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Human Resources for Health Philippine Masterplan 2020-2040

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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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Acronyms

AO	Administrative order
BHERT	Barangay Health Emergency Response Team
BHS	Barangay health stations
BHW	Barangay health worker
BNS	Barangay nutrition scholar
BSC	Balanced scorecard
CHED	Commission on Higher Education
CFO	Commission on Filipinos Overseas
CHD	Center for Health Development
CHEEG	High Commission on Health Worker employment and Economic Growth
CPD	Continuing Professional Development
CPG	Clinical practice guidelines
CSC	Civil Service Commission
DBM	Department of Budget and Management
DFA	Department of Foreign Affairs
DICT	Department of Information and Communications Technology
DILG	Department of Interior and Local Government
DND	Department of National Defense
DOF	Department of Finance
DOH	Department of Health
DOLE	Department of Labor and Employment
DOST	Department of Science and Technology
FHSIS	Field Health Services Information System
FLO	Flexible learning option
GIDA	Geographically isolated and disadvantaged areas
HCPN	Health care provider network
HEI	Higher Education Institution
HFDP	Health Facility Development Plan
HHRDB	Health Human Resource Development Bureau
HRH	Human resources for health
HRHMP	Human Resources for Health Masterplan
IACEH	Inter-Agency Committee on Environmental Health
IRR	Implementing rules and regulation

LCE	Local chief executives
LFA	Logical framework approach
LGC	Local Government Code
LGU	Local government unit
LIPH	Local Investment Plan for Health
M&E	Monitoring and evaluation
MDG	Millenium Development Goal
NCD	Non-communicable diseases
NDHRHIS	National Database of Selected Human Resources for Health Information System
NEDA	National Economic and Development Authority
NGO	Non-government organization
NHWA	National Health Workforce Account
NHWR	National Health Workforce Registry
NOH	National Objectives for Health
OSH	Occupational safety and health
OWWA	Overseas Workers Welfare Administration
PDP	Philippine Development Plan
PGH	Philippine General Hospital
PHB	Provincial Health Board
PHC	Primary health care
POEA	Philippine Overseas Employment Administration
PPE	Personal protective equipment
PRC	Professional Regulation Commission
PS	Personal services
PSA	Philippine Statistics Authority
QA	Quality assurance
RA	Republic Act
RSA	Return service agreements
SA	Situation analysis
SDG	Sustainable development goals
SGLG	Seal of Good Local Governance
SO	Strategic objective
SUC	State universities and colleges
TESDA	Technical Education and Skills Development Authority
TWC	Technical working committee

UHC	Universal Health Care
UP	University of the Philippines
USAID	United States Agency for International Development
WHO	World Health Organization
WISN	Workload indicators of staffing needs

Executive Summary

Inspired by the passage of the Universal Health Care (UHC) Act in 2019, the 2020-2040 Human Resources for Health (HRH) Masterplan will serve as a long-term strategic plan for the management and development of HRH. The development of this overarching document is guided by the whole of society and whole of government approach to meet the desired HRH outcomes stipulated in b--UHC Act. The Masterplan shall address "outcomes pertaining to sustainable production, appropriate skill mix retention in the health sector, equitable distribution and practice-ready training and education for HRH" and contribute to the achievement of universal health care and the improvement of the country's health outcomes. The law further stipulates that the HRH MasterPlan will be implemented through a multi-stakeholder Human Resources for Health (HRH) Network, composed of both public and private organizations and agencies, to formulate and oversee the sustainable implementation, monitoring, periodic evaluation, and reformulation of the National Health Human Resource Master Plan.

Consistent with the UHC Act, the goal of the 2020-2040 HRH Masterplan is to provide policies and strategies for the appropriate generation, recruitment, retraining, regulation, retention, and reassessment of the health workforce based on population health needs. The HRH Masterplan defines the current situation of HRH in the Philippines, the strategies that will address the issues that impact on the performance of the HRH and the health sector, the governance and accountability mechanism among the HRH stakeholders, the monitoring and evaluation mechanism that will track the progress of its implementation, and the communication plan to guide its dissemination. The Masterplan will be progressive, technically, economically feasible and sustainable document with sufficient details for implementation and operationalization to guide the health sector to achieve better HRH management and development.

