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Universal Health Care in the Philippines through the Lens of Workforce 2030:

An Omnibus Review of Human Resources for Health Policies

ACKNOWLEDGEMENTS

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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)

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Acronym

CHED	Commission on Higher Education
CHEEG	Commission on Health Employment and Economic Growth
CSC	Civil Service Commission
DBM	Department of Budget and Management
DILG	Department of Interior and Local Government
DOH	Department of Health
DOLE	Department of Labor and Employment
GAD	Gender and Development
GIDA	Geographically Isolated and Disadvantaged Areas
HCPN	Health Care Provider Network
HHRDB	Health Human Resources Development Bureau
HLM	Health Labor Market
HR	Human Resources
HRH	Human Resources for Health
HRHMP	Human Resources for Health Master Plan
HRHN	Human Resources for Health Network
ICT	Information, Communications and Technology
IPE	Interprofessional Education
LGC	Local Government Code
LGU	Local Government Unit
MCPHW	Magna Carta of Public Health Workers
NDHRHIS	National Database of Selected Human Resources for Health
NHWSS	National Health Workforce Support System
OWWA	Overseas Workers Welfare Administration
PCPN	Primary Care Provider Network
PRC	Professional Regulation Commission
PRIME-HRM	Program to Institutionalize Meritocracy and Excellence in Human Resource Management
SGLG	Seal of Good Local Governance
SHF	Special Health Fund
SPMS	Strategic Performance Management System
UHC	Universal Health Care
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Improving the country's health outcomes and achieving universal health care (UHC) is unlikely unless there is a sufficient number of "appropriately skilled and motivated, equitably distributed and well supported" health workers in the system. Thus, the USAID's Human Resources for Health in 2030 in the Philippines (HRH2030/Philippines) Activity works to strengthen the health workforce for better tuberculosis (TB), family planning (FP) and maternal and child health (MCH) services by improving human resources (HR) planning and workforce systems for deployment, distribution, and skills mix; strengthening competency development through e-learning and post-training evaluation (PTE); improving human resources for health (HRH) data for decision making; and strengthening national HRH governance through developing a National HRH Masterplan (HRHMP).

Responding to a provision of the UHC law enacted in 2019, USAID's HRH2030/Philippines will support the development of the 2020-2040 HRH Masterplan, including short-, medium-, and long-term operational plans, to guide the country in addressing its HRH challenges. As part of its development and taking off from the completed policy scoping review that assessed 54 health related policies largely issued by DOH, an omnibus policy review was conducted to encompass 134 policies that relate to the spectrum of a health worker's movement across the World Health Organization (WHO)'s Working Lifespan Strategy. Guided by the Health Labor Market (HLM) framework towards UHC accomplishment, the omnibus policy review aimed to determine the scope of existing policies that impact HRH management and development. After comparing the existing policies that we have in the Philippines with HRH policy, gold standards the WHO Workforce 2030 and CHEEG, the emergent policy agenda will guide the proposal of priority policies to support HRH management and development in support of UHC.

A policy content assessment using the HLMA framework identified key policy developments and policy issues by assessing the content of existing policies vis-à-vis the provisions of the UHC law and global standards set by the WHO. The review showed that the policy environment is generally supportive of the HRH provisions introduced by the UHC Act. Common focus of most of the supportive policies were on HRH production and management of Filipino health workers that are within the country's current labor force. However, there are still several policy issues that needs to be resolved like the need for strengthening and harmonizing fragmented (i.e. national vs. local, cadre-specific vs. interprofessional, private vs. public, etc.) governance systems in HRH production, development, management and information system. Key recommendations identified in this review aim to reinforce the key policy developments and further address the policy issues. These recommendations include a proposed policy agenda covering different HRH issues across the working lifespan, highlighting the need for an omnibus policy for HRH management and development, calling for the integration of HRH strategies in the UHC transition plan, and ensuring that the result of this omnibus policy review will be incorporated in the HRH master plans and strategies.

This report is divided into four main sections. Section I provides the background and methodology used to conduct the policy review. Section II gives a broad discussion about the HRH policy environment in the Philippines including the results of an inventory and timeline of policies covered by the review. Section III presents the key policy developments and policy issues identified in the review. Section IV discusses the recommendations and conclusions from the review.

Background

A growing middle-income country like the Philippines[1] need a healthy population to ensure economic growth, social development and poverty reduction towards a strongly rooted, comfortable, and secure life.[2] Filipinos' access to health and social services are essential to ensure good health and well-being. In addition, Filipinos need to be protected from financial risk arising from the cost of health care in the country. These are promised by the universal health care law that became a major health reform. This allows the needed health services to be accessible and available to every Filipino, when and where they need these services, while not burdening them economically.[3]

In a country like the Philippines where health workers, especially nurses, leave to work abroad for better opportunities, poor quality health care that is unresponsive to the population's health needs is likely to occur.[4] Improving health outcomes and achieving UHC for Filipinos will be difficult unless there is enough "appropriately skilled and motivated, equitably distributed and well supported" health workers supporting the health system.[5] [6] Human resources drive the efficient operation of the health care system towards successful health reforms and improved health status. Studies show that the Philippines does not lack HRH, however, equitable distribution is problematic as evidenced by the substantial proportion concentrated in urban areas.[7]

The WHO global strategy on human resources for health: Workforce 2030 provided recommendations to member states that advocates for a strengthened health workforce as a measure to ensure UHC and achievement of the Sustainable Development Goals (SDGs).[8] The WHO High-Level Commission on Health Employment and Economic Growth (CHEEG) also provided parallel recommendations with particular focus on solutions to "ensure that the world has the right number of jobs for health workers with the right skills and in the right places to deliver UHC" following the rising global demand and need for health workers.[9] In the Philippines, there are policies in place and initiatives taken to address issues experienced by Filipino health workers. However, the environment of the country's health workforce is still very challenging, especially for health workers who decided to stay and are now facing workload pressures beyond their capacity.[10]

Recently, the Philippine Congress passed the UHC Act to protect and promote the right to health of all Filipino citizens and ensure their access to a comprehensive health service without financial hardship. This law aims to address the recurring problems in the decentralized health system, one of which is the poor state of the country's health workforce.[11] The focus and opportunities provided by the UHC Act on its HRH provisions is a recognition of the important role that health workers play in achieving universal health coverage in the country. This landmark law introduced strong HRH management and development measures responsive to the plight of the Filipino health workforce in addressing current and emerging issues they are facing. However, it is critical to determine the extent by which preceding laws and policies may affect UHC law implementation. It will also be beneficial to identify the alignment of the country's existing policy environment to the vision articulated by the WHO and the CHEEG. In doing this, the Philippines can set up a policy agenda to address contradicting provisions and or provide needed policies to provide a supportive policy environment create a synergistic approach to guide its

implementation of the UHC Act to successfully navigate though the challenges faced by the Filipino health workforce in the domestic and the global settings.

Methodology

The USAID's HRH2030/Philippines, in partnership with the Department of Health (DOH) – Health Human Resources Development Bureau (HHRDB), accomplished a policy scoping review of all HRH laws and policies or those with provisions on HRH that may support or hinder the implementation of the UHC Act in the Philippines. A policy content evaluation[12] methodology was adopted to determine and resolve policies that impact HRH which have overlapping and/or opposing intentions and provisions to create coherent synergies for UHC[13] that will benefit Philippine HRH. The search was only limited to policies in the national and departmental levels with the inclusion criteria utilizing three steps (*See Box 1)*. While the review was initially limited to a five-year period (2015-2019) to cover the most updated policies, it expanded to policies preceding 2015 if they are relevant to the inclusion criteria and the UHC provisions.

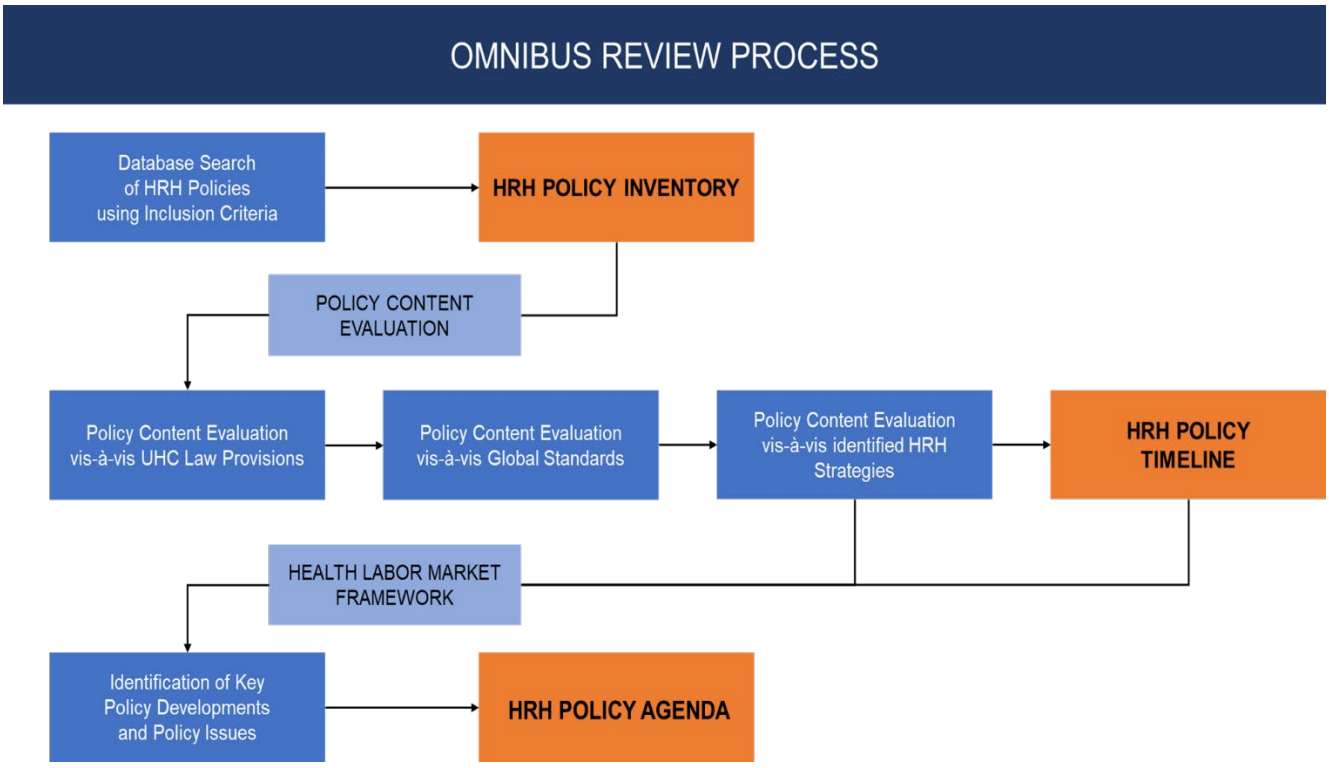
Box 1. Inclusion Criteria for HRH Policies in the Omnibus Review

Inclusion Criteria, Steps 1-3
Inclusion criteria, step 1: • Philippine HRH Laws or those with provisions affecting HRH (Republic Acts, Executive Orders, Presidential Decrees, Batas Pambansa) • Philippine HRH Departmental Policies or those with provisions affecting HRH (Administrative Orders, Department Orders/ Memoranda/ Advisories/ Circulars, Memorandum Orders/ Circulars, Board Resolution, HRHN Memorandum of Understanding, Joint Department Issuances such as AOs, Circulars, etc.) **Inclusion criteria, step 2:** • If amended, most updated law is used in lieu of preceding laws; unless, if amendments only apply to certain provisions of the preceding law. **Inclusion criteria, step 3:** • Policies supporting/ hindering the Philippine Universal Health Care Law (RA 11223 and IRR) provisions

The HRH policy inventory resulted to a review of 134 policies consisting of 73 laws and 61 DOH departmental policies. The inventoried policies were then assessed using the following steps. First, the policy content from the inventory were analyzed as to whether they fully or partially support; or, fully or partially hinder the provisions of the UHC Law in the basis of policy content. Second, the relevant policies were then assessed as to whether they are aligned with the global HRH standards (WHO's Workforce 2030 and CHEEG), Third, a qualitative analysis was done to determine the policy priorities and milestones within a timeline of the reviewed HRH policies from the inventory. The qualitative analysis is used to understand the evolution of policies relevant to HRH up to the passing of the recent UHC law as well as the preparation of the HRH Master Plan (HRHMP) 2020-2040. Fourth, policy issues were identified using the Health Labor Market (HLM) framework[14]. Key policy developments refer to laws and

policies that were instituted during the period covered by this review which are fully or partially supportive to UHC or have negative effects to HRH and are aligned with the global standards. Policy issues refer to health workforce problems which were promulgated fully or partially by the laws and policies or may have hindering impact to the implementation of the UHC Act and the global standards. The policies are also analyzed based on how they are supportive to the identified strategies for the Human Resources for Health Masterplan. This systematic review process is summarized in Figure 1.

