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POLICY BRIEF

Investing and Financing Human Resources for Health as a Strategy to Attain Health Outcomes

Background

The WHO Global Strategy on Human Resources for Health: Workforce 2030 articulated that investing in HRH can deliver returns on health outcomes, global health security and economic growth¹, which the WHO High-Level Commission on Health Employment and Economic Growth reiterated and an article further supported by citing arguments that showed the positive associations of health workforce investments to socio-economic development and productivity.²

The health sector is a key economic sector and a job generator. The aggregate size of the world's health sector is over US\$ 5.8 trillion annually. Theoretically, the increase in demand for health services should trigger creation of new jobs. Available global estimates suggest that each health professional is supported by one to two other workers. Economic growth and development depend on a healthy population. Around one quarter of economic growth between 2000 and 2011 in low- and middle-income countries is estimated to result from the value of improvements to health. The returns on investment in health are estimated to be 9 to 1. One extra year of life expectancy has been shown to raise GDP per capita by about 4%. This contributes to a faster demographic transition and its associated economic benefits, often called the demographic dividend. Investments in the health system also have multiplier effects that enhance inclusive economic growth, including through the creation of decent jobs. Targeted investment in health systems, including in the health workforce, promotes economic growth along other pathways: economic output, social protection and cohesion, innovation and health security.³

As a growing middle-income country⁴, the Philippines needs a healthy population to ensure economic growth, social development and poverty reduction towards a strongly rooted, comfortable, and secure life.⁵ One of the pillars in the FOURmula One Plus of the DOH, the medium term health agenda of the country, looks at sustained investments for equitable health care. According to the Philippine National Health Accounts, total health expenditure's share in gross domestic product (GDP) in the country—including government and private health spending and health capital formation—is 4.6 percent (PHP 799.1 billion) in 2018.⁶ The country's current health expenditure per capita (at PHP 7,496)⁷, is lower than most countries in Southeast Asia with comparable GDP like Vietnam, Indonesia, Thailand and Malaysia. The National Objectives for Health 2017-2022 identified health financing fragmentation and low absorptive capacity of the DOH as hurdles in sustained investments for equitable health care.⁸

Access of and availability to Filipinos of health and social services are essential to ensure good health and well-being. In the Philippines, while health expenditure is increasing—in 2018 it contributed 4.6 percent to the country's gross domestic product—employment in health and social work is consistently at 1 percent of total employment from 2016 to 2018.⁹ Health workers in the country—especially nurses—leave to work abroad for better opportunities and more decent work conditions leading to challenges in delivering quality health care to the population.¹⁰

Policy Issue

Improving health outcomes and achieving universal health care for Filipinos will be difficult unless there is enough “appropriately skilled and motivated, equitably distributed and well supported” health workers supporting the health system.^{11 12} Human resources drive the efficient management and



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operation of the health care system towards successful health reforms and improved health status. Even with the recognition of health workers' role in attaining health outcomes, investments are affected by the perception that the health economy and its health workforce 'consumes resources' rather than think of it as a "contributor to socio-economic development".¹³ Thus, governments tend to control its resource allocation.

In the Philippines, provision of health services and all functions associated with it is devolved.¹⁴ Budget allocation of local governments for human resources for health is restricted and less prioritized because of the personal services limitation on local government budgets.¹⁵ This constraint facilitated the local governments to circumvent the policy and hire health workers on a non-regular employment (i.e., job orders and contract of service), which provided them with no job tenure, non-competitive compensation, and no statutory benefits.^{16 17} The poor work conditions being faced by health workers on the ground might be one of the causes for the observed shortage of health workers based on different estimates and data available. This is especially true for primary care workers covering frontline health facilities in the country.¹⁸ The response of the national government was to augment the supply of health workers, especially in geographically isolated and disadvantaged areas (GIDAs), through the national deployment program. This stop-gap strategy, albeit non-sustainable, helped the local governments to cope with the health worker shortage in their localities. While the deployment program provided competitive salaries and job satisfaction (i.e., serve their communities) to deployed health workers, the need for job security and other practical arrangements are still key considerations in their decision to leave the service after the end of their contract.¹⁹ Furthermore, it is perceived that there is high burden in being a health worker in the country due to the heavy workload pressure despite the low salary.²⁰ The Magna Carta for Public Health Workers was enacted amidst the realization that "local health workers may have been the most severely affected parties in devolution". However, not all local government units were able to implement the provisions of this landmark law, as they argued that they did not have the financial capability to do so.²¹ It is because of challenges like these that many Filipino health workers opt to work overseas as they are offered higher salaries and better social, and economic benefits and opportunities.²²

The WHO Global Strategy on Human Resources for Health: Workforce 2030 and the Philippines' Universal Health Care Act underscore the importance of investing in the health workforce to improve health outcomes.^{23 24} This policy brief analyzes options to address the persistent issue of lack of adequate investments to improve the situation of human resources for health in the country in order to facilitate their meaningful contribution to health outcomes improvement.

