives attract healthcare professionals to remote/underserved areas. ^{17 18}</p>	Facilitating factors include the availability of funds and that this is existing and ongoing in CARAGA and R9. Barriers are budget constraints and the reluctance of students to RSA due to the length of service in return for the scholarship. Other barriers include the lack of a strong RSA policy and/or the loopholes in the current policy e.g. students can pay the scholarships rather than provide service; students don't have to return to place of origin to serve.
Establish inter-profession education and training in universities and institutions	Three systematic review mentioned that inter-professional education has positive outcomes on the students and patient care. ^{19 20 21}	A facilitating factor is that this is already being done e.g. UP Manila's knowledge and experience is present. Barriers identified are the compliance of schools, culture, and professional laws that define the scope of practice of different health workers.
Incentivize schools (e.g. tax incentives) to ensure quality graduates		Not feasible due to lack of budget (i.e. source of incentives), structure, policy e.g. COA polices on giving incentives, and political factors.

Strategic Objective 2

Create systems for developing HRH **competencies** and the careers of health workers to promote greater HRH retention

Proposed strategy	Evidence	Facilitating/ hindering factors
Enable health workers to obtain appropriate skills, knowledge and attitudes through training and other learning methods to provide high quality healthcare e.g. develop/institutionalize system to increase access to continuing professional development	<p>Four systematic reviews and one literature review reported that continuing education based on local needs has an important role in improving health professional skills and performance.^{22 23 24 25 26}</p> <p>An overview of systematic reviews found moderate evidence that supporting continuous professional development in remote/ underserved areas has an effect on nurse retention in remote/underserved areas.²⁷</p> <p>A systematic review mentioned that eLearning has a high utility yet there is a need to ensure that the time, cost, and interactivity are considered prior to the sessions.²⁸</p>	Facilitating factors include the available opportunities e.g. DOH has existing eLearning platform, and budget. Hindering factors include the lack of time by HRH, the disapproval of LCEs since this may cause absenteeism, the high cost of trainings and conventions, policy, and access to CPD. For online learning, barriers include internet access, and the quality of trainings. On the job coaching and mentoring rarely happen due to inadequate supervisory skills and time devoted for this purpose.
Develop career paths of health workers	<p>An overview of systematic reviews reported that implementing career pathways for remote/underserved area may have a positive effect on recruiting healthcare professionals in remote/underserved areas.²⁹</p> <p>A systematic review showed that strategies such as part time employment, decreased workplace bureaucracy, and workload pressure, supporting workforce's health and providing opportunities for career development supported an increase in intent to stay in job positions.³⁰</p>	Facilitating factors include the career progression and specialization program of PRC using the PQF and AQRF and the feasibility of the strategy in the national level but not in LGUs. Hindering factors include policy, political factors, the varying conditions of LGUs, and the lack of career paths for HRH in LGUs.
Support career development of BHWs	12 systematic reviews and one single study reported on the	Facilitating factors include the existing TESDA National Certificate II (NCII) program for BHWs and the stepladder program of UP

Proposed strategy	Evidence	Facilitating/ hindering factors
	<p>benefits of community health workers. One systematic review conducted in low and middle income countries reported that community health workers interventions are effective regarding prevention, knowledge and attitude in the following areas malaria prevention, health education, breastfeeding promotion, essential newborn care and psychosocial support.³¹ The benefits of community health workers was also reported in providing immunization and raising awareness on immunization³², conducting home visits for antenatal and neonatal care,³³ providing NCD interventions which resulted in NCD prevention, tobacco cessation, blood pressure management, diabetes control³⁴ and HbA1c changes,³⁵ decreased asthma symptoms and emergency care for asthma patients,³⁶ and reducing BMI percentile of children that are obese.³⁷ A stepwise approach to integrate community health workers can reduce some of the barriers of implementation.³⁸ Community health workers need to be formally linked to the health system and be regularly trained to prevent feelings of frustration and ensure safe services.³⁹ It is also critical to ensure that the volunteers are trained, there is sufficient financial incentives, clear role identification, infrastructural support and sufficient monitoring and supervision.^{40 41}</p>	<p>SHS in Palo, Leyte. No law supports the trainings of BHWs and are co-terminus with LCEs, no security of tenure. Other barriers are budget constraints, structures/processes, and political factors i.e. not a priority for LGUs and accreditation depends on support</p>
Enforce/strengthen the provision of coaching,	An overview of systematic reviews showed moderate evidence that supportive supervision (i.e. mentorship,	Facilitating factors include the existing pool of experts, easy to implement since this is already existing e.g. private sector practices in mentoring and coaching. Hindering factors