Figure 1. The Omnibus Review Process



This review declares the following limitations. First, the policy content evaluation methodology in this review does not consider as to whether these policies are still in effect or are implemented in the country. Second, international and regional policy instruments that may have bearing to the policy environment of UHC in the Philippines were also not included in this review. For instance, ASEAN declarations or commitments were not included in the inventory. Third, any law or policy that may have HRH provisions but are not available online are not included in this review since the main source of the database search was conducted online. Any excluded and seminal policy determined after this writing will be recommended for inclusion and consideration to inform the completion of the policy recommendations outlined in this review.

Results

HRH Policy Inventory

A total of 134 policies consisting of 73 laws and 61 executive policy issuances of different government agencies were completed the HRH Policy Inventory in this review. *Box 2* summarizes the number and aggregation as per type of policy included in the review.

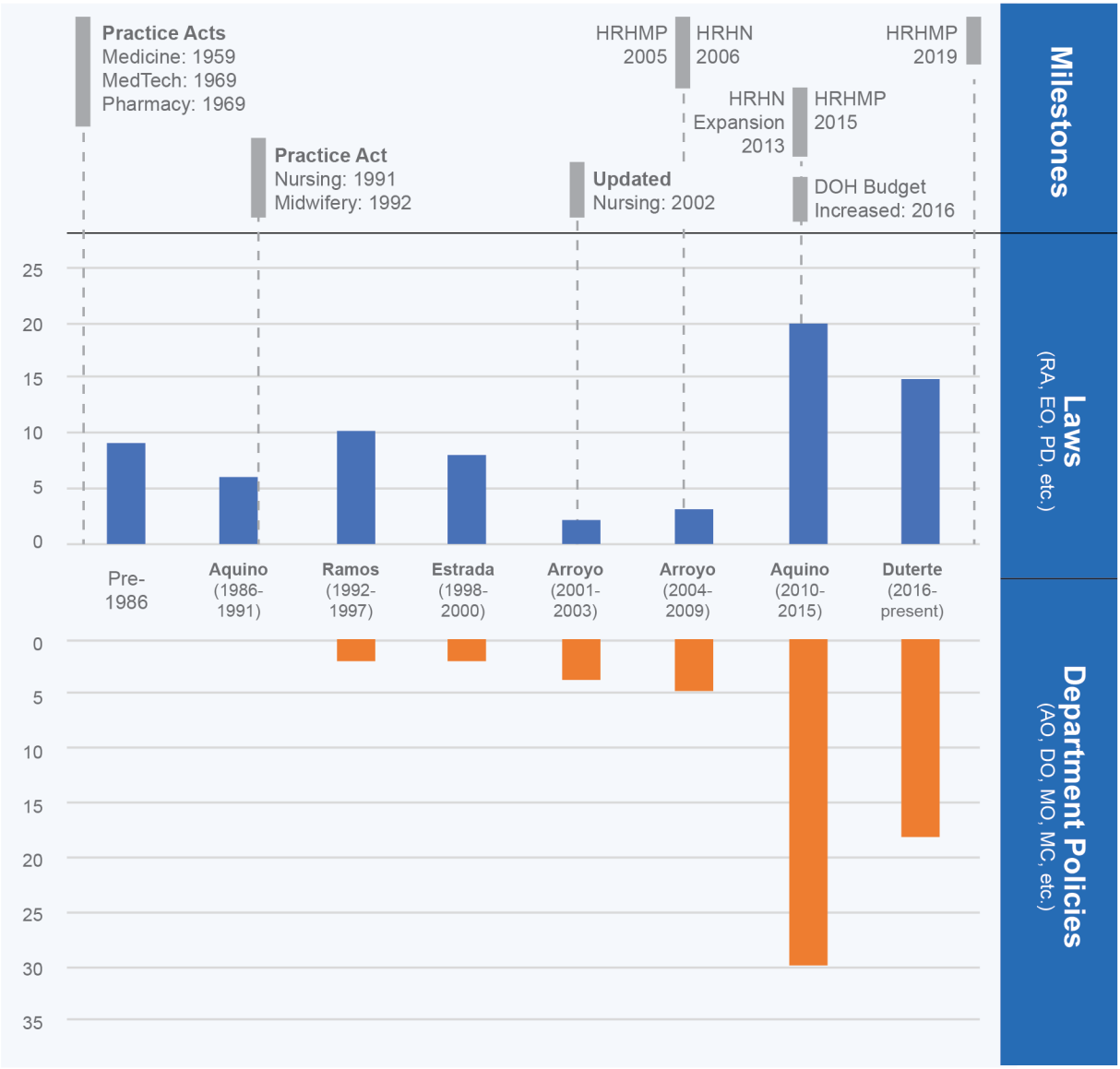
Box 2. Number and Aggregation of HRH Policies

Number and Aggregation of HRH Policies or those with HRH provisions	
1. **Laws (n=73)** • 61 Republic Acts • 9 Executive Orders • 2 Presidential Decrees • 1 Batas Pambansa	**2. Executive policy issuances (n=61)** • 26 Administrative Orders • 8 Department Orders • 5 Memorandum Orders • 5 Memorandum Circulars • 4 Department Memoranda • 4 Joint Circulars • 3 Department Circulars • 2 Department Advisories • 2 Joint AOs • 1 Board Resolution • 1 MOU

On the other hand, *Figure 2* summarizes the number of policies aggregated by national and departmental policies within a timeline of the different Presidential administration terms starting from pre-1986 to present. Important milestones were also identified in the timeline including the practice acts, the HRH Network establishment and expansion, the increase of DOH budget and the completion of the HRH Master Plans.

From a glance, most of the HRH policies started to increase in number during Former President Aquino's administration followed by the current administration of President Duterte. The growth of the number in HRH policies may also be attributed by three milestones identified: the expansion of the HRH Network in 2013, the updating of the HRH master plan in 2015 and the increase in the budget allocation of the DOH in 2016. It can also be observed that when a lot of HRH laws were passed, there was a parallel growth in the number of departmental policies crafted in order to provide clear guidelines and operationalization among the government agencies. It is striking to note though that there were fewer departmental policies passed prior to 2010 but this may be also due to unavailability of the relevant HRH policies during this time online or have already been considered void due to updated departmental policies. The milestones in the timeline also show that the main practice acts haven't been updated since, except for nursing profession, although the latter is also more than a decade old.

Figure 2. HRH Policy Timeline



Key Policy Developments

The UHC Act aims to respond to the recurring health system problem on HRH by improving the state of the Philippine health workforce. The review showed that the policy landscape is supportive of HRH provisions introduced by the UHC Act through direction on production and management of Filipino health workers within the country's labor force. Major shifts in planning and governance is in the pipeline targeting to strengthen management and development of HRH. Using the HLMA framework, the review identified seven significant developments in the current policy landscape *(See Box 3)*. The HLMA framework uses the 2 components of the health labor market – the education market that is analyzed for its contribution to the production of health workers and the workforce market that shows how the health workforce is employed and lost (through attrition, migration).

Box 3. Policy Developments Based on the HLMA Framework

Policy Developments Identified in the Omnibus Policy Review (Clustered Based on the HLMA Framework)

Policies on HRH Production: **(1) Continuous Quality Improvement to Health Worker Education**

Policies on HRH Inflow and Outflow: **(2) Decent working conditions for HRH**

Policies on Workforce Distribution and Efficiency:
- **(3) Planning for adequate and competent health workforce**
- **(4) Prioritized HRH deployment**

Cross-cutting Policies
- **(5) Institutionalization of HRH Governance**
- **(6) Investments for HRH**
- **(7) ICT growth in HRH**

These critical policy areas show the country's recognition of the importance of the health workforce for a more synergistic approach towards universal health coverage and improved health outcomes. This section discusses how the current policy environment is supportive of the UHC provisions on HRH. This also includes a discussion on how existing policies are aligned with recommendations of the WHO and the CHEEG.

HRH Production

Within the health labor market, the education market is a key driver for the supply of health labor. Production policies and practices in place are critical to ensure that enough skilled and motivated health workers will be produced to respond to population needs.

Continuous Quality Improvement to Health Worker Education. Current policies in the country institutionalized governance of public and private educational and training institutions between the periods of 1992 to 2001 to regulate the quality of basic education,[15] higher education[16 17 18] and vocational programs,[19]. Most of these laws and policies cover setting minimum standards for programs, monitoring and evaluating the performance of such programs, and designating members of technical panels for the various programs. However, despite the current policy landscape, the 1st Human Resources for Health Masterplan (HRHMP) in 2005 identified the problem of declining quality of health professional education especially in nursing. This was attributed to the increased privatization of higher education institutions (HEIs) that resulted to the commercialization of education for health workers. Also, the increasing global demand for health workers was another driver for the commercialization of education and the increased number of schools in the country. Although from the outset it seemed that this might help augment the

workforce production in the country, this commercialization however led to higher attrition rates of health sciences education students especially those who took up nursing. [20] This encouraged policy-makers to advocate for the creation of new standards, quality assurance processes, monitoring and evaluation systems, and improvement of access to education, especially designed for health professions.

Following this, the next steps taken by the Philippines was to introduce stronger measures and policies to improve quality of health worker production. The passage of the UHC law recognizes the importance of the education sector in ensuring quality HRH production. This was why the UHC law explicitly articulated the need for the following: 1) regulate the education sector and the quality of education of medical and allied medical professionals,2) ensure effective health professional certification and regulation as well as 3) reorient these programs with educational outcomes focusing on primary care to respond to the needs of the country .[21] The basic education system was also re-designed and enhanced to be at par with standards in the region and the world by making kindergarten mandatory and compulsory for entrance to Grade 1,[22] adding two more years to high school[23] and regulating the presence of foreign schools and students in higher education.[24] [25] To better link high school and vocational students to take up courses for health professionals, the program on Science, Technology, Engineering and Mathematics (STEM) was introduced as one of the tracks in Senior High School[26] and ladderized education was launched to open pathways for vocational students to enter the educational ladder easier.[27] To ensure quality pre-service education and to deter its commercialization, several policies, standards and guidelines (PSG) were passed by the Commission on Higher Education (CHED) to strictly enforce guidelines on health professional education[28] with some specifically designed for programs for doctors,[29] nurses[30] and barangay health workers.[31] Following the PSG policies, quality assurance policies were also set in higher educational institutions (HEIs) requiring that educational systems must be outcomes-based and typology-based and should respond to country's population needs.[32] This level of quality assurance system was institutionalized nationally with the introduction of the Philippine Qualifications Framework that required the development, recognition and award of qualifications based on the standards of knowledge, skills and values acquired by students educated or workers trained in the Philippines.[33] [34] For in-service health professional training, policies focus on ensuring quality through the guidelines for assessing and monitoring clinical competencies,[35] accreditation of health program trainers[36] and Continuing Professional Development (CPD) programs;[37] establishment of post-training evaluation;[38] and, increasing access through the introduction of more distance education programs.[39] [40]

All these steps taken established the Philippines' commitment to ensure that there are continuous quality improvement measures in place on health worker education. The strength of the current policy environment on health worker education is its apparent alignment with the WHO High-Level Commission on Health Employment and Economic Growth recommendations of scaling up transformative, high-quality education and lifelong learning that responds to the needs of the populations.