Magnitude of the Problem

In the Philippines, even the devolved setup of the health system did not assure that local health expenditures will increase.²⁵ Budget allocation in the local government for human resources of health is particularly challenging due to prevailing policy restrictions²⁶ and political dynamics. It is alarming that, even with the country's recognition of its disjointed health system and low absorptive capacity²⁷ and the realization that "local health workers may have been the most severely affected parties in devolution",²⁸ not all local government units implemented the provisions of the Magna Carta for Public Health Workers because of an argument that they do not have the financial capability to do so. Furthermore, the private sector, whose share in the national health expenditure is 54.2 percent due to out-of-pocket spending, do not provide competitive compensation to its health workers due to considerations on operating capacities.²⁹

Health workers are the front-liners delivering the health services. They are exposed to 'complex variety of health and safety hazards' due to the nature of their role in caring for the sick and injured.³⁰



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Protecting and caring for the welfare of our health workers are particularly important, especially with the recent events happening that challenges our health system. Health workers are heavily exposed to increased workload pressure and higher risk of being infected due to the high prevalence of Tuberculosis³¹ and HIV³², re-emergence of Polio³³, the recent outbreak of Dengue³⁴ and Measles³⁵, and the alarming local transmission of COVID-19^{36 37} among Filipinos.

Given the burden of disease faced by Filipinos, there appears to be a shortage of health workers based on different estimates. Data shows that there is shortage of 9,287 health workers (mostly doctors and nurses) in DOH facilities alone and an estimated deficit of 77,113 primary care workers to cover local health facilities in the country.³⁸ Thus, the perception that being a health worker in the country is a big burden due to the heavy workload pressure and low salary.³⁹ Studies further show that underfunding of the health system, and unemployment or underemployment are push factors for exit of health workers from the health labor force (i.e., migration to other countries, transfer to business process operations).^{40 41} Aside from their concern on wages, health workers are faced with weak support mechanisms such as availability of proper tools and equipment, and sometimes even commodities.⁴² Despite the DOH's investments to construct and upgrade local health facilities and deploy critical health staff, access remains highly inequitable due to the maldistribution of health facilities, health personnel and specialists.⁴³

Poor health care infrastructure, job insecurity, inconsistencies in practice, outdated or inappropriate curricula, institutional politics, inadequate opportunities for specialty training, and prospect of better social, economic, and professional opportunities were all cited as factors influencing exit to the Philippine health labor force.⁴⁴ Some health workers opt to shift to work overseas⁴⁵ or for business process outsourcing companies because these types of jobs has better work conditions with their workload lighter compared to local health facilities.⁴⁶

Poor implementation of policies, poor work conditions and job insecurity due to poor investments to the health workforce demotivate health workers to perform their full potential. Failure to invest in and reform the supply of qualified health workers to meet both current and projected needs will result in the continuation of inefficiencies in health care.⁴⁷ Investments in health infrastructure and human resources should be ensured and sustained to address inequities and narrow the gap in utilization of health services between urban and rural areas, especially with the emerging and re-emerging diseases burdening the population.⁴⁸

With the recent events concerning the spread of COVID-19 that triggered Luzon-wide community quarantine and economic loss in the country, the Filipinos have seen first-hand how inaction and chronic underinvestment can compromise human health, and lead to serious economic and social setbacks. Investing in health workers is a key step in strengthening health systems and social protection, which should constitute the first line of defense against an international health crisis like COVID-19. Complementing monitoring and crisis response mechanisms, health workers are the cornerstone of a resilient health system. We need our “Front-liners and Everyday Heroes” to meet our country's needs and expectations.

Existing Policies

Investing in health workers to improve health outcomes is not a new concept in the country. Even before the devolution⁴⁹, there had been fiscal space provided for investments to be allocated, particularly for rural health workers, to strengthen health service delivery.^{50 51 52} Since then, there had been several laws passed that provided direction and guidance to increase the fiscal space^{53 54} by aligning investments to current population needs^{55 56}, creating decent health sector jobs^{57 58 59},



investing in education, continuous professional development, employment and retention,^{60 61 62 63} and mobilizing resources for HRH.^{64 65 66}

In response to these directives, further guidance on implementing the HRH investments directed by these laws particularly for health workers in the public sector have been released by government offices. The CSC established the Local Scholarship Program⁶⁷ for public sector workers to provide opportunities for continuous professional education. This scholarship is available to all health workers working in the public sector; however, it was indicated in the guideline that this is in a “first come, first serve” basis. The DOH also issued guidelines and sub-allotments covering the health workforce in public service to support pre-service education for aspiring health workers that will eventually enter the local health workforce.^{68 69 70 71 72 73 74 75 76 77}

General appropriations allotted to the personal services of the DOH and its attached agencies is generally increasing. However, personal services allocation data available in the General Appropriations Act for the last five years does not identify the personal services allotment for the local health system.⁷⁸