Proposed strategy	Evidence	Facilitating/ hindering factors
mentoring, and supportive supervision to health workers	<p>preceptorship, clinical supervision) have a positive effect on promoting nurse retention in remote/ underserved areas.⁴²</p> <p>Two systematic reviews mentioned that supportive supervision improves patient health outcomes, and supports staff with safe utilization of resources (Snowdon, Leggat, & Taylor, 2017)⁴³ and retention of staff in rural areas.⁴⁴</p>	include the inadequate coaching and mentoring in the public sector
Identify and implement appropriate outreach activities to facilitate cooperation between health workers and the development of professional networks		<ul style="list-style-type: none"> ▪ A facilitating factor is that Marinduque, Davao, and Southern Philippines Medical Center (SPMC) have telehealth in place so can learn from their experience. ▪ Hindering factors include the lack of policy support, structure, support of LCEs and the Data Privacy Act which prevents sharing of information. Other barriers are the need for strong/stable connectivity and electrical supply, the non-existence of accredited professional organizations (APOs) in some areas, the lack of support of the DOH for Philippine Physical Therapy Association (PPTA), the need for health workers to develop partnerships with professional organizations and for strong leadership.

Strategic Objective 3

Raise HRH **productivity and responsiveness** by promoting job satisfaction and motivation at all levels and improve greater HRH retention

Proposed strategy	Evidence	Facilitating/ hindering factors
Create permanent positions for health workers		Hindering factors include policy, regulation, budgetary constraints, limited number of plantilla positions, and political support. Other factors are HRH not informed about vacancies and the CSC website that only posts vacancies in the public sector is not user friendly.
Standardize health workers' positions and competitive compensation and benefits		Facilitating factors are the Magna Carta and the UHC laws. Hindering factors include funds to provide benefits under the Magna

Proposed strategy	Evidence	Facilitating/ hindering factors
(public and private sectors; national and local)		Carta law, no existing health worker registry, salary difference in different levels, political support e.g. LCEs may not want to spend more for HRH, policies, private sector compliance, and the influence of market forces.
Institutionalize a system of providing incentives for HRH (including BHWs & BNS) to meet public health goals	Two systematic reviews and one literature review and one overview of systematic reviews reported on financial incentives to retain and recruit staff in rural/remote areas. Financial incentives lead to higher attraction rates to rural and remote areas ^{45 46 47 48}	Facilitating factors include policies (e.g. BHW law, some LGU ordinances to adopt the BHW law), the special health fund of the UHC law, existing workers' organizations that can lobby for BHWs, and potential provision of PhilHealth shares as incentives to HRH. Highly feasible in the context of UHC, at the national level, and for BHWs, if the DOH absorbs them. Barriers include the budget, policy, structure, status of employment i.e. HRH with job orders do not have employee-employer relationship, political and other support e.g. Romblon gives honorarium for BHWs but was disallowed by COA. LGUs don't have similar income and cannot provide similar incentives. Laws are present but funding is not assured.
Ensure well-being of health workers including their mental health (e.g. hospitalization benefits, wellness programs, etc.)		Facilitating factors include RAI 1058 (compliance with occupational safety and health (OSH) standards), some hospitals having special lanes for health workers, and existing practices like in Sultan Kudarat. Hindering factors are the lack of a system by which the rank and file can be served, no assessment of the effect of the rationalization plans, LGUs have limited plans, and the hazard policy does not cover actual exposure. Other barriers are time, policy, and political support.
Define and ensure that the appropriate skills mix in health facilities is met		Hindering factors include the absence of standard skills mix, policy support, and political factors. However, with the passage of UHC, this will be highly feasible.
Introduce and regulate enhanced scopes of practice of health workers i.e. task shifting	An overview of systematic reviews found evidence that policies to expand scope of practice of nurses and midwives were successful in increasing supply of nurses and midwives in	A facilitating factor include laws such as RA 10912 (CPD law) and RA 9173 (Nursing Act). A hindering factor is the lack of policy on task shifting/enhanced scopes of practice. There are also outdated policies such as the Philippine Midwifery Law that restricts