The deficiencies of the policy environment on the other hand, which is discussed under the policy issues section of this paper, is on the development of coordinated approach to link HRH planning and education as well as in institutionalizing interprofessional education . These are necessary to maximize the full potential of the health workforce to fulfill population health needs especially to facilitate the shift on

HRH production towards health care provider networks (HCPN) and primary care provider networks (PCPN) within UHC.

HRH Inflows and Outflows

Human resources for health inflows and outflows rely heavily on strong and sound retention policies. Evidence shows that factors such as pay,[41] working conditions, mandatory service requirements, career development, children's education, political stability, family ties abroad may influence health workers leaving the country. Those that stay in the country tend to be in senior positions, have better pay and privileges or are in preferred locations (i.e. urban).[42] [43]

Decent working conditions for HRH. In the Philippines, several laws and government policies are in place to ensure decent work conditions for health workers. The UHC Act formally established a mechanism called the National Health Workforce Support System (NHWSS). This system unifies strategies for addressing inflows and outflows of the health workforce by promoting decent working conditions, particularly for deployed health workers, in the country. This mechanism includes human resource management and development system components; salaries, benefits and incentives; and, occupational health and safety of deployed health workers. The discussion on human resource management and development systems is detailed in the subsequent sub-section.[44] Even before the UHC Act, there were policies such as the Magna Carta for Public Health Workers, DOLE's occupational and health safety standards, and CSC's policies, that articulate opportunities and measures to ensure health worker retention . All these focus on promoting decent working conditions for HRH, but mostly target only government-hired health workers. These policies that were mostly passed in the 1990s, comprehensively cover remuneration, occupational health and safety, fair terms for health workers and merit-based career development opportunities.

In terms of remuneration, health workers are protected by laws ensuring minimum wage rates that are applicable to their region, provinces or industries.[45] The Magna Carta of Public Health Workers (MCPHW)[46] and the fourth tranche of adjustments under the salary standardization law[47] have pushed for increases in the pay of public health workers. The salary increase from the MCPHW is attributed to the change in salary grades as well as allowances (i.e. hazard, subsistence, longevity pay, laundry, remote assignment). In addition, there are also available performance-based allowances, incentives or compensation for public health workers.[48] [49] However, the MCPHW and the adjustments being implemented under the salary standardization law, do not cover health workers in the private sector. For barangay health workers, there is an existing law,[50] the BHW Benefits and Incentives Act, that provides for their benefits and incentives as they render voluntary health services to their respective communities.

On health workers' occupational health and safety, there is a general law that promotes the health and safety in the workplace. Through this, workers are ensured a safe workplace free from conditions that could cause death, illness, or physical harm.[51] Specific guidelines on such including medical, dental and

occupational safety for all health personnel in both public and private sectors are outlined in the country's labor code.[52] [53] The DOH and DOLE also have policies promoting the occupational health and safety in the healthcare facilities to protect health workers from undue hazards and risks.[54] [55] In terms of fair terms for health workers, the MCPHW provides for security of tenure, equality of salary scale, and additional compensation in the form of allowances; bans discrimination (including gender); and prohibits understaffing/overloading of health staff.[56] Finally, for merit-based career development and promotion, the DOH is mandated to develop a career and personnel development plan that describes the merit promotion, performance evaluation, in-service training grants, job rotation, suggestions and incentive award system.[57] In relation to this mandate, the CSC encouraged government institutions like the DOH, to implement the Program on Awards and Incentives for Service Excellence (PRAISE), which is an employee suggestions and incentive awards system "to encourage creativity, innovativeness, efficiency, integrity and productivity in public service" by recognizing civil servants for their suggestions, inventions, accomplishments, and other personal efforts that contributes to improved government operations.[58]

Although the existing policy ecosystem actually provides for retention strategies that also align with global standards on remuneration, occupational health and safety, fair terms for health workers, merit-based career development opportunities and a positive practice environment,[59] several reports acknowledge that working conditions of the health workforce in the Philippines still needs further improvement,[60] [61] [62] This review, however again is limited only to analysis of the content of policies and not whether these are currently implemented. However, it is generally known that some of the aforementioned policies like the Magna Carta for Public Health Workers are unevenly implemented. The more endowed LGUs implement the Magna Carta but the poorer LGUs just declare that they cannot afford to pay the benefits specified in the law. Other policies are observed to not be implemented meaningfully at all. The policy content however falls short in exploring non-financial incentives as well as shaping gender-specific and gender-sensitive retention and employment conditions. These shortcomings are discussed later under the policy issues section of this review.

Workforce Distribution and Efficiency

The UHC law strengthened current initiatives to respond to maldistribution and inefficiencies of the health worker distribution in the country. First, it institutionalized the sustainable implementation, monitoring, periodic evaluation and reformulation of the National HRHMP which refers to the long-term strategic plan in managing and developing the Filipino health workforce. Second, it also provided clear guidelines in the hiring of health professionals and health workers for deployment in the National Health Workforce Support System (NHWSS).[63] The policy environment surrounding these two initiatives are discussed in the sub-sections below.

Planning for adequate and competent health workforce. Appropriate planning is important to ensure adequate deployment and distribution, proper skill mix, and decent work conditions for health workers. Since 1992,[64] there was a call to develop an agency-led human resource development study and plan to ensure staffing needs are met. In 2005,[65] the DOH and WHO developed the HRHMP 2005-2030, a long-term strategic HRH plan for the same purpose of guiding production, deployment and development of health workers (See Table 1). The master plan had been updated in 2014 with a corresponding

operational plan in response to evolving population needs; facilitate education and continuous professional development of the health workforce; and introduce measures for HRH utilization, management and retention.[66] Implementation of the HRHMP is also guided by other government issuances setting standards for staffing health facilities.[67] [68]

The louder call to formulate and implement a masterplan for HRH was driven by the continuous and emerging issues being faced by the health workforce in the country. Outmigration of health workers is one of the current realities that adversely affects the stock of health workers in the country. Even as the Philippines continues to be one of the major sources of health workers globally, particularly nurses, it is ironic that the country is facing HRH shortages and challenges in health worker distribution.[69] Although remittances from health worker migrants are beneficial to the economy, negative consequences plague the health sector including issues on brain drain and loss of investment to human capital. These further hampered effective response to the health challenges and inequities confronting the population.[70]

The UHC Act provided measures to address these HRH concerns by strengthening the existing planning approach and "adopting a whole-of-system, whole-of-government and whole-of-society approach" in HRH planning. As part of the approach, a multisectoral action to support human resources for health is supported. The DOH, the local governments and the HRH Network (HRHN), a multisectoral entity composed by health workforce stakeholders from the private and public sector, collaborate to formulate the HRHMP and implement measures in recruiting, managing, developing and retaining HRH, and respond to current and future population needs on national and local scale, especially in the underserved areas of the country.[71]

Because of its mandate in the HRH planning, the HRH Network is considered essential and strategic for the workforce projections and planning processes.[72] [73] Prior to the UHC law, the MCPHW[74] required the DOH to conduct a periodic health human resource development/ management study which served a similar purpose (See *Table 1* for a comparison of their contents).

The institutionalization of the HRH network through the UHC Act,[75] specifies the mandate of the network in formulating and overseeing the implementation, monitoring, periodic evaluation and reformulation of the HRH masterplan. Its contents are specified in the UHC Act's IRR[76] , largely shifting from the preceding master plan's main objective of addressing the numerical imbalance of HRH due to migration[77] towards expanding it to a renewed objective of achieving HRH management and development to accommodate the changing population health needs.

Table 1. Content Differences between HRHDMS (1992) and HRHMP (2019)

Health Human Resource Development/ Management Study (RA 7305, 1992)	National Health Human Resource Master Plan (RA 11223, 2019)
1. Health workers' opportunity to grow and develop their potentials and experience	1. Comprehensive health labor market study adopting a whole of society approach

Health Human Resource Development/ Management Study (RA 7305, 1992)	National Health Human Resource Master Plan (RA 11223, 2019)
2. Staffing patterns and standards of health care 3. Ways and means of enabling rank-and-file workers to avail of education opportunities 4. Reclassification of positions and salaries of public health workers 5. Assessment of national policy on exploration of skilled health human resource	2. Standards for HRH, in both public and private sector, on staffing requirements, appropriate generation, recruitment, retraining, regulation, retention, productivity mechanisms, and reassessment of the health workforce that would be updated to accommodate changing population health needs 3. Outcomes pertaining to sustainable production, appropriate skill mix retention in the health sector, equitable distribution and practice-ready training and education for HRH

Furthermore, the UHC Act also strengthened the policy framework in absorbing and utilizing domestic and international resources available, especially during emergency and humanitarian response.[78] The DOH already have existing policies[79] [80] [81] [82] to guide stakeholders during health emergencies, and further guidance was issued to provide policy framework, core processes and role delineation in relation to disaster and risk reduction in health.[83] The recent issuance greatly considers provisions of the UHC Act, particularly in strengthening the health care provider network to appropriately respond to emergencies and disasters.[84] [85]

Prioritized HRH Deployment. The geographical maldistribution and shortage of health workers especially in geographically isolated and disadvantaged areas (GIDA) have prompted the national government to design several deployment programs focusing on the mobilization of health workers to complement the GIDA and rural health workforce. Deployment isn't new – in fact a year after the devolution[86] of health, the national government introduced the "Doctors to the Barrios" (DTTB) Program which deployed centrally-hired physicians to work as local health officers in resource-poor municipalities that cannot afford to hire their own doctors. [87] [88]

Currently, there are five deployment programs *(Box 4)* implemented by the DOH for physicians, medical specialists, nurses, midwives, dentists, medical technologies and nutritionist-dietitians who are primarily mobilized to supplement the rural health workforce in municipalities that are resource-poor or are in GIDAs.[89] In a health system review from 2011 to 2017, a total of 2241 doctors, 111,668 nurses and 20,730 midwives have been deployed to RHUs.[90] Before the UHC Act, all deployment programs were just enforced through departmental policies by the DOH [91] [92] [93] [94] [95] which again echoed the need to prioritize deployment in GIDAs.

Box 4. Description of current DOH deployment programs

Current DOH Deployment Programs (Accessed from the DOH Website, as of Nov 2019)

1. **Medical Pool Placement and Utilization Program (MP-PUP)** – Physicians and/or medical specialists are assigned in DOH hospitals and/or Provincial Hospitals based on needs and program criteria.
2. **Doctors to the Barrios (DTTB)** – Physicians are assigned, for two years primarily in 4th to 6th class municipalities that has not have a doctor for at least 2 years.
3. **Registered Nurses for Health Enhancement and Local Service (RN HEALS)** – Deployed nurses are assigned for 6 months in the community (Rural Health Units) and then another 6 months for hospital service.
4. **Rural Health Midwives Program** – Midwives are assigned in Barangay Health Stations and Rural Health Units for improved maternal and childcare. These facilities can then provide Basic Emergency Obstetric and Newborn Care (BEmONC) or Comprehensive Emergency Obstetric and Newborn Care (CEmONC)
5. **Rural Health Team Placement Program (RHTPP)** – Dentists, medical technologists, and nutritionist-dietitians are assigned in field health facilities to complement existing RHU personnel.