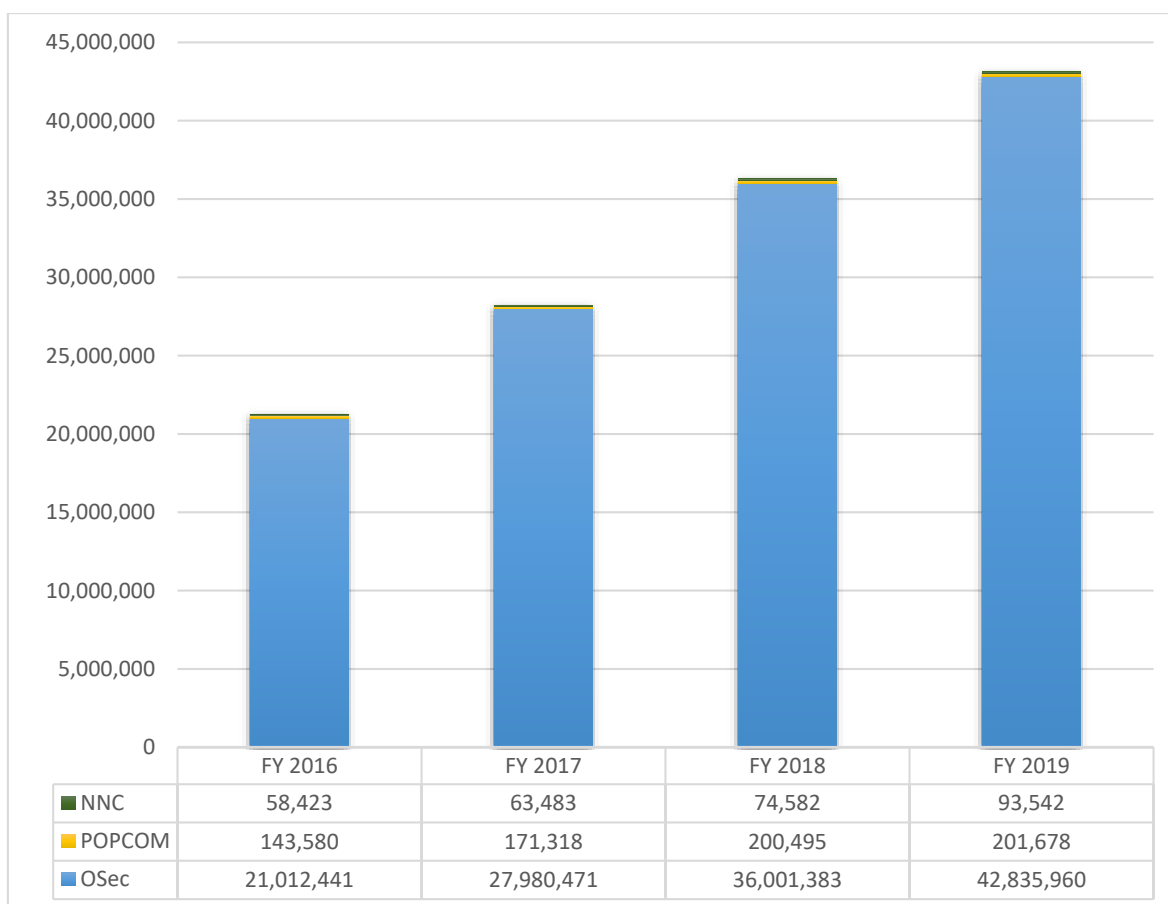


Figure I. Personal services budget allocation for the DOH and its attached agencies (in thousands), 2016-2019