Proposed strategy	Evidence	Facilitating/ hindering factors
	<p>primary healthcare centers and remote/underserved areas.^{49 50}</p> <p>A systematic review evaluated the impact of doctor-nurse substitution in primary care found that nurses and physicians may lead to similar health outcomes for patients.⁵¹</p>	midwives to perform new tasks already performed by midwives in other countries.
Standardize care through the implementation of national Clinical Practice Guidelines (CPGs)		Hindering factors include the policy, the process of developing CPGs takes too long, and the lack of harmonization or standardization of CPGs.
Establish quality assurance/ accountability mechanisms in health facilities	Two systematic review discussed accreditation and its effect on human resources for health. The study reported that nursing accreditation increased staff and patient satisfaction, improved the relationship between the nurse and the patient and the quality of care, and reduced turnover rates. ⁵² Healthcare providers are more likely to work in hospitals that are awarded excellence such as magnet status. ⁵³	Facilitating factors are policies such as the PQF, the CPD law, political will, and existing systems such as PAASCU. Hindering factors include the priorities of LCEs, available manpower, time, policy, structure, and the lack of a QA system in all health facilities.
Ensure a good and safe working environment by implementing OSH standards and the provision of appropriate equipment and supplies	<ul style="list-style-type: none"> Two systematic reviews discussed human resources working hours. One systematic review showed that strategies such as part time employment supported an increase in intent to stay in job positions. Another systematic review mentioned that for physicians weekends off during a 14-day work period reported significantly less burnout.⁵⁴ Sick leave decreased by 90% when physician working hours dropped from 56 to 58 hrs. per week. Shift based time arrangement resulted in less burnout.⁵⁵ 	<ul style="list-style-type: none"> Facilitating factors include the Joint Memorandum Circular and law on OSH for the public and private sectors. The private sector is already implementing OSH and the DOH has an action plan for occupational health. Hindering factors include policy, budget, political support, and the system of procurement.

Proposed strategy	Evidence	Facilitating/ hindering factors
	<ul style="list-style-type: none"> One systematic review found strong evidence of training on occupational health and safety on the behavior of the healthcare worker.⁵⁶ 	

Enabling strategies

Enabling strategies comprise of broad actions that will facilitate collaboration among many HRH stakeholders; establish HRH information systems that are interoperable with other HRH systems, with clear data sharing and data standards; undertake operations and other research; and, the crafting and implementation of policies that support HRH management and development. By mounting these strategies, the crosscutting issues that are the root causes of the HRH core problem can be fully addressed. These strategies should not be implemented discretely and independent of each other but as bundles to increase the likelihood of successfully making systemic changes and ensuring that persistent HRH issues are resolved and do not recur.

Strategic Objective 4

Foster sustained intersectoral collaboration/co-development to develop responsive and coherent plans and policies among health and non-health agencies and organizations to generate shared goals, synergize functions, and produce collective impact

Proposed strategy	Evidence	Facilitating/ hindering factors
Integrate policies on production, employment and migration involving the education, labor, and other relevant sectors	<p>A systematic review found that intersectoral collaboration was important to reduce prevention and control of vector borne diseases. However, very few studies measured how much intersectoral collaboration contributes to the impact.⁵⁷ A review that included one systematic review, 14 quantitative studies and two qualitative studies found that intersectoral collaboration have moderate to no effect on social determinants of health or health equity. However, this may be due to the limited body of evidence or the poor methodological quality of available evidence as opposed to the effectiveness of interventions.⁵⁸ Other reviews have found that there is limited literature evaluating the evidence of intersectoral action on health equity,⁵⁹ evidence for intersectoral actions are in early stage of development but suggest</p>	Hindering factors include policy and agencies have different mandates.
Strengthen private sector regulation in HRH production and employment e.g. rapid growth of schools		Hindering factors include political will, lack of unity of purpose, and the need to strengthen CHED's regulatory functions.
Enhance health workers migration policies to consider the country's population health needs		<ul style="list-style-type: none"> Facilitating factors include the WHO code of practice of ethical recruitment of health workers, POEA only deploys workers to countries with bilateral agreements (BLAs) which are 'numerous', recognition of the HRH needs of the country, and the existence of DOLE bilateral review committee. Hindering factors are the Data Privacy Act that impede effective data collection and sharing, political support/will, budget, policy, structure, economic considerations, the contents of the