Cross-cutting Policy Developments

The review found that already existing laws and departmental policies prepared the ecosystem for HRH governance, investments and technology. These are also being established now through UHC. In terms of governance, the law formalized the functions and mandates of the DOH in leading and institutionalizing the HRH Network as well as required the periodic completion of the National HRHMP. In terms of investments, the passage of the law created additional fiscal space complementing existing laws and government issuances. The UHC law introduced measures that consider sustainable production, appropriate skill mix retention, equitable distribution and practice ready training and education for the health workforce belonging to the private or the public sector, and prioritizing GIDAs/underserved areas. It further facilitated opportunities for strengthening the employment agenda through the return service agreement (RSA) and NHWSS. Moreover, it introduced innovative financing mechanisms such as the incentives for improving competitiveness of the public health service delivery system and the Special Health Fund (SHF). The SHF is a mechanism to pool resources (financial grants/subsidies and donations, official development assistance, PhilHealth payments or local budget) of the province- or city-wide health system that enables allocation for remuneration and incentives of public health workers. In terms of technology, the UHC Act reiterates the mandate of the DOH in maintaining a registry of medical and allied health professionals including their number and location of practice. The department of health will be responsible for data collection and management of the registry. This also includes data and information from relevant agencies such as NGOs, private organizations and facilities.[96] The policy environment surrounding these cross-cutting key policy developments are discussed in the sub-sections below.

Institutionalization of HRH governance. Good governance infrastructure and mechanism between government and non-government institutions[97] facilitates sustainable and responsive health workforce. Currently, the DOH is the major actor governing the health workforce as implied in its mandate.[98] [99] As the overall technical authority in the health sector, the DOH also collaborates with different government (e.g., CSC, DILG, DOLE, DBM, CHED, PRC, LGUs, OWWA, etc.) and non-government institutions (e.g., professional societies, private organizations, health worker unions, etc.) to create a sustainable and responsive health workforce. The MCPHW and the UHC Act both established a multisectoral infrastructure convening public and private entities that aims to facilitate coordination and collaboration at the national level among health workforce stakeholders.

Given the current policy structure, there should exist, at the national, regional, provincial/city and municipal level, a Management-Health Workers Consultative Council primarily mandated by the MCPHW to formulate policies governing the social security of public health workers, professional and health workers organizations or unions, and to facilitate continuing dialogue with health workers issues/concerns arising from the implementation of the Magna Carta.[100] However, no such policy-making body is known to be functioning at national or local level. On the other hand, the DOH and the HRHN are being mandated by the UHC Act to formulate and oversee the sustainable implementation, monitoring, periodic evaluation, and reformulation of the long-term strategic plan for the management and development of HRH.[101] The HRHN started work even before its creation through the UHC Act. The recognition of various public and private stakeholders in 2006 of the need for the healthcare, employment and migration sectors to collaborate to further healthcare worker development and regulation[102] paved for the signing of a memorandum of understanding first signed in 2006, and later strengthened in 2013, by 20 different organizations convening what we know today as the HRHN. The creation of this network was initially formalized by an administrative order issued by the DOH as a demonstration of its commitment for managing development of HRH at multiple levels.[103] In its initial conception, the HRHN was the country's means to respond to the unyielding Filipino nurse brain drain, however, the network will also be important at addressing Workforce 2030's[104] recommendation on "strengthening the content and implementation of HRH plans as part of long-term national health and broader development strategies to strengthen health systems." However, it should be noted that there are currently no existing structures or mechanisms that cascade the HRHN recommendations to the local levels. There are also no effective accountability mechanisms between the national structures and governance systems with those of the local government.

On the other hand, the Local Government Code (LGC) delegated the authority to govern the local health system workforce to the local government through the local health boards[105], which was further supported by the provisions the UHC Act's provisions on strengthening the province- and city-health systems especially in managing the local health workforce. Thus, the local health workforce is subject to the management and supervision of the local chief executive and the local health boards, with the guidance of policies and issuances provided by the DOH, CSC, DILG and DBM in recruiting and employing health workers as civil servants.

Existing policy environment also provides guidance on governance mechanism covering mostly health workers practicing in the public sector. For instance, the Civil Service Commission (CSC) issued a policy

instituting the Program to Institutionalize Meritocracy and Excellence in Human Resource Management (PRIME-HRM), which empowers the DOH and its attached agencies, and the LGUs to improve human resource management competencies, systems, and practices toward HR excellence through a program of reward, recognition, empowerment and continuous development.[106] Further complementing that, a Strategic Performance Management System (SPMS)[107] was established to emphasize the link of employee performance with the organizational performance, which enhances results and performance orientation of the government. Existing laws also provide further guidance in governing HRH in terms of accountability and supervision[108] [109], participation, collaboration and coordination, evidence-based decision and policy making, and continuous improvement.[110] [111] In particular, the Seal of Good Local Governance (SGLG) Act of 2019 articulates concrete measures to ensure transparency and accountability of the local governments in implementing health programs, and human resource processes and investments.[112] Guidance to the private sector is limited, with majority of the policies emanating from DOLE[113] [114].

Investments for HRH. 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 growth[115], which an article further supported by citing findings from studies that showed the positive associations of health workforce investments to socio-economic development and productivity.[116] Investing in health workers to improve health outcomes is not a new concept in the country. Even before devolution[117], there was fiscal space provided for investments to be allocated, particularly for rural health workers, to strengthen health service delivery.[118] [119] [120] Since then, there had been several laws passed that provided direction and guidance to increase the fiscal space[121] [122] by aligning investments to current population needs[123] [124], creating decent health sector jobs[125] [126] [127], investing in education, continuous professional development, employment and retention, [128] [129] [130] [131] and mobilizing resources for HRH.[132] [133] [134]

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 Program[135] 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 implemented on 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.[136] [137] [138] [139] [140] [141] [142] [143] [144] [145]

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.[146]

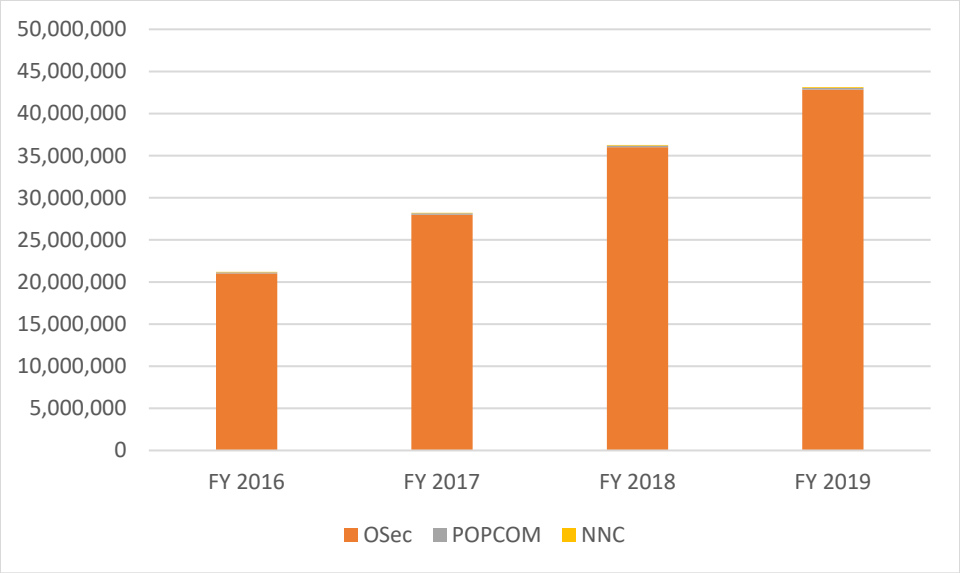


Figure 3. Personal services budget allocation for the DOH and its attached agencies (in thousand), 2016-2019

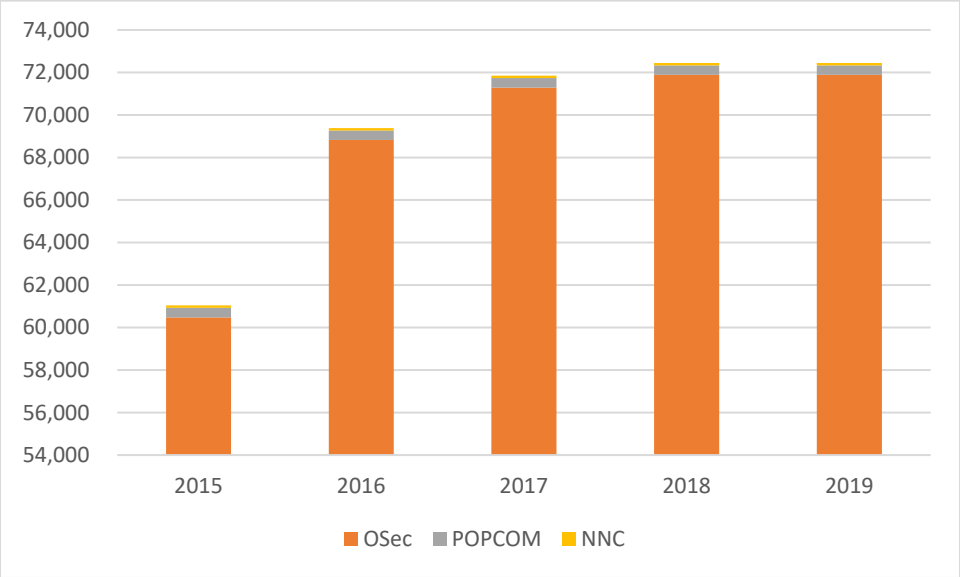


Figure 4. Available permanent positions in DOH and its attached agencies, 2015-2019

Investments to increase supply of health workers in the local health system have been placed by DOH since 1997[147] and have been maintained through the succeeding issuances supporting deployment of health workers such as doctors,[148] [149] nurses,[150] [151] midwives,[152] [153] dentists[154] and other types of health workers[155] [156] [157] [158] 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 tuberculosis[159], adolescent and youth health[160] [161] and family planning.[162] [163] 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.

ICT Growth in HRH. As early as 1995,[164] [165] the Philippines has already recognized that the best available and affordable technologies are important for building and developing the nation. Technologies have become convenient and effective means for collection of data required by policies governing information systems on labor market,[166] disease surveillance, health,[167] migration,[168] [169] [170] trainings,[171] among others. Policies related to these information systems include legal provisions on comprehensive regulation of ICT services,[172] provisions for formulation of human resource development to enable personnel to operate and use technology, establishment of physical infrastructure,[173] [174] processes for data exchange[175] [176] and sharing, utilization of data,[177] [178] and data privacy.[179] [180] [181] [182]

In terms of HRH, the Department of Health – Health Human Resource Development Bureau (HHRDB) manages a comprehensive HRH database called the National Database of Selected Human Resources for Health (NDHRHIS) which contains a list of basic aggregated demographic information about selected cadres of health professionals (*Box 5)*.[183] In 2015, a policy[184] was enforced to require hospitals to submit health worker data in their facilities to update the NDHRIS as a condition for licensing.[185] In 2017, the Integrated Database System for HRH Information Systems (IDS) was launched which collects aggregate HRH data in multiple sectors following the WHO's lifespan strategies approach.[186] There is no updated policy governing the IDS, but according to the DOH Information Systems Strategic Plan,[187] this is in line with the outdated EO 102 which redirects the functions of the DOH.