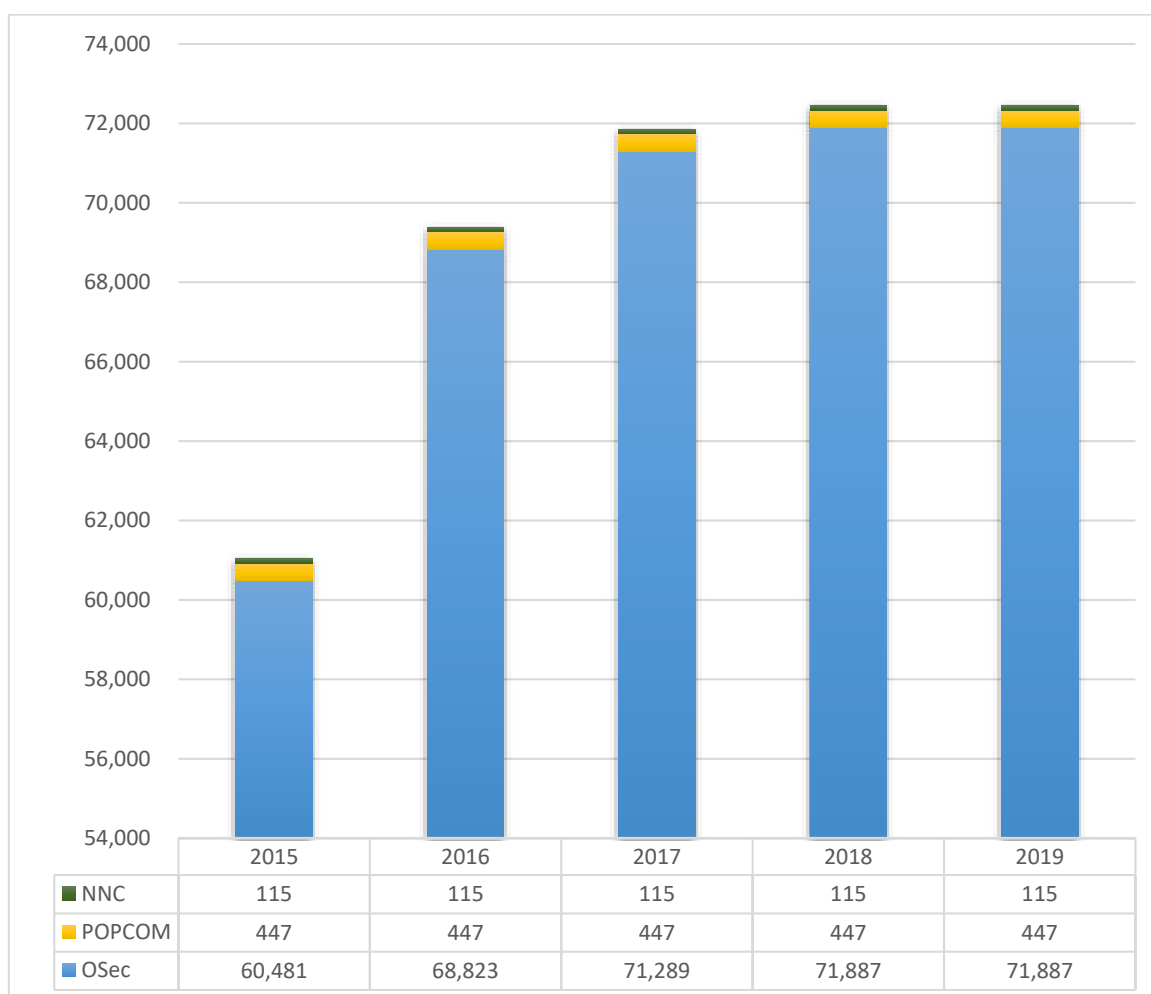


Figure 2. Available permanent positions in DOH and its attached agencies, 2015-2019

Investments to increase supply of health workers in the local health system have been placed by DOH since 1997⁷⁹ and have been maintained through the succeeding issuances supporting deployment of health workers such as doctors^{80 81}, nurses^{82 83}, midwives^{84 85}, dentists⁸⁶ and other types of health workers^{87 88 89 90} to augment LGU-hired health workers and address the changing local health system needs. On the other hand, measures for boosting market demand for these health workers have been articulated in several republic acts supportive of specific health programs such as tuberculosis⁹¹, adolescent and youth health^{92 93} and family planning^{94 95}. However, most of these government issuances only cover the public sector and are usually driven by vertical programs. Even with these policies in place that ensure investments for HRH, it had not been enough to retain HRH in the country.

Policy Goals

The goal of this policy brief is to stimulate action from policy-makers, decision-makers, and key stakeholders in investing on the Philippine health workforce as a key strategy in achieving universal health care for all Filipinos. Taking into consideration the recommendation of the High-level Commission on Health Employment and Economic Growth, enablers to maximize returns on human resources for health investment are:



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1. Stimulate investments, raise adequate funding and consider broad-based health financing reform, where needed, in creating decent health sector jobs, while ensuring that health workers are with the right skills, in the right numbers and in the right places
2. Ensure investments in transformative, high-quality education and lifelong learning, including International Health Regulations core capacities, so that all health workers:
 - a. can work to their full potential
 - b. have skills that match the health needs of the populations they serve
 - c. are enabled to serve effectively in humanitarian settings and public health emergencies, both acute and protracted

Policy Options

Given the policy goals, three policy options are considered to stimulate investments and strengthen financing of HRH. Each policy option is evaluated based on the following criteria⁹⁶.