	potential for improving health outcomes for indigenous children and their family, ⁶⁰ or determinants and implementation variability on intersectoral action on childhood obesity was not explained. ⁶¹	agreement, and the priority of the government. Other barriers are limited data on returning HRH, the willingness of other countries to compromise, and some countries' visa requirements make it easier for HRH to obtain residency.
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Strategic Objective 5

Strengthen **information systems/data** on HRH for monitoring, informing decision making, and ensuring accountability

Proposed strategy	Evidence	Facilitating/ hindering factors
Strengthen and integrate information systems to ensure up-to-date HRH data and data sharing across the HRH sector e.g. National Health Workforce Registry, NHWA	<ul style="list-style-type: none"> Two studies mentioned that human resources data is critical secure skill mix of specialties^{62 63} according to the need of the community. A literature review showed that information technology is essential in collecting evaluating and communicating data. This leads to better-targeted interventions and higher efficiency in providing services.⁶⁴ One case study reported that monitoring of human resources data is critical to understand the matches/mismatches between demand and supply of human resources in terms of skill mix gender and specialties. This can be accomplished through strong involvement of stakeholders in the process of development and implementation of information systems.⁶⁵ 	<ul style="list-style-type: none"> Facilitating factors include budget, policy (e.g. UHC, Data Privacy Act), the technical assistance from USAID's HRH2030, and the sustained commitment of agencies to collaborate on this undertaking. Hindering factors include time, policy (e.g. Data Privacy Act), budget, and political support.
Undertake robust research (including operations research) and analysis of health labor markets, using harmonized metrics and methodologies, to strengthen		Facilitating factors are the available funds from PSA for nationwide surveys, the law mandating PSA to provide technical assistance for community-based monitoring system, and the research support from DOST. Hindering factors include the high cost of research, the

	limited funds. Success factors include supportive and committed leaders, provision of training by building on existing initiatives, and creating good regional and international partnerships. The collaborations of North-South and South-South was also important in increasing research capacity. ⁶⁸	
Institutionalize HR management at all levels		Facilitating factors include policies such as the Magna Carta and HR Prime by the CSC, and training from TESDA. Hindering factors include the lack of compliance on hiring standards, political patronage, the classification of BHWs as volunteers, and 'biases' of CSC policy on recruitment. Other barriers are budget, political support, time, and that this is labor intensive.

Strategic Objective 7

Increase **investments** in HRH and align investments with current and future population health needs and of health systems

Proposed strategy	Evidence	Facilitating/ hindering factors
Generate resources for HRH from various sources (domestic, international, and other sources)	A review of 51 documents on the use of different financial mechanisms to facilitate intersectoral collaboration on health promotion found that common approaches to financing included earmarked funding, recurring delegated financing, and joint budgeting between two or more sectors. Influencing factors included legal and organizational structures, differences in culture and objectives between sectors, and the level of mutual trust and respect between participants.	Facilitating factors include the presence of international partners, private companies that can fund programs of the public sector, sources of funds like the GAA, IRA, sin tax, and funds earmarked for health. Hindering factors include the lack of policy, budget, and political factors.
Invest in the education and training, recruitment, deployment and retention of health workers to meet national and subnational needs	However, few publications have explicitly looked at the effectiveness of intersectoral financing mechanisms. ⁶⁹	Facilitating factor is the availability of funds that can be used to invest in staff education and training. Hindering factors are the lack of specific amount allotted to health in the IRA of LGUs, the priority of LCEs, time, policy, and structures.
Develop capacity to absorb and utilize effectively and transparently both domestic and international resources		A hindering factor identified was policy and weak financial management system.