Although the ICT sector in HRH has developed through the current policy landscape with clear provisions on physical infrastructure, regulation and capacity development in the use of technology. There are many gaps that policies need to address in terms of harmonizing several existing information systems which may have different processes for data exchange, sharing and utilization. The global standards also underline the need to shift health information systems to be responsive and people-centered bridging the interconnection of human resources and technology. These are discussed as policy issues identified in this review.

Box 5. Types of Information Collected by the NDHRHIS

Basic Disaggregated Demographic Information Collected by the NDHRHIS (As of Dec 31, 2017 Archive)

1. **Distribution of Selected Health Providers According to**
   a. Age
   b. Sex
   c. Overall Service Type
   d. Overall Employment Category
   e. Overall Ownership Type
   f. Employment Category of Affiliation
2. **Distribution of Provider Affiliation According to Place of Practice**
   a. Nationwide by Region
   b. Specific Province

Policy Issues

As discussed in the key policy developments, it may be presumed that the policy environment in the country is already closer to being able to comprehensively address the challenges and gaps that faced the management and development of the Filipino health workforce. It would appear from the review that the policy landscape of the Philippines, as any other in the world, continues to face important and critical gaps and/or opposing intentions which may impede the full realization of UHC in the country. Using the HLM framework, the review identified these eight policy issues *(See Box 6)*.

Box 6. Policy Issues Based on the HLM Framework

Policy Issues Identified in the Omnibus Policy Review (Clustered Based on the HLM Framework)

1. **HRH Production Issues :** Expanding and adjusting interprofessional education to the needs for healthcare provider networks (HCPNs) and primary care provider networks (PCPNs)

2. **HRH Inflow and Outflow Issues**
    a. Overcoming policy and implementation impediments in providing competitive salary and enabling work environment to the health workforce
    b. Promoting re-entry of migrant HRH into the health labor force

3. **Workforce Maldistribution and Inefficiencies**
    a. Operationalizing task shifting and task sharing
    b. Rationalizing staffing pattern and standards based on needs

4. **Cross-cutting Issues**
    a. Revisiting mandate of DOH and accountability mechanisms for managing and developing Filipino HRH
    b. Transitioning HRH governance with UHC
    c. Harmonizing institutional governance for HRH data systems
    d. Going beyond Gender and Development (GAD) compliance

These issues show that the country still falls short in strengthening and harmonizing the very fragmented (i.e. national vs. local, cadre-specific vs. interprofessional, private vs. public, etc.) governance systems in HRH production, development, management and data. This section discusses how the current policy environment may not fully or partially support the UHC provisions on HRH. This also includes a discussion about how existing policies that do support UHC are not in line with the global standards.

HRH Production Issues

Expanding and adjusting interprofessional education to the needs for HCPNs and PCPNs. With the health care delivery system reorganized through the UHC, health workers have to be reoriented to work within HCPNs and PCPNs. Because of this structure, the UHC law requires the development and planning for the expansion of existing and new allied and health-related degree and training programs to be responsive to the health needs of the population especially those in GIDAs. Although UHC was clear

about this expansion as well as the inclusion of primary care competencies in health professional and health worker curricula,[188] it was not clear whether this was directly promoting interprofessional education (IPE). The WHO refers to IPE as a collaborative pedagogical approach where students from two or more professions engage together in undergraduate and postgraduate courses to enable effective collaboration and improvement of health outcomes.[189] The UHC law provides opportunities for the medical and health science schools to re-orient health sciences program curricula and offer expanded allied and health-related degree and training programs in regions where there are inadequate health workforce production and limited access to training facilities. Interprofessional education is an approach that will facilitate the reorientation of HRH to function better as teams within HCPNs and PCPNs.[190] Both international standards[191] on HRH also recommend the need for health workers of different cadres to collaborate closer and according to a more linked scopes of practice fully utilizing their skills across their scope of professions so that they are more responsive to population health care needs. The High-Level CHEEG[192] recommendation encourages the need to scale up transformative education so that health workers can match their skills with the needs of populations based on their full potential.

The idea of IPE is not new in the global application of HRH. Applied to medical and nursing students, IPE showed the development and promotion of interprofessional thinking and acting, attainment of shared knowledge, improvement in knowledge exchange and mutual understanding. However, it was found that the major barrier of IPE is coordinating and harmonizing curricula of the two professions.[193] In a comprehensive survey of IPE initiatives around the world, research shows that most of these initiatives are undertaken in developed countries, mostly at the undergraduate level, and mostly conducted under the main discipline in nursing.[194] The Philippines still follows the traditional model of HRH professional training in which health profession students and workers are educated and trained respectively in isolation from the other cadres[195] despite the recognition that they are expected to work within teams[196], even more so now in the reorganized health care delivery system of UHC[197]. This is mainly due to disparate professional practice acts which specifically require the siloes of curricula among the different professions, required competencies, and scope of practice. Although not supported by any clear national policies, there are emerging IPE examples in the country but to a limited extent in short-term pharmacology trainings[198] or among other cadres such as occupational therapists, physical therapists and speech pathologists[199].

HRH Inflow and Outflow Issues

Although the policy environment has been supportive of promoting decent working conditions for HRH in the country, there are two major gaps that needs to be addressed. These refer to policy and implementation barriers in providing for competitive salary and decent working conditions for the health workforce in the country as well as the re-entry of health workers who are unemployed, out of the labor force or out of the country. Furthermore, it should be noted that although there are policy issuances that promote decent work conditions, these do not guarantee successful implementation unless there are defined operational guidelines and strong buy-in among stakeholders.

<u>Overcoming policy and implementation barriers in providing competitive salary to the health workforce.</u>
The Sustainable Development Goal 8 advocates for "…creation of conditions that allow people to have

quality jobs" to facilitate economic growth.[200] In a tripartite meeting on improving employment and work conditions in health services, health worker shortages, health financing, and changing demands were some of the identified challenges faced by the health sector.[201] In the Philippines where basic services and facilities are decentralized,[202] the local governments have the responsibility to ensure that enough resources are allocated to ensure good health and quality of life for the population within its jurisdiction. However, LGU-managed health facilities compete with other units of the local government for human resource allocation.

The health workforce is an important building block of the health system. Existence of HRH problems like health worker shortages or poor work conditions hinder quality service delivery. The existing policy environment covering health workers hired by the local government in the country placed measures to encourage retention by improving compensation or incentives[203] [204] and work conditions,[205] [206] [207] [208] [209] [210] [211] and providing opportunities for professional development. [212] [213] [214] [215] However, Section 325 of the Local Government Code (LGC) had set a limit on local government appropriation for personal services known as the Personal Services (PS) cap set at 45% for 1st to 3rd class provinces, cities and municipalities, and 55% for 4th to 6th class provinces, cities and municipalities.[216] Personal services (PS) refer to all budget items intended to pay for salaries, wages, step increment, and other compensation of LGU-hired employees.[217] With the allocation limit to hire health workers, health facilities tend to be understaffed and public health workers are faced with high workload pressure.

Recent policy developments brought about by the MCPHW and the UHC Act attempted to address the understaffing and overloading in the public health sector through contextualizing staffing requirements,[218] and directing relevant agencies to create job positions as necessary to respond to the changing population needs.[219] Unfortunately, neither of these policies explicitly overrule Section 325 of the LGC. It is unclear whether the Special Health Fund (SHF) arising from the financial integration of the province- and city-wide health system established by the UHC Act will also be subjected to PS limitation.

Current policy landscape provides guidance on fiscal space and decent work conditions for HRH. There are limited policies on salaries and compensation of health workers in the public sector, while these rarely cover the private sector. Public health worker salary and compensation is covered by the Compensation and Classification Act of 1989 and subsequent issuances concerning salary standardization across all civil servants. Public health workers also enjoy compensation provided by the MCPHW, while nurses working for and with government health facilities are entitled to the salary and compensation provision indicated in their professional act[220]. Guidance to salary and compensation of health workers in the private sector, however, are limited to the provisions provided by the labor code and subsequent supporting issuances like the Magna Carta for Women,[221] [222] and recently the UHC Act. Existing policy environment governing the private sector only provides measures to the promote decent employment and work condition, and provisions on promoting competitive salaries are not yet articulated.

<u>Promoting re-entry of HRH into the health labor force.</u> Currently, there are limited policies in place promoting re-entry of licensed health professionals into the health workforce. The Amendment to the Migrant Workers Act provided guidance for re-entry of migrants, regardless if they are health workers or not, into the Philippine labor force. [223] [224] However, policies promoting re-entry of professionals who

are currently out of the labor force are outside the scope of any policy reviewed. Although it has a provision on job creation, even the UHC Act does not have provisions on measures in handling and facilitating re-entry of licensed professionals who are out of the Philippine health labor force, especially migrant health workers who would want to serve again when they come back into the country.

Workforce Maldistribution and Inefficiencies

The main approach of UHC to address workforce maldistribution and inefficiencies aside from HRH planning, management and deployment is its introduction of the HCPNs and PCPNs.[225] This introduction of networks also provide an opportunity for the current health workforce to become practice-ready as health service delivery becomes even more collaborative rather than provided in silos or cadre-specific.[226] The whole-of-society approach to support the practice of primary health care would address the maldistribution and inefficiencies brought about by the fragmented health care system during the pre-UHC period.[227]

Operationalizing task shifting and task sharing. Given this, there is a need to rethink how available HRH in areas especially those with maldistribution and high inefficiencies will be fully optimized to deliver health services within HCPNs and PCPNs. Task shifting and task sharing, in the policy context for HRH, refers to a method where health professional groups can substitute for one another in fulfilling specific tasks while still achieving the best results and outcomes in the model of care given the available and often limited health workforce.[228] There is evidence to support the benefits of task shifting and task sharing in the delivery of health care services and programs given the proper mechanisms supported by policy.[229] [230] [231] [232]

Task shifting isn't new to the Philippines. In fact, the HRH practice acts - of medicine[233], nursing[234] [235] and nutrition-dietetics[236] - have limited provisions that allow for a special or temporary permit to practice the scope of profession. For the three professions, task shifting is applied to specific nationalities when shortages of HRH may be filled by foreign-licensed doctors, nurses or nutritionist-dietitians given certain regulations by the respective approving Boards. An additional provision on this limited practice is also present in the Medical Act where medical students who have completed the first four years of medical course, graduates of medicine and registered nurses can render medical services only during the duration of epidemics or national emergencies[237] [238] as declared by the Secretary of Health. The medical technology[239], midwifery[240] and pharmacy[241] practice acts do not have parallel provisions on task shifting. To support task shifting, the policy environment on IPE has to be closely tied with preparing health workers within interprofessional teams from pre-service training to actual practice and to continuous in-service training to build on the synergies of health workers regardless of their cadres. The main policy obstacle is that all practice acts continue to support traditional education of health workers in silos as well as limited practice of the scope of profession. The policy-making community should explore mechanisms that will continue to respect the boundaries of professional training and specialized practice but at the same time consider the need for efficient distribution of HRH in order to provide greater access to quality health care to many areas with challenges in HRH adequacy.

A less radical alternative to task shifting is task sharing. Task sharing is different from task shifting because the former is focused on sharing the responsibility of delivering of cost-effective and high-quality care

among all health workers,[242] while task shifting is allowing certain cadres to perform functions that are normally ascribed to specific professions. With UHC's HCPNs and PCPNs, there is a need for a policy to operationalize how health workers from different cadres can share tasks within the network without having to be prevented from providing necessary services when needed (i.e., from doing life saving procedures when there is a lack of specific cadres like doctors or pharmacists in a disadvantaged area) but instead blurring out the silos of their practice and providing a whole-of-society approach in the delivery of health care service.