1. Population benefit - Potential for the policy to impact the population health considering risk factors, quality of life, disparities, morbidity and mortality
 - a. Health outcomes and quality of life (morbidity, mortality, QALY, DALY, etc.)
 - b. Improved health care access
 - c. Reduced disparities in access, quality of care, outcomes
2. Health labor market benefit – potential effect of policy on health workforce
 - a. Quality of graduates
 - b. Entry to Philippine health labor force
 - c. Competency of health workers
 - d. Distribution of health workers
 - e. Security of tenure
 - f. Attrition
3. Economic and budgetary impact - Comparison of the costs to enact, implement, and enforce the policy with the value of the benefits; this criterion looks at the potential of the policy to improve efficiency of the health system
 - a. Cost and benefit (maximize positive effects given input costs) for public (federal, state, local) and private entities to enact, implement, and enforce the policy
 - b. Efficiency (potential measure: QALYs, DALYs)
 - c. Contain costs (to stay within available resource budget and to insure “margin” between input and output costs)
4. Feasibility - Likelihood that the policy can be successfully adopted and implemented
 - a. Political feasibility
 - i. Current political forces or the extent of influence of various parties, individuals or groups
 - ii. Stakeholder acceptability considering interest and values (for health workers, health facility managers and employers, national government agencies, LGU/LCE, civil society and NGOs, general public)
 - iii. Social, educational and cultural perspectives (e.g., lack of knowledge, fear of change, force of habit)
 - iv. Impacts to other sector and high priority issues (e.g., sustainability, economic impact)
 - b. Operational feasibility
 - i. Degree of control



- ii. Resource, capacity, and technical needs in developing, enacting, and implementing the policy
- iii. Timeframe to enact, implement and enforce the policy
- iv. Simplicity/robustness, scalability, flexibility of the policy
- v. Legal/regulatory issues

Each of the policy options were evaluated using the scoring definition presented in Table I.

Table I. Scoring definition

Criteria	Weight	Scoring Definition
Population benefit	2	<ul style="list-style-type: none"> 1 (Low): small reach, small effect size, and small impact on disparate populations 2 (Medium): small reach with large effect size or large reach with small effect size 3 (High): large reach, large effect size, and large impact on disparate populations
Health labor market benefit	2	<ul style="list-style-type: none"> 1 (Low): small reach, small effect size, and small impact on disparate populations 2 (Medium): small reach with large effect size or large reach with small effect size 3 (High): large reach, large effect size, and large impact on disparate populations
Economic and budgetary impact	2	<ul style="list-style-type: none"> 1 (Less favorable): costs are high relative to benefits 2 (Favorable): costs are moderate relative to benefits (benefits justify costs) 3 (More favorable): costs are low relative to benefits
Political Feasibility	1	<ul style="list-style-type: none"> 1 (Low): No/small likelihood of being accepted 2 (Medium): Moderate likelihood of being accepted 3 (High): High likelihood of being enacted accepted
Operational Feasibility	1	<ul style="list-style-type: none"> 1 (Low): No/small likelihood of being implemented 2 (Medium): Moderate likelihood of being implemented 3 (High): High likelihood of being enacted implemented

Option I: Maintain current investments and financing mechanisms (Status Quo)

The current investment and financing scheme that influences HRH investments are covered and guided by the existing national and local budget circulars. In this current scheme, funding for health workers in primary care facilities managed by local government units are subjected to local budget rules and regulations following the 1991 Local Government Code where limitation on the personal services budget is imposed. Local government budget will increase following the Supreme Court ruling on the petition filed by the former Batangas 2nd District Representative Hermilando Mandanas in 2012 where he questioned the government's wrong computation and alleged misappropriation of IRA funds for LGUs.⁹⁷

Meanwhile, funding for 'deployed health workers' (staff augmentation scheme for local governments) and health workers in DOH retained hospitals come from General Appropriations to DOH.



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Option 2: Maximize funding sources and quality assurance mechanisms for Human Resources for Health defined in the Universal Health Care Act

Maximize domestic financing mechanisms to support human resources for health management and development is defined by the Universal Health Care Act⁹⁸ and its implementing rules and regulations⁹⁹ to protect and promote the right to health of all Filipinos. Funding streams and mechanisms defined in the Act from which the health workforce will benefit are:

- National government financing of population-based health services, where human resources for health capacity building will be financially supported
- Pre-payment mechanisms like social health insurance, private health insurance or HMO plans that will finance individual-based health services, where incentive mechanisms for health care provider networks can be explored
- Special Health Fund is an instrument of province-wide and city-wide health systems to pool and manage resources (coming from different streams) for health services. Per the implementing rules and regulations, the Special Health Fund can be allocated for delivery of population-based and individual-based health services, remuneration of additional health workers and incentives for all health workers
- Financial and non-financial matching grants in human resources for health to improve functionality of province- and city-wide health systems
- Incentive scheme for health facilities through the PhilHealth Rating System for healthcare providers that will qualify to the prescribed standards and requirements for receiving such incentives

However, it should be noted that although features of this option are heavily based on what is stipulated in the Universal Health Care Act, some funding mechanisms and implementation characteristics present in Option 1 may also exist during the implementation of the law.