Next steps

With the goal of validating and obtaining inputs on the strategies of the 2020-2040 HRH Masterplan by the HRH Network and other stakeholders across the country in October 2019, the following will comprise the next steps:

- Present draft final strategies to the HRH Network Meeting
- Draft Masterplan strategies will be validated with the regions for input and feedback,
- Revision of the Masterplan strategies based on regional consultations,
- Presentation of the revised Masterplan strategies to the HRH Network and stakeholders, and
- Preparation for the policy dialogue including a policy brief.

Appendix I. Issues and proposed strategies for 2020-2040 HRH Masterplan from the HRH Network 2nd Quarterly Meeting

Issues	Strategies from WHO, other sources				
	Recruitment	Retention	Competency	Productivity	HRH Network meeting
Need for better recruitment					Improve recruitment
<u>PRE-SERVICE</u>	Increased production of HRH (pre-service/ post graduate training) (Dieleman and Harnmeijer 2006)				Sustainable production of HRH
Improve screening of the students to be admitted to health sciences schools (include values and attitude)		Target enrolment of students with rural backgrounds (WHO 2010)			Set up qualifications (screen) for entry of HRH (students) which should be harmonized with needs
Limited scholarships for health sciences education, which is expensive	Relocate schools to rural areas (Araújo and Maeda 2013)				Support students in the GIDA / rural areas thru education loans or scholarships with return service agreements
					Provide incentives for schools producing quality HRH
Need to strengthen curriculum which can help enforce return service agreements		Revise under and post graduate curricula to include rural health topics (WHO 2010)			Revise/innovate the curriculum of health sciences schools (e.g. ladderized) in order to respond to the demand/ needs of the Philippines including

		Expose students to rural community experiences (WHO 2010)			<ul style="list-style-type: none"> - re-orienting to PHC, - working in rural areas - demands of BPOs, telehealth and global demand - integrating 'nationalism'
					<p>Enhance return service programs and implement strictly:</p> <ul style="list-style-type: none"> - Change to contract and add penalties; use Civil Service ruling to back RSA - Strict screening of students in state universities willing to have RSA; - Provide clear orientation prior to signing the RSA - Disallow students with RSA to work abroad - Provide career development for graduates - Assess previous grantees and track them
<i><u>IN-SERVICE</u></i>					
Improve recruitment of HRH; need fair and ethical recruitment, recruitment standards	Improve planning, recruitment and deployment (Dieleman and Harnmeijer 2006)	Improve living conditions for health workers and their families and invest in infra and services as these have significant influence on decisions to locate to and remain in rural areas (WHO 2010)			Equitable distribution of HRH

	<p>Improve skills mix (Dieleman and Harnmeijer 2006)</p> <p>Institute targeted recruitment policies e.g. recruit health workers from rural areas (Araújo and Maeda 2013)</p>	Use combination of fiscally sustainable financial incentives (WHO 2010)			
		Introduce different types of health workers with appropriate training and regulation for rural practice (WHO 2010)			Consider the placement of HCWs to GIDA areas and with low supply of HCWs
		Introduce and regulate enhanced scopes of practice i.e. training lower level health workers to do higher skilled tasks, in rural and remote areas to increase potential for job satisfaction (WHO 2010)			Assess demand and quantify and qualify HRH needs (there must be a safe minimum staffing standards) based on demand
<i>INTERNATIONAL</i>					
<p>Migration of health workers</p> <ul style="list-style-type: none"> - Health workers leave after training - Social cost of migration should include psychosocial problems - Need more training for nurses to [meet] the qualification requirements of other countries - Need for more BLAs with other countries 	WHO Global Code of Practice on Ethical Recruitment of Health Personnel				Promote fair and ethical recruitment of health personnel in multilateral and bi-lateral agreements