Rationalizing staffing pattern and standards based on needs. Having the right health workers in the right place with the right skills mix is critical to achieving the health goals. In the Philippines, HRH is recognized in the National Objectives for Health (NOH) 2017-2022 as the "main drivers of the health care system and are essential for the efficient management and operation of the public health system". Setting staffing norms had been a practice prior to the devolution.[243,244] Since the adoption of the Local Government Code of 1991, identification of local health system staffing has been the role of the local government due to the devolution of health service delivery.[245] Post-devolution, issuances from the Philippine Government focused on staffing requirements for government hospitals, while the Department of Health have released administrative orders limited to those for licensing hospitals, infirmaries and birthing homes.[246,247]

Despite this, inadequacy in number and exacerbated by maldistribution[248] of health personnel has been an identified challenge in providing service delivery since the NOH 2011-2016, and is still articulated in NOH 2017-2022. Human Resources for Health with permanent plantilla positions at the local level remained generally insufficient to serve the needs of the country in 2016. Cited reasons for the HRH challenge are the Philippines' archipelagic nature, and uneven population distribution and varying levels of economic growth in the regions.[249,250] Furthermore, health care professionals are exposed to high workload pressures that affect the quality of health care services they provide to communities. Workload pressures, especially at primary care facilities, are influenced by various factors such as health workforce supply, utilization rates of health care services, and other health care activities undertaken by the facility.

Although there are provisions in the recently passed UHC Act that provides for creation of additional positions in government for health workers and the creation of a national health workforce support system that can aid local public health systems in addressing their human resource needs, existing challenges in inadequacy and maldistribution of health workers are a manifestation of the need to update current policies and practices on determining staffing requirements of the local health system to be more responsive to the needs of the population and the demand that will result from the passage of the UHC Act implementation. There is a need to put in place policies to strengthen local planning and management of human resources for health (HRH) to ensure that primary care facilities are adequately staffed with trained health care workers who can provide quality health care services and meet the population's health needs.

Cross-cutting Issues

The main cross-cutting policy issues identified in the review refer to concerns revolving governance with the passage of the UHC law. First, there is a need to revisit the accountability mechanisms and the mandate of DOH in terms of HRH management and development since there were several gaps not specified by the law. Second, in preparation of the practice-ready health workforce, UHC will facilitate the transition of several governance systems pre-UHC period including those in-service training, deployment and investment to more evidenced-based effective systems. Several existing policies continue to support governance systems of the pre-UHC period which potentially may serve as barriers to fully achieve the provisions of UHC. Third, UHC strengthened the need and the mandate to fully implement the registry of health workers. With several existing data systems mandated by different laws and policies, the main challenge is to harmonize all of them to provide a supportive and synergistic policy environment. Finally, UHC was silent about strengthening the efforts of the DOH in terms of gender and development (GAD). While UHC continued to underline social inclusion through its prioritization of GIDA and indigenous people communities, there were no provisions for GAD as global standards on HRH management and UHC recommend. Hence, the review also looked into these policy challenges to not only comply with current GAD requirements but to also go beyond it based on global standards.

Revisiting DOH, LGUs and private sector accountability mechanisms for HRH management and development. The UHC Act strengthened the measures for managing and developing country's health workforce to be more responsive to the changing population needs. Provisions of the law focusing on human resources for health reflected an enhanced mandate for the DOH in their role as the major actor in governing the health workforce. The Health Human Resource Development Bureau (HHRDB)[251] is expected to assume the delegated roles and functions in HRH governance arising from the mandate given to DOH by the UHC Act.

The mandate of HHRDB was established by executive orders from the Office of the President for the DOH, the most recent directing the department to ensure quality of training and health human resource development at all levels or the health care system and capacitate the health sector.[252] However, the scope of HHRDB's mandate articulated in the existing policy environment is not reflective of it being the primary HRH unit. According to the definition of the WHO, an HRH unit has the capacity, responsibility, financing and accountability for a standard set of core functions of HRH policy, planning and governance, data management and reporting.[253] [254] Currently, there are components of these functions distributed to other DOH units and other government agencies like CSC, DOLE, LGUs, DBM, PRC, among others.

For instance, the Personnel Administration Division, which is the division responsible to matters pertaining to personnel recruitment, selection and placement, compensation and benefits, performance appraisal, personnel management and welfare service of DOH staff, was transferred to the DOH Office for Administration, Finance and Procurement in 2017[255]. Supervision of the health workforce of the local health system was delegated to the local governments and its corresponding local health boards due to the decentralized nature of the Philippine health sector as mandated in the LGC.

Furthermore, the UHC Act emphasized the DOH's role in managing the health workforce data of the country. This UHC Act provision implies that HHRDB will be the data repository and intelligence unit that will enable evidence-based decision-making in managing and developing the Philippine health workforce. However, this new and critical role is not yet reflected in any policy document of DOH or HHRDB. There is also a need to define the mechanisms on how the private sector will be engaged in managing and developing human resources for health in the country. Currently, the participation of the private sector in HRH management and development are mostly in facility based HRH management and development. With the LGUs primarily responsible for health care delivery and employing health workers at the front lines, they need to coordinate and align with DOH HHRDB HRH development directions.

Transitioning HRH Management with UHC. With the country's transition to UHC, DOH is now shifting to province-wide and city-wide health systems for the delivery of population-based health services. This requires a change from the previous vertical programming or disease-specific health service delivery[256] towards a more integrated approach centering health services on the comprehensive needs of people and communities.[257] This has serious implications to HRH governance specifically in in-service training, deployment and investment. The UHC provision on the six-year transition period[258] should articulate specific strategies from shifting to the programmatic to the people-oriented approach not only focusing on the end point of health service delivery but also from its source which are its human resources.

For instance, the UHC provisions on the integration of over 100 provincial and city health systems challenge previous governance systems set by laws[259] [260] [261] [262] mandating LGUs to implement health services that are structured based on the burden of locally endemic diseases (e.g. malaria, dengue, schistosomiasis) and delivery of health programming (e.g. expanded program of immunization, maternal and child health, family planning).[263] Because of this previous focus, in-services trainings of HRH were heavily focused on the control of diseases and health programming. Under UHC, health professional and health worker curricula (both pre-service and in-service) are now reoriented to primary care competencies. There needs to be a transition from the fragmented in-service training approach prior to UHC where development of competencies is adapted to the readiness of health professionals and health workers to deliver the disease-specific interventions (e.g. cancer[264], tuberculosis[265] [266], HIV and AIDS[267] [268]) or health programs (e.g. family planning[269] [270], immunization[271]).

Personnel and infrastructure have also been complemented to such programmatic approach. For instance, under the National Integrated Cancer Control Program, the number of personnel increased in the program under the Disease Prevention and Control Bureau (DPCB) as mandated by its corresponding law. The same law also created complementary infrastructure such as Cancer Care Centers and Regional Cancer Centers which also require funding from the local investment plan for health (LIPH) and the Philippine Health Facility Development Plan.[272] There may be a challenge in sourcing funds for specific disease-based programs, and UHC mandated service delivery integration since devolution principles necessitate that public health programs should be prioritized in the multi-year budgets focusing on the reduction of burden of diseases.[273] [274] Since most programs have parallel training, deployment and infrastructure provisions based on the programmatic approach, both HRH and the LIPH may be overburdened by conflicting provisions set by the laws. Another issue with competing funding

sources between vertical programming and people-oriented approach is that HRH hired or staffed by national health programs may receive different incentives compared to those hired by local health systems as mandated by law based on program or health system performance.[275] If UHC provisions do prevail over in the implementation, a systematic transition should be in place to address these issues.

Aside from the funding source, the governance of financial resources to support UHC especially the introduction of the special health fund (SHF) may be vulnerable to local government politicization. This fund refers to all incomes derived from PhilHealth payments which is supposed to be used for the improvement of the health system in the LGU.[276] The UHC transition plan should consider lessons learned[277] from the devolution of health care when LGUs were unprepared to take over health governance especially in terms of financial resources through clear rules and regulations for transparency and accountability.

From issues on national funding, another significant challenge for the transition within the country on UHC is harmonizing international funding which is mostly oriented to vertical programming and not towards a people-oriented approach. Since the issue of "de-verticalizing" international financial support for health is a matter outside the Philippine policy landscape[278], harmonizing the strategies in UHC transition plan should consider and not abandon both financial and technical support to public health programs. For instance, current USAID Philippines funding streams are based on program priorities such as detecting and treating tuberculosis as well as improving family planning and maternal, neonatal and child health.[279] Three major direct implications of the international funding of vertical programs to HRH are the discrepancy in salaries between national and international funded HRH[280] [281]; the production of fragmented information management systems; and, the different monitoring and evaluation mechanisms for reporting to funding agencies and host countries[282]. A related concern with internationally funded HRH may also produce a false perception that health worker shortage is addressed when in fact these may just be filled up by unsustainable sources of HRH and not permanent health worker positions which will also spur poor LGU absorption of deployed health workers.[283] Internationally-funded health projects must be systematically engaged in UHC transition from vertical programming to people-oriented approach by ensuring that gains from previous and current initiatives of international vertical programs are integrated to the strategies for achieving UHC.

Harmonizing Institutional Governance for HRH Data Systems. There has been significant ICT growth in the HRH sector strengthening HRH data collection through UHC. However, there are several looming issues in ensuring that different systems of institutional governance for HRH data systems and standards are harmonized among LGUs and even between the national and local governments. The harmonization of institutional governance for HRH data systems require that existing policies address challenges in HRH data collection, support a commonly shared information system, develop capacity building strategies to improve current practices on data systems, and maximize use of data in policymaking.

Despite several laws and policies[284] [285] mandating the collection of data and information in several sectors including HRH, the DOH HHRDB recognizes challenges in completely addressing gaps in data collection on HRH in the country.[286] Much of these challenges are brought about by presence of several information

systems[287] [288] and the lack of human resource or capacity to implement these at the LGU and national levels.[289]

From the national to the local levels, different information systems exist, created either by different laws or policies. At the national level, the GovCloud hosts seven data and information management systems which do not include HRH.[290] At the department and agency level, LGUs are required to collect and submit data and information for several program-based indicators which become tedious due to repetitive reporting forms[291]. At the DOH, each agency has its own database with HRH data collection components as needed and as specific to the particular agency.[292] At the local government level, every city and municipality are required to collect and submit data for various information systems.[293] For instance, cities and municipalities have to implement the community-based monitoring system which is an organized technology-based system connected to a national databank of collated economic and social information.[294] Since UHC is designed with a governance system of province- or city-wide health systems, HRH data systems will also follow such reporting mechanism. Therefore, there is a need to harmonize this government structure with current ones at the LGU level to make sure personnel are not overburdened with tedious processes of data reporting and their efforts are not unnecessarily duplicated. There have been steps to harmonize the implementation of the various information systems and to feed to the over-all monitoring strategy[295] of the country. For instance, an interagency committee is mandated by law[296] to require all government agencies to make available and establish free-flow data exchanges but this is only limited to migration data, including HRH migration. The national government has committed to minimize these duplicated efforts and to increase interoperability and interconnection of all these databases but is yet to craft a law or policy. [297]

Another issue is the availability and capacity of personnel, especially in the local level, to set up the mechanisms and processes required to implement health information systems including HRH. In the local government code (LGC)[298], information officers are lodged in the municipality, city and province but their scope of work doesn't focus much on the operations of information systems but rather on information dissemination. Training programs are institutionalized for ICT but these relate mostly on making personnel capable of operating and utilizing electronic appliances and computers.[299] In 2006, an inventory of capacity development activities in the LGU level reveals that while there are some activities specifically focusing on network and database administration, these are mostly heavy on building information and knowledge without clear strategies for converting such in knowledge application or in improvement of current practices.[300] Laws and policies should address the designation of specific personnel or maximization of available human resources to fully operate and manage the various information systems in the different levels and should be equipped with the necessary and updated knowledge and skills to apply in the work setting. The DOH HHRDB has communicated this priority in 2019 highlighting the need for improving HRH information system governance, operationalization, dissemination, funding and sustainability.[301]

The end goal for information systems which is to maximize the use of data to inform policies has been challenging as well. The Seal of Good Local Governance[302], a monitoring mechanism for LGUs, reward local governments' capability to make use of data from health information systems but this data utilization emphasizes only monitoring improvement of peoples' health status but does not include data utilization

for updating and strengthening HRH management. The DOH acknowledges this limitation noting that data utilization and research results are directed only towards improving traditional[303], alternative, preventive and curative health care modalities.[304] [305] [306] There is no system or incentives that facilitates the utilization of data from HRH information systems to update competency, curricula and training methodologies for health worker education.