As a key initiative that will address the prevailing issues that confront HRH and simultaneously address current critical health issues such as COVID19, the HRH Masterplan posits that: if fit for practice and fit for work HRH with rural background are provided scholarships and developed near their places of origin; provided decent work, learning and development opportunities, and improved working conditions with their protection and well-being in mind; then HRH in the Philippines will contribute to the improvement of the health system performance and to the improvement of individual and population health outcomes. This is the theory of change that underlies the HRH Masterplan.

The 2020-2040 HRH Masterplan is composed of three sub-plans. Each sub-plan defines the scenarios that need to be addressed, strategic foci of the HRH management and development interventions to address the identified HRH issues, resource requirements, and monitoring and evaluation considerations.

Short-term Plan

The short-term plan (2020 to 2022) is defined based on the current health scenarios that the Philippine health system must respond to. The short-term plan includes an implementation plan defining the activities, schedule, budget and resource requirements, and the monitoring and evaluation considerations. The strategic foci for the first 2 years of implementing the HRH Masterplan are to:

- Produce adequate number of quality HRH to support national and local health system needs
- Recruit and retain sufficient number of HRH towards attaining equitable distribution of HRH at all levels of the health care system
- Promote decent work and protection for HRH
- Build HRH capacities to deal with triple disease burden, prevent and control emerging & re-emerging diseases, and respond to health emergencies
- Establish HRH systems to support strategic health system goals (e.g., HRH governance, information systems, health technologies, etc.)
- Engage policy makers and key stakeholders, at national and local levels, to substantially invest in the health workforce
- Engage communities to participate in providing health promotive and disease preventive care for families (by raising awareness and capacity building)

Strategic objectives and corresponding strategies have been determined and aligned with the abovementioned strategic foci:

Strategic objective 1 (SO 1)

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

SO 1 comprise of four production strategies in the short-term that embeds retention in order to produce adequate number of HRH and reduce inequitable HRH distribution. The strategies address where future HRH should be educated, the admission guidelines of

HEIs, providing scholarships linked to return service agreements (RSAs), and re-orienting current curricula to emphasize primary health care, exposure and immersion to rural topics and practice, and the use of technology. The development of a new range of skill sets, particularly in the delivery of health services using technology, has been incorporated in the strategy on re-orienting curricula. This is vital in public health emergencies such as the ongoing pandemic.

Strategic objective 2 (SO 2)

Create and sustain systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention

Part of the workforce strategies in the short-term, SO 2 focuses on a) improving HRH competencies by enabling them to engage in learning and development through traditional and alternative learning methods including the use of technology, and providing coaching, mentoring, and supportive supervision; and, b) developing the careers of volunteer and professional health workers. The strategies will improve HRH productivity and responsiveness in the workplace and promote greater retention.

Strategic objective 3 (SO 3)

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

SO 3 comprises of short-term strategies on the creation of permanent positions in response to health sector needs and standardizing positions, compensation, benefits, and incentives. The creation of permanent positions will respond to the issue of inadequate HRH in the sector and both strategies will improve job satisfaction and motivation. Three other strategies that will promote job satisfaction and motivation are: ensure the well-being of HRH including their protection, ensure compliance with occupational safety and health standards and infection and prevention control initiatives to improve conditions in the work setting (e.g. telehealth, telemedicine), and ensure that health facilities have the appropriate skills mix. These three strategies will also enable a better response to public health emergencies such as the current pandemic that is COVID19.

Strategic objective 5 (SO 5)

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

SO 5 includes short-term strategies on improvement of HRH information systems to ensure up-to-date and accurate information, and the carrying out of HRH-related research. These speaks to the need for evidence that will regularly inform decision-making and accountability.