Low retention/low productivity					Improve retention and productivity
Low wages, lack of standardized salaries		Use combination of fiscally sustainable financial incentives (WHO 2010)		<u>Health facility level:</u> Improve motivation and job satisfaction (Dieleman and Harnmeijer 2006)	Develop appropriate financing schemes for the implementation of the HRH Salary standardization including: <ul style="list-style-type: none"> - Better performance (population) based incentive system which can be done with PhilHealth - Competitive - Salary increases - Improved benefits for HCWs - Incentivize HRH in the 5th and 6th class municipalities
Poor working conditions including safety issues, poor working environment, poor facilities, inadequately equipped facilities, lack of opportunities, distance to work and cost, long work hours, and overworked (load and scope) health workers		Provide a good and safe working environment including appropriate equipment and supplies, and supportive supervision and mentoring (WHO 2010)		<u>Health system level:</u> Health sector reform with health workers' participation in the planning and implementation (Dieleman and Harnmeijer 2006)	Prioritize promoting decent work in the health sector
				<u>Health facility level:</u> Improve working conditions (Dieleman and Harnmeijer 2006)	Improve working conditions: <ul style="list-style-type: none"> - Address safety (both client and provider), effectiveness (specialist vs primary care) and access (to facilities for public workers) - Flexibility in working hours

		Develop and support career development programs and provide senior posts in rural areas (WHO 2010)		<u>Health facility level:</u> Improve motivation and job satisfaction (Dieleman and Harnmeijer 2006)	Provide career pathways/ ladder for health workers
		Adopt public recognition measures e.g. rural health days to life profile of working in rural areas to improve motivation (WHO 2010)		<u>Health facility level:</u> Improve motivation and job satisfaction (Dieleman and Harnmeijer 2006)	Recognition activities from the Leaders/ LCEs
Lack of positions, lack of security of tenure				<u>Health facility level:</u> Improve human resource management	Standardize classification of positions in private sector as in government; additional plantilla items
Potential mental health issues				<u>Health facility level:</u> Improve motivation and job satisfaction (Dieleman and Harnmeijer 2006)	Lo into the mental health of HRH
Need to use of technologies and innovative mechanisms to provide healthcare especially to underserved and GIDAs Dissatisfaction of users with health services expresses as anger against frontline health workers		Identify and implement appropriate outreach activities to facilitate cooperation between health workers from better to underserved areas and where feasible use telehealth to provide additional support (WHO 2010)			Establish enabling mechanisms for HRH to provide healthcare using innovative mechanisms and technologies to GIDAs (including research grants, policies)
Health performance affected by deskilling		Support development of professional networks, rural health professional associations, etc. to improve morale and status of rural providers			“Balik dtor, balik nars” concept to motivate doctors/ nurses availing of visitor program to come back to the Philippines

		and reduce feelings of professional isolation (WHO 2010)			
Low priority given to health compared to teachers and soldiers so that the health budget is low					Increase budget for HRH due to the understanding that more services are needed
Competency issues					Improve competencies of health workers
<p>Level of competencies of HRH in the Philippines</p> <ul style="list-style-type: none"> - Experienced health workers have left the country - Quality of services - Need to review performances 		Design continuing education and professional development programs that meet needs of rural health workers and are accessible to where they live and work (WHO 2010)	Continuous professional development through training and other learning methods (Dieleman and Harnmeijer 2006)	<p><u>Health facility level:</u> Implement quality assurance (QA) and performance improvement (Dieleman and Harnmeijer 2006)</p>	<p>Build capability of HCWs based on their competency needs</p> <p>Make use of eLearning (to include JO and deployed health workers and health workers in the private sector)</p>
Some policies lacking or some not implemented					Policies
<p>Weak implementation of policies and plans such as the Magna Carta</p> <p>No clear policies for re-entry and integration</p> <p>Effect of interplay of the UHC law with the LGU code unclear</p>					<p>Develop responsive and coherent policies that support the HRH sector</p> <ul style="list-style-type: none"> - Data sharing agreements across agencies strengthened including what data is produced, DOH as repository, and interoperable, updated database and data management system