Option 3: Institute and finance multi-sectoral collaboration between health and other sectors, and co-develop multi-sectoral investment and action plans for human resources for health

The social determinants of health include all aspects of daily living conditions and are influenced by resource distribution at global, national and local levels. To address these determinants, health initiatives often require collaboration between health and other sectors. As different sectors are subjected to discrete regulatory structures and have distinct goals, funding multi-sectoral collaborations can be problematic. Separate funding streams, organizational budget silos, a lack of flexibility in funding arrangements and restrictions on the use of funds can significantly impede investment in inter-sectoral health promotion activities. Well-designed financing mechanisms may overcome some of these barriers to inter-sectoral collaboration. Furthermore, the Universal Health Care Act and its implementing rules and regulation defined the formulation and implementation investment and action plans for health workforce strengthening through the Human Resources for Health Master Plan and the cascade of its contents to the Local Investment Plan for Health and the Annual Operations Plan of local governments. Listed below are suggested financing mechanisms that can be explored to support multi-sectoral collaboration for human resources for health:¹⁰⁰

- Earmarked funding, delegated financing and joint budgeting schemes can ensure that resources are available for inter-sectoral activities



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- When looking at the architecture for inter-sectoral working, legislation and regulations that allow budget sharing between agencies and ensure accountability for funds received may provide a framework for financing inter-sectoral collaboration
- Identifying outcomes of interest to all potential inter-sectoral partners within a partnership, in addition to the economic costs and payoffs, can facilitate partnerships. Financial compensation may be helpful for partner sectors that do not receive direct funding
- Making ongoing financing of inter-sectoral activities conditional on routine effective monitoring and evaluation of whether defined outputs and outcomes have been achieved (i.e. phased funding) could lead to replication and/or scaling up
- Voluntary joint budgeting with appropriate regulatory safeguards may be more sustainable through developing mutual trust, rather than imposing mandatory requirements to pool budgets
- Most of the existing experiences are at the local rather than national level. Pioneer areas can share experiences with others to help improve subsequent replication of approaches.
- Fiscal incentives and access to technical advice and support may be effective in stimulating intersectoral activity, particularly with private sector workplaces

However, it should be noted that although features of this option are treated as independent from the other policy options, overlaps in implementation characteristics may exist with Option 1 or Option 2.



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Policy Option	Criteria					Total Score*
	Population benefit Weight=2	Health labor market benefit Weight=2	Economic and budgetary impact Weight=2	Political Feasibility Weight=1	Operational Feasibility Weight=1	
Option I Maintain current investments and financing mechanisms (Status Quo)	2 (Medium) Current investments on HRH is dispersed nationwide, with both national- and local- driven investments and funding. However, contributions of these HRH investments (not discounting contributions from other building blocks of health system) resulted to: <ul style="list-style-type: none"> • limited access to healthcare, especially of the poor¹⁰¹ • Fragmented health service delivery¹⁰² • 52.2% out of pocket health spending (2016) of total health expenditure¹⁰³ • Mixed health outcomes¹⁰⁴ <ul style="list-style-type: none"> ○ Increasing life expectancy (70 years) ○ Slow decline in MMR (currently at 114/100,000 live births) ○ Slow decline in infant (21/1000 live births as of 2017) and under five mortality rates (27/1000 live births as of 2017) ○ High prevalence of stunting among under five children (33.4%) ○ Triple disease burden, with high prevalence of communicable diseases, increasing prevalence of non-communicable diseases, and risks arising from globalization and climate change/disasters ○ Outbreaks and re-emergence of communicable diseases (Polio, Measles, Dengue) 	2 (Medium) Effect of the current investment and financing mechanisms on the health labor market ¹⁰⁵ shows that: <ul style="list-style-type: none"> • human resource for health is maldistributed, where there is high concentration of health workers on urbanized and economically developed areas • 298,013 health sciences program enrollees entering the Philippine education system • Only 2 out of 10 students graduates per year • There is annual entry of 50,674 HRH into the labor market • 4 out of 10 positions are vacant in public hospitals • 31% of HRH are out of the labor force • International migration of licensed health workers at 12,976 per year • 11,820 health workers in business process outsourcing industry 	1 (Less favorable) Approximating the budget allocation currently provided from the current fund sources, costs are high compared to the extent of population and health labor market benefits gained. <i>According to the General Appropriations Act 2019</i> (current appropriations on personal services where the health sector is the recipient) <ul style="list-style-type: none"> • 42.8B (Department of Health) • 201.7M (Commission on Population) • 93.5M (National Nutrition Council) <i>Current cost considerations (national level):</i> <ul style="list-style-type: none"> • Deployment program (national funded) • Training cost (face-to-face) of health workers in public sector covered by government • DOH Medical Scholarship Program (medical and allied health professionals) <i>Current budget allocation for HRH at the local level:</i> <ul style="list-style-type: none"> • No data on personal services cost of HRH on LGU level. However, given existing government policy, it is most likely that budget to HRH constitute only a portion of the 45% (or 55%) allowed budget of the LGU for personal services 	3 (High) Likelihood of this option being accepted by stakeholders is high because: <ul style="list-style-type: none"> • Current political environment will not contradict status quo • Stakeholder acceptability is likely high because they are used to the status quo processes. They can already navigate according to their values and gain interest • No radical change is expected, thus, stakeholders will not allocate additional effort, capacity or resources • Minimal impact to other sectors as most of the expected actions is assigned to DOH and LGUs 	3 (High) Likelihood of this option being enacted is high because: <ul style="list-style-type: none"> • Current resource and capacity enough for the option to be implemented; less likely to have additional technical needs • Access to usual fund sources like IRA, LGU income • Implementation will follow the usual timeframe • No conflict with existing legal or regulatory processes, or government rules 	16