Going Beyond Gender and Development (GAD) Compliance. The Philippines prides itself as the only nation from Asia to be part of the top ten most gender equal countries in the world. However, in 2018, the country reopened a previously closed gender gap on health and survival.[307] That is why much of the gender and development (GAD) initiatives by the government centered on addressing the reopened gap by focusing its efforts on health service delivery for women's needs, e.g. maternal and child health, reproductive health, family planning, etc. In addition to these efforts, the country's commitment to GAD is evident in its legislation through policies like the Women in Development and Nation Building Act[308], the Anti-Sexual Harassment Act[309], the Anti-Violence Against Women[310] and their Children Act and the Magna Carta of Women[311]. These GAD-related laws also have relevant provisions that are applicable to the health sector. Other laws that are not specifically GAD in nature but contain provisions protecting women's human rights[312] and GAD integration in government agencies[313] are also covered in other policies. However, most of these GAD-related policies and provisions mostly cover strategies and interventions focusing on service delivery and less on actual HRH development and management. This is not unique to the Philippines though, as there is an actual dearth of studies or investigation that looks into gender equity records and practices in planning, development and management of HRH.[314] The policy landscape in the country that is related to HRH development and management relates only to strategies especially in the elimination of gender discrimination and sexual harassment in the workplace.[315]

But as pointed out in the Workforce 2030 and CHEEG[316] strategies, GAD strategies in HRH must also include "gender-sensitive attraction and retention policies," "gender-balanced opportunities to correct competency gaps," "institutionalize women's leadership" and "tacking of gender concerns during health reform processes." The move to push for these gender-transformative initiatives especially targeted to HRH may be low even in the DOH leadership as there is no discussion of gender or women and men's issues in the HRH management and development strategies outlined in the recent National Objectives for Health 2017-2022.[317] From a health systems review, the GAD agenda relies on the availability and capacity of the focal points in the LGU as health is devolved and there is a persistent perception that GAD only refers to women and children's issues.[318] Currently, GAD is still seen from the lens of provision of health services and setting up or improvement of service facilities dedicated to maternal and child health (MCH). At times, the mandated GAD budget is used for implementation of MCH and RH health programs[319] or are used for activities promoting personnel's physical fitness or healthy lifestyle.[320] There is a need to shift this perception limited to compliance for the DOH especially HHRDB to look at GAD with the CSC's view of gender which includes the inclusion of "gender-sensitive HR/OD systems in the government" as well as the development of "competent and credible civil servants who are gender responsive."[321] For instance, policies can look into how gender-specific issues relate to improving career mobility, ensuring supportive and inclusive work environment, promoting family-and-work balance, and guaranteeing access to education and professional development. All of these issues are highly correlated

with enhancing job satisfaction and retention especially for the HRH workforce who are mostly women especially in childbearing age, and their partners, retaining them in the active labor market. [322]

Although UHC doesn't clearly include specific provisions on GAD, there are existing opportunities that can be maximized through policies that includes gender competencies in health workforce[323], integration of gender and rights-based concerns in the training for integrated reproductive health, and mainstreaming of gender-related concerns in the POPDEV planning guide.[324]

Policy Support to the Human Resources for Health Masterplan

Policies included in the inventory were analyzed with regards to its potential support to the identified strategies to address persistent and emerging issues being faced by Human Resources for Health. It was observed that the existing policy environment is generally supportive of the 30 strategies being considered in the Human Resources for Health Masterplan. The illustration below summarizes the extent of current policy support in implementing these policies.

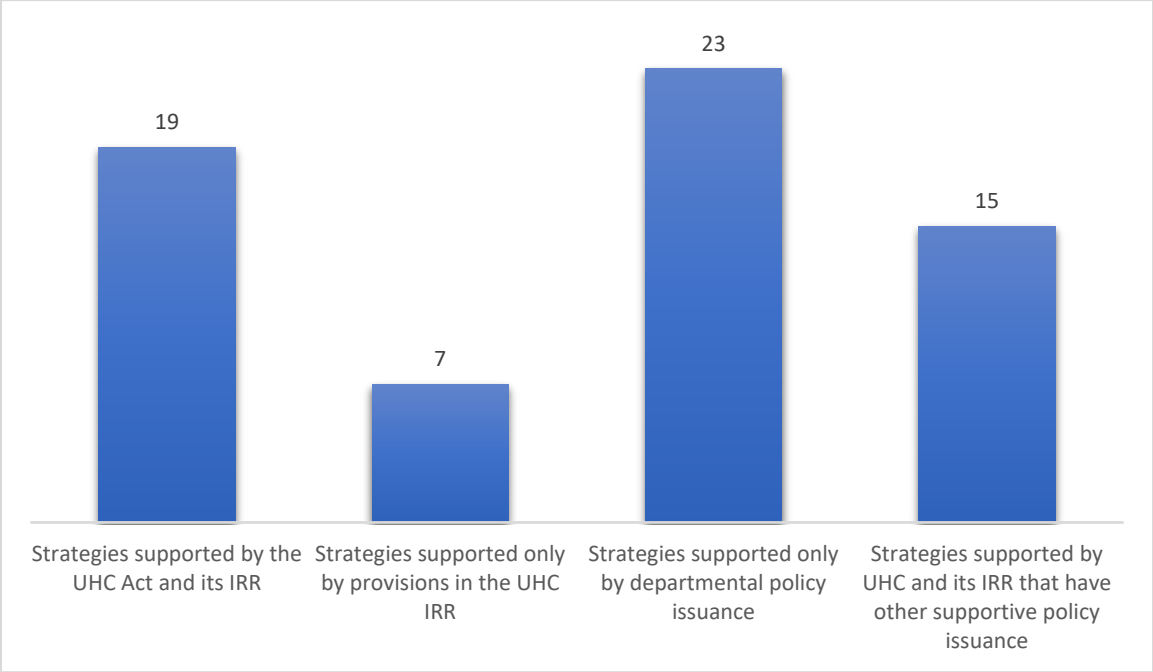


Figure 5. Policy support to identified HRH strategies

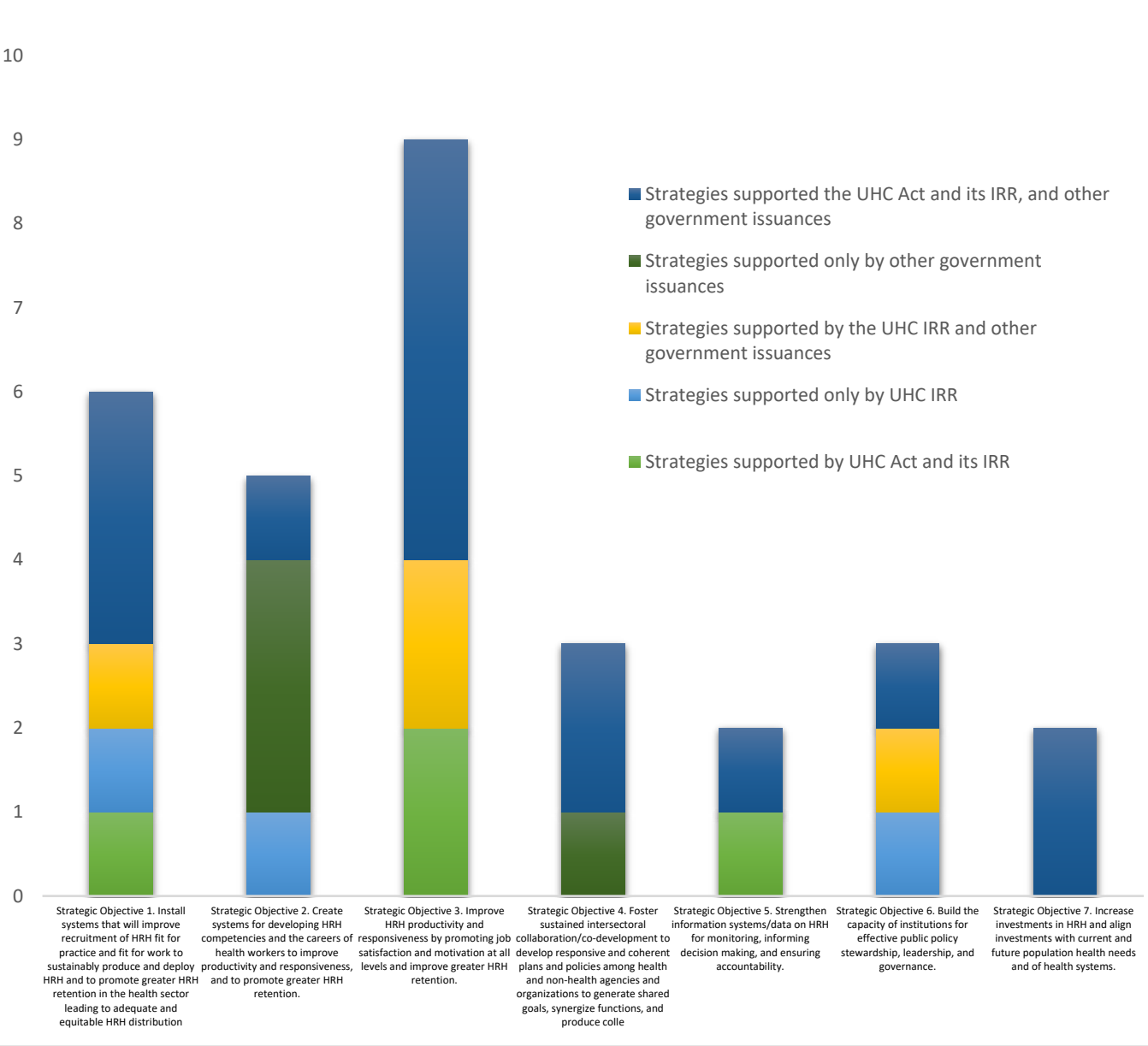


Figure 6. Policy support to identified HRH strategies per Strategic Objectives

It is important to note that there are 10 short-term, 1 medium-term, and 4 long-term strategies explicitly supported by UHC and its IRR that have other supportive policy issuances. It was further observed that there are 4 strategies not currently covered by provisions of the UHC Act and its IRR, which includes a long-term strategy (i.e., Enhancing health workers migration policies to consider the country's population health needs) and short-term strategies (i.e., Support career development of BHWs; Enforce/strengthen the provision of coaching, mentoring, and supportive supervision to health workers; and, Develop career paths of health workers)

Given the current policy environment, it was observed that translations of provisions from the UHC Act and its IRR to implementation policies and operational guidelines is limited. Although all strategies

are supported by either the UHC Act or other existing policies, some strategies were found to be just implicitly supportive and might need further policy support in articulating implementation arrangements to ensure effective implementation. Furthermore, existing policies need to be reviewed to ensure that provisions of the UHC Act and its IRR are reflected or articulated.