Data related issues such as lack of baseline data, inconsistencies, data sharing, lack of data from the private sector, and interlinkages of data					<ul style="list-style-type: none"> - Do interagency review of policies and produce/share omnibus of policies; - Harmonization/consistency and integration of policies among government and national agencies of systems - Prepare a communication plan for uniform implementation - HRH Network law - Identify policy champions in the Congress, Office of the President
					<p>Specific policy-related suggestion:</p> <ul style="list-style-type: none"> - Standardized salaries with the regional review boards defining compensation structure and DOLE setting the minimum wage - Fully implement Magna Carta for PHW - Re-nationalize health care - Revisit the BHW law - Review and revise the LGU code, especially in the rural areas; review personnel services cap and

					improve working conditions - Advocate for policy of hiring health workers locally
Increasing influx of foreign students in health sciences education. Schools exceed the 30% cap on foreign students per EO285					Implement policies more strongly
Lack of collaboration					Intersectoral collaboration
Agencies and organizations working in silos - Conflicting /Incongruent policies, priorities, and mandates of government agencies in charge of managing HRH planning and production - Lack of oversight and monitoring powers on the roles and responsibilities of members - Communication and planning between supply side and needs do not happen					Foster effective collaboration/co-development of plans among health and non-health agencies and organizations to generate shared goals, synergize functions and produce collective impact - Create framework for collaborative planning for HRH planning - Introduce culture of collaboration early on and encourage interprofessional collaboration - Align goals, priorities, policies and implementation - Establish a governing body that will monitor and oversee the policies and plans in relation to HRH

					<p>planning and production</p> <ul style="list-style-type: none"> - Collaborate on workforce planning - Centralize strategies in production, promotion of courses, development of curriculum, developing job opportunities, and retention - Common strategy of CHED and DOH to address mismatch in demand and supply - Establish the leadership of the Department of Health
LGU-related issues					LGU-related strategies
<p>Local government code strongly impacts on health service delivery</p> <ul style="list-style-type: none"> - Health is not a priority for LGUs - IRA impacts compensation classification of LGUs - Need to improve program support and learning on good practices of LGUs - Lack of ample support from LGUs - LGU budgets may be disrupted by implementation of the Magna Carta 					<p>Capacity building of LGUs/LCEs</p> <p>Educate the LGU about health programs</p> <p>Change the mindset of LCEs to give more support/priority to health—should be proportionate to increasing population</p>
Need for private sector regulation					

Quality is regulated but quantity is not. Opening of new schools and programs are not being regulated					
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Additional suggested strategies

1. On monitoring and evaluation: Strengthen monitoring and evaluation efforts; monitor program implementation, targets, and accomplishments; use health systems approach
2. On participation: Expand membership of the Network and strengthen involvement of stakeholders
 - Involvement of private sector
 - Involvement of decision makers i.e. heads of agencies
 - Stronger participation of health sciences students and organizations

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A nurse at Datu Sakilani Memorial Hospital in Bongao, Tawi-tawi, a USAID pilot site for staffing and workload analysis, administers medication to patients. Photo Credit: Blue Motus/USAID HRH2030Philippines.

Program Partners

- Chemonics International
- American International Health Alliance (AIHA)
- Amref Health Africa
- Open Development
- Palladium
- ThinkWell
- University Research Company (URC)

About HRH2030

HRH2030 strives to build the accessible, available, acceptable, and high-quality health workforce needed to improve health outcomes.

Global Program Objectives

1. **Improve performance and productivity of the health workforce.** Improve service delivery models, strengthen in-service training capacity and continuing professional development programs, and increase the capacity of managers to manage HRH resources more efficiently.
2. **Increase the number, skill mix, and competency of the health workforce.** Ensure that educational institutions meet students' needs and use curriculum relevant to students' future patients. This objective also addresses management capability of pre-service institutions.
3. **Strengthen HRH/HSS leadership and governance capacity.** Promote transparency in HRH decisions, strengthen the regulatory environment, improve management capacity, reduce gender disparities, and improve multi-sectoral collaboration for advancing the HRH agenda.
4. **Increase sustainability of investment in HRH.** Increase the utilization of HRH data for accurate decision-making with the aim of increasing investment in educating, training, and managing a fit-for-purpose and fit-for-practice health workforce.



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