* Computation of total score considers the weight for each criterion



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HUMAN RESOURCES FOR HEALTH IN 2030

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Option 2 Maximize funding sources and quality assurance mechanisms for Human Resources for Health defined in the Universal Health Care Act	<p>3 (High)</p> <p>Assuming full implementation of the UHC Act, the Philippine health care model will give all Filipinos access to comprehensive set of quality and cost-effective, promotive, preventive, curative, rehabilitative, and palliative health services. Given this, potential HRH investments when the UHC Act is implemented (along with measures targeting other health system building blocks provided in the UHC Act) that will be provided will result to:</p> <ul style="list-style-type: none"> Increased access to healthcare, especially of the poor Improved health service delivery Less out of pocket health expenditure (50%) Anticipated better health outcomes:¹⁰⁶ <ul style="list-style-type: none"> Increasing life expectancy (72 years) Improved MMR (less than 70/100,000 live births), infant (15/1000 live births) and under five (25/1000 live births) mortality rates Decreased prevalence of stunting among under five children (21.4%) Prevented triple disease burden Low likelihood of outbreaks and re-emergence of communicable diseases 	<p>3 (High)</p> <p>Given the strong support that the UHC Act provides in strengthening HRH and the nationwide coverage of its implementation, it is likely that investment and financing on HRH will improve. Given that, the health labor market will thrive and will probably have:</p> <ul style="list-style-type: none"> Better quality of graduates aspiring to enter the workforce (approximately 5-6 out of 10 health sciences education will graduate) Practice-ready health sciences program graduates entering the workforce Enter to Philippine health labor force due to RSA Highly motivated and satisfied health worker pool (Turnover rates lower) Health workers with better skills and competency Adequately distributed health workers Enough health worker positions to respond to health needs Better compensation packages for health workers Improved retention of HRH in the health labor force and in underserved areas Health workers are less likely to be out of labor force due to migration (overseas nor outside the health sector) 	<p>2 (Favorable)</p> <p>Given the expected population and health labor market benefits, the economic impact will be favorable with the increased budgetary implications that the UHC Act implementation will require. Chapter 6 of the law and its IRR provides for providing adequate resources to implement reforms in strengthening HRH development and management, which would require higher budget share than what is currently being provided to support HRH.</p> <p>Although the budgetary requirements of UHC implementation will have access to various fund sources, it is expected to result in increased premium rate of as high as 5% of monthly income that will be covered by paying Philhealth members.</p>	<p>2 (Medium)</p> <p>Likelihood of stakeholder acceptance is moderate because:</p> <ul style="list-style-type: none"> Policy environment is supportive of implementing the option due to the UHC Act Stakeholder acceptability is might be varied depending on the effect of the UHC implementation in their interests <ul style="list-style-type: none"> Health worker acceptability will be high because of potential benefits they can gain Employers acceptability might be moderate due to the probable increased expenditures requirement by the law for improved compensation benefits for health workers National government agencies and LGU/LCE acceptability will be moderate due to the reforms introduced by the UHC Act that will trigger changes with current government processes, rules and practices General public acceptability might be mixed due to the consequence of increase rate of premium contributions for paying Philhealth members Large change is expected, thus, stakeholders will need to allocate additional effort, capacity or resources Moderate impact to other sectors as the various sectors are expected to participate in UHC Act implementation With increased investments on HRH, the benefits will accrue both to the supporters of UHC and greater population who will gain better access to health services 	<p>3 (High)</p> <p>Implementation is highly likely because:</p> <ul style="list-style-type: none"> The UHC Act provided supportive measures that will facilitate implementation of the option The UHC Act reinforces the significance of linking and aligning the city- and province-wide investment plans (basis of local health funding and access to SHF) for health to HRH Masterplan to ensure the cascade of the identified strategies and interventions towards strengthening HRH Various fund sources were identified in the UHC Act that can be tapped New funding mechanisms are identified to support HRH at all levels 	21



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HRH2030
HUMAN RESOURCES FOR HEALTH IN 2030