Recommendations

The passage of the UHC provides several opportunities for building on the strengths of the previous policies on HRH development and management as well as addressing the gaps brought about by policy provision conflicts or deficiencies. From the identification of the key policy development and policy issues, this review yields five major recommendations:

1. Raise the HRH policy agenda

There is an opportunity to bring forward a policy agenda which addresses the major issues that covers the working lifespan of health workers, from pre- and in-service training and education, workforce, to exit and re-entry (Table 1). The genda also includes key crosscutting issues that impact on HRH management and development. Resolving the policy agenda will contribute to the crafting of an omnibus policy, as discussed in in the next section.

Table 1. Proposed policy agenda

Issues	**Rationale**	**Policy agenda**
HRH Production		
Expanding and adjusting inter-professional education (IPE) to the needs for HCPNs and PCPNs	The UHC law is unclear about IPE, which is a collaborative pedagogical approach where students from two or more professions engage together in undergraduate and postgraduate courses to enable effective collaboration and improvement of health outcomes.[325] A major barrier of IPE is coordinating and harmonizing curricula of the two professions.[326] Most IPE initiatives are undertaken in developed countries, mostly at the undergraduate level, and mostly conducted under the main discipline in nursing.[327] There are emerging IPE examples in the country but limited to short-term pharmacology trainings[328] or among other cadres such as occupational therapists, physical therapists and speech pathologists.[329]	Craft a national policy on IPE to guide collaborative pedagogical approach.
HRH entry, exit & re-entry		

Issues	Rationale	Policy agenda
Need to overcome policy barriers in providing competitive salaries and enabling work environment to the health workforce	The existing policies covering health workers hired by the local government encourage retention by improving compensation or incentives and work conditions, and providing opportunities for professional development. However, section 325 of the 1991 LGC sets an allocation limit to hire health workers which has led to health facilities being understaffed and public health workers faced with high workload pressure. The Magna Carta for Philippine Health Workers (MCPHW) and the UHC law does not explicitly overrule the provision in the 1991 LGC. There are limited policies on salaries and compensation of health workers in the public sector, while there are rarely covering the private sector.	Identify national policy that will address Section 325 of the 1991 LGC code which sets the limit on appropriations for personal services Extend policy provisions that provide competitive salaries and improved working conditions for health workers in the public sector to those in the private sector
Need to provide incentives to encourage re-entry of HRH into the health labor force	The Amendment to the 1995 Migrant Workers Act provided guidance for re-entry of all migrants into the Philippine labor force. The UHC Act does not have provisions on managing and facilitating re-entry of licensed health professionals who are out of the Philippine health labor force, including migrant health workers.	Craft policies to support the re-entry of HRH into the health labor force
Need to operationalize task shifting and task sharing to facilitate team work in primary care	Task shifting and task sharing, are approaches where HRH can substitute for one another in fulfilling the professional practice or specific tasks in the context of a limited health workforce while still achieving the best results and outcomes. There is evidence to support the benefits of task shifting and task sharing in the delivery of health care services and	Craft policies on task shifting and task sharing of health workers in order to fully optimize the delivery of health services within HCPNs and PCPNs especially those in areas with inadequate HRH and high inefficiencies

Issues	Rationale	Policy agenda
	programs given the proper mechanisms supported by policy. Task shifting in the Philippines is possible for medicine, nursing and nutrition-dietetics during shortages when foreign-licensed professionals are allowed to practice. It is also possible in times of epidemics or national emergencies when students who have completed the first four years of a medical course, graduates of medicine and registered nurses can render medical services.	
Need to rationalize staffing patterns and standards based on needs	Having the right health workers in the right place with the right skills mix is critical to achieving the health goals. However, in the Philippines, inadequacy and maldistribution[330] of health personnel has been an identified challenge in providing service delivery. Furthermore, health care professionals are exposed to high workload pressures that affects the quality of health care services they provide to their communities.	Establish appropriate and evidence-based HRH planning and management mechanism that will ensure adequate and responsive health workforce Institutionalize HRH staff
Cross cutting		
Determine whether DOH has the mandate and accountability mechanisms for managing and developing Filipino HRH	The Health Human Resource Development Bureau (HHRDB)[331] is expected to assume the delegated roles and functions in HRH governance arising from the mandate given to DOH by the UHC Act. However, the scope of HHRDB's current mandate is not reflective of it being the primary HRH unit. At present, components of the functions around capacity, responsibility,	Develop accountability mechanisms among national government agencies, the LGUs, and the private sector to ensure a standard set of core functions of HRH policy, planning and governance, data management, and reporting

Issues	Rationale	Policy agenda
	financing and accountability for a standard set of core functions of HRH are distributed to other DOH units and other government agencies like CSC, DOLE, LGUs, DBM, PRC, among others.	
Transitioning HRH governance synchronized with UHC provisions	With the transition to UHC, a change from vertical programming or disease-specific health service delivery[332] towards a more integrated approach centering health services on the comprehensive needs of people and communities is needed.[333] This implies the re-alignment of in-service trainings, personnel, infrastructure, and national and international funding away from disease-centric approaches. It is also necessary to put governance measures in place to avoid potential local government politicization of financial resources to support UHC especially the SHF.	Develop national and sub-national policies that will articulate HRH strategies that support the shift from vertical programming to a people-oriented approach focusing on the delivery of primary health care services
Need to harmonize institutional governance for HRH with their data systems and make them inter-operable	From national agencies to LGUs, different and independent information systems exist created by laws or policies. While there have been steps to harmonize the various information systems and to feed to the over-all monitoring strategy, this is insufficient to meet the requirements of inconsistent with UHC implementation that requires a governance system of province- or city-wide health systems. Compounding the problem is availability and capacity of personnel, especially in the local level, to set up the mechanisms and processes required to implement health information systems including HRH.	Establish policies to harmonize the different systems of institutional governance for HRH data systems and standards among LGUs and between the national and local governments thereby improving current practices on data systems, and maximizing the use of data in policymaking.

Issues	Rationale	Policy agenda
Need to go beyond Gender and Development (GAD) compliance	The policy landscape related to HRH development and management largely consist of strategies on the elimination of gender discrimination and sexual harassment in the workplace. However, GAD strategies in HRH must also include "gender-sensitive attraction and retention policies," "gender-balanced opportunities to correct competency gaps," "institutionalize women's leadership" and "tacking of gender concerns during health reform processes." [334] [335]	Develop policies that includes integration of gender and rights-based concerns in the pre- and in-service training of HRH, gender competencies in the health workforce, and a gender sensitive work environment.

2. Develop an HRH omnibus policy

The review resulted in the realization that there are many policies that have high variance of provisions that directly and indirectly affect HRH management and development. With such diversity, it is important to harmonize all the strategies and guidelines set by different provisions in various policies into one omnibus policy. The omnibus policy will help set an integrated and comprehensive approach that the DOH, especially HHRDB, can operationalize in the entire process of HRH development and management. It will also be a tool to declare all existing orders, memoranda, and other related issuances inconsistent with UHC and the omnibus policy to be superseded. In addition, gaps based on the policy issues found in this review can also be addressed. This omnibus policy can therefore further reinforce the implementation of currently existing HRH provisions in the UHC law.

3. Integrate governance systems in the UHC transition plan

Several policy issues identified in the review relates to the governance systems set by policies during the pre-UHC period that may be partially in conflict with UHC provisions. This includes the shift of the approach of health service delivery, the creation of new health systems, the establishment of provider networks, among others. In order to avoid the same challenges that happened with devolution shift in health systems in the country, it is important that the UHC transition plan must take into consideration the bringing in of the strengths and best practices of former governance systems prior to UHC and integrate this to the current one. There is also a need to clearly indicate the role of HHRDB in this transition process especially in terms of leadership in HRH development and management.

4. Incorporate policy development and issues into the HRHMP

The reforms introduced in the UHC law recognizes the critical role of the health workforce in the UHC era especially as universal access seeks to improve health outcomes. The formulation and implementation of a National HRHMP espoused by the UHC Act will facilitate a more strategic development and management of human resources for health at all levels of the Philippine health system. This long-term strategic plan will be the overarching guide of the Philippines in its whole-of-society and whole-of-government approach in achieving health sector goals, particularly in harmonizing policies and strategies for the appropriate production, recruitment, retraining, regulation, retention, and reassessment of the health workforce based on population health needs. The master plan should also consider the inclusion of necessary policy development identified in this review to make sure that the strategies are in line with the policy landscape towards UHC attainment.

Next steps

1. Share the results of the omnibus policy review

The quantity and diversity of policies that directly and indirectly impinge on HRH point to the presence of many stakeholders involved in their training and education, management, and development. The review has identified overlapping and/or opposing intentions and provisions in existing policies that can block the development of coherent synergies that will benefit HRH. For instance, the policy landscape supports HRH provisions introduced by the UHC Act particularly on production and management of Filipino health workers within the country's labor force. On the other hand, action is needed in strengthening and harmonizing the very fragmented (i.e. national vs. local, cadre-specific vs. interprofessional, private vs. public, etc.) governance systems in HRH production, development, management and data. By sharing the results of the omnibus policy review, a) awareness can be raised regarding dissonant policies, which can lead to a necessary resolution, and b) stakeholders can update/strengthen their policies that will provide support to HRH.

2. Undertake a policy implementation review

Assessment of the implementation and performance of existing policies in place is imperative to follow this omnibus policy review. This will provide substantial insight on policy implementation - in terms of its output or outcome, its impact, and on whether it contributed to economic or social development. The results of the policy implementation review will inform stakeholders about the capability of existing policies to ensure the achievement of the desired outcomes of the UHC Act and its HRH provisions.

A major result of the policy omnibus and implementation review will be to inform policymakers whether a new law needs to be created or any existing policy will be amended. Creating new laws or amending policies based on evidences generated from the evaluation of the existing policies and their implementation will make the policy environment more supportive of the HRH's performance of their role to ensure universal health care and improve health outcomes. There are already current initiatives from the USAID HRH2030 Philippines activity and DOH HHRDB in crafting policy briefs to guide this recommendation for law creation or amendment.

3. Hold a high-level policy dialogue

A policy dialogue is necessary to bring the policy agenda to the attention of decision makers. The dialogue will be a platform where policy solutions to the prevailing and persistent HRH issues can be identified. Furthermore, commitments to support the HRH masterplan components need to be obtained to generate investments and other resources needed to effectively implement the HRHMP.

Conclusion

The UHC Act, in its aim to protect and promote the right of all Filipinos and instill health consciousness among them, stirred the Philippine health reform towards universal health coverage and improved tje focus on HRH as a critical driver of health system performance. A supportive policy environment to this landmark law, and the measures it introduced to respond to existing HRH issues, is essential to achieve health goals towards an improved quality of life for every Filipinos.

The review showed that there is a growing body of evidence that signals the need for a supportive policy environment of UHC implementation . However, the policy review did not yield too many supportive and updated policies specifically on health workforce management and development in the Philippines. Through this review, it was found that although some of the HRH issues in the country are already being addressed by certain policies even prior to UHC, some real and potential conflicts, overlaps or gaps were present in the current policy environment that may reinforce the persistence of some HRH issues. As a result of the review, a policy agenda to address these policy issues is offered. The potential contributions of this omnibus policy review are dependent on how much the recommendations are taken seriously and implemented by the key policy and program implementation actors in the government and the private sectors. Collaboration of all stakeholders in the government and private sectors as well as civil society will be important to ensure that the aims of the UHC law is carried out into fruition.

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