Policy Option	Criteria					Total Score*
	Population benefit Weight=2	Health labor market benefit Weight=2	Economic and budgetary impact Weight=2	Political Feasibility Weight=1	Operational Feasibility Weight=1	
Option 3 Institute and finance multi-sectoral collaboration between health and other sectors, and co-develop multisectoral investment and action plans for human resources for health	<p>2 (Medium)</p> <p>According to the High Commission on Health Employment and Economic Growth, targeted investments in health systems, including HRH, promotes inclusive economic growth along with economic output, social protection and health security. Global data trends show that: ¹⁰⁷</p> <ul style="list-style-type: none"> • returns on investment in health are estimated to be 9 to 1 • One extra year of life expectancy has been shown to raise GDP per capita by about 4% • Reduced likelihood of child mortality in countries with high fertility rates like the Philippines <p>Thus, should the country implement and invest in multi-sector led and supported health systems strengthening interventions targeting HRH (along with measures targeting other health system building blocks), it will likely result to:</p> <ul style="list-style-type: none"> • Increased access to healthcare, especially of the poor • Improved health service delivery • Anticipated better health outcomes <ul style="list-style-type: none"> ○ Increasing life expectancy (72 years) ○ Improved pace of decline in MMR, infant and under five mortality rates ○ Decreased prevalence of stunting among under five children (21.4%) ○ Still with triple disease burden, but with less prevalence of communicable diseases, decreased prevalence of non-communicable diseases, and better management risk arising from globalization and climate change/disasters 	<p>2 (Medium)</p> <p>Should there be increased multi-sectoral support and investment that targets strengthening of HRH development and management, the health labor market will thrive and will probably have:</p> <ul style="list-style-type: none"> • Gradual improvements in quality of graduates aspiring to enter the workforce • Substantial entry of aspiring health workers into the Philippine health labor force • Motivated and satisfied health worker pool • Health workers with better skills and competency • Improved distribution of health workers • Increased health worker positions to respond to health needs • Improved working conditions and compensation packages for health workers 	<p>2 (Favorable)</p> <p>Given the expected population and health labor market benefits, the economic impact will be favorable due to the increased potential to access resources from multiple sectors towards strengthening HRH management and development. The option will likely result to distribution of economic benefits to all sectors involved because they actively participated in the process.</p>	<p>1 (Low)</p> <p>Likelihood of stakeholder acceptance is low because:</p> <ul style="list-style-type: none"> • Policy environment needs to be reformed so that collaboration and sharing of resources of multiple stakeholders (regardless if from private or public sector) can be maximized • Stakeholder acceptability might be varied depending on the effect of multi-sectoral collaboration in their interests <ul style="list-style-type: none"> ○ Health worker acceptability will be high because they are the target beneficiaries of the interventions ○ Employers acceptability might be moderate due to the potential increased expenses due to the strong provisions in the law for improved compensation benefits for health workers ○ National government agencies and LGU/LCE acceptability will be low due to the unknown or varying expectations that may trigger changes with current government processes, rules and practices ○ Private sector acceptability might be moderate depending on how they can advance their interest when engaged • Large change is expected, thus, stakeholders will need to allocate additional effort, capacity or resources • High impact to other sectors as they will be more involved in strengthening HRH 	<p>2 (Medium)</p> <p>Likelihood of implementation is moderate because:</p> <ul style="list-style-type: none"> • More funding streams can be tapped due to partnership among multi sectors (both government, non-government and private) and this can result to resource sharing • New funding mechanisms can be implemented jointly by multiple stakeholders • Reforms on processes, government rules and practices need to be done to maximize multi-sectoral collaboration • Substantial resource, capacity and effort needed to establish mutual trust, partnership and multi-sectoral collaboration 	15



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Policy Option	Criteria					Total Score*
	Population benefit Weight=2	Health labor market benefit Weight=2	Economic and budgetary impact Weight=2	Political Feasibility Weight=1	Operational Feasibility Weight=1	
	<ul style="list-style-type: none">○ Better capacity to respond to emerging and reemerging communicable diseases					



Conclusion

From the evaluation of the policy options, maximizing the funding sources and quality assurance mechanisms for Human Resources for Health defined in the Universal Health Care Act seems to be the best course of action. Shown to have high benefits for the population and the health labor market, favorable economic and budgetary impact, and the moderate likelihood of feasibility in terms of political dynamics and operational considerations will stimulate action from policy-makers, decision-makers, and key stakeholders in investing on the Philippine health workforce as a key strategy in achieving universal health care for all Filipinos. However, it should be noted that implementation of this option will still require satisfying the assumptions and conditions defined in the Universal Health Care Act and its implementing rules and regulations like increased premium payments from paying PhilHealth members and setting up guidelines (e.g., Special Health Fund, provincial/city- wide health systems, etc.) in implementing provisions of the Act. It should also be noted that some features of the status quo can still be adapted, should there be policies or guidelines not affected by the implementation of the Universal Health Care Act provisions. Furthermore, multi-stakeholder collaboration, a key feature of the 3rd policy option, is also considered in the Universal Health Care Act. It is likely that this will also contribute in stimulating HRH investments.

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