Strategic objective 7 (SO 7)

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

SO 7 comprises of strategies in the short term that aim to increase investments in HRH and HRH systems and build fiscal capacity in order to respond to current and future population health needs and of health systems.

Medium-term Plan

The medium-term plan (2023 to 2028) shall focus on strategies that will:

- Sustain production of practice-ready health workforce
- Promote recruitment, and equitable distribution of quality HRH working in underserved areas
- Retain appropriate skill mix in national and submational health systems
- Support career development an advancement of HRH in the health sector
- Enhance HRH competencies to deal with triple disease burden and to prevent and control emerging & re-emering diseases, including strengthening health emergency response teams.
- Improve working conditions to motivate health workers to practice in underserved areas
- Optimize existing health workforce
- Increase health literacy

The corresponding strategic objectives and strategies are as follows:

Strategic objective 1

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

Production strategies under SO 1 launched in the short-term will be sustained, while introducing two more strategies: a) establish inter-profession education (IPE) and training in universities and institutions, and b) provide incentives to HEIs (e.g., tax breaks and subsidies) to ensure quality graduates and provide scholarship grants.

Strategic objective 3 (SO 3)
Raise HRH productivity and responsiveness by promoting job satisfaction and motivation at all levels and improve greater HRH retention

In the medium term, strategies launched in the short-term will be sustained, while sustaining improved health outcomes through standardize care via the implementation of national Clinical Practice Guidelines (CPGs) for priority health conditions.

Strategic objective 4 (SO 4)
Foster sustained intersectoral collaboration/co-development to develop responsive and coherent plans and policies among health and non-health agencies and organizations to generate shared goals, synergize functions, and produce collective impact

Implemented in the medium term, SO 4 focuses on health worker migration policies and programs that should factor in the population health needs of the country, strengthen meaningful private sector regulation particularly in HRH production and employment, and align policies on production, employment, and migration. The nature of these strategies requires close and sustained collaboration and co-development in order to achieve shared goals.

Strategic objective 6 (SO 6)
Build the capacity of institutions for effective public policy stewardship, leadership, and governance

In the medium-term, the HRH Network will be strengthened by expanding its membership and improving representation from a wide array of HRH stakeholders. Other short-term cross-cutting strategies such as on investments in HRH, HRH systems, and technology, improving fiscal capacity, and conducting research will also be continued to ensure that gains are sustained.

Long-term Plan

The long-term plan (2029-2040) shall focus on strategies that will:

- Develop highly competent and motivated HRH who are responsive to individual and population health needs
- Retain HRH for the needs of the health system at national and local levels
- Institutionalize governance, financing, regulation and information systems for HRH management and development
- Support progressive investments for HRH
- Provide sufficient resources and srong legislative or policy support to HRH rights, benefits and welfare
- Ensure that Filipinos share accountability for their individual, family and community health outcomes

The strategic objectives and strategies for the long term include:

Strategic objective 2 (SO 2)
Create and sustain systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention

In the long-term plan, institutionalizing the short-term and medium-term plan strategies are vital. It is also important to identify and implement appropriate activities to facilitate cooperation and support among health workers across HCPNs and the development of professional and health worker networks. This will reduce of professional isolation, promote learning among health workers, and encourage communities of practice.

Strategic objective 3 (SO 3)
Raise HRH productivity and responsiveness by promoting job satisfaction and motivation at all levels and improve greater HRH retention

In the long term, strategies launched in the short-term and medium term should be sustained, while introducing, facilitating and regulating an enhanced and more aligned scopes of practice to health workers' function and population health needs.

Strategic objective 6 (SO 6)
Build the capacity of institutions for effective public policy stewardship, leadership, and governance

In the long term, strategies began in the medium term will be sustained. Additionally, the following strategies will be introduced: building HRH development and management capacity at all levels of the health sector; and establishing, and strengthening where present, quality assurance (QA)/ accountability mechanisms in health facilities. These will build capacity in public policy stewardship and improve leadership and governance.

Implementation plan

There are necessary preparatory activities for the short-term plan that should be carried out prior to the implementation of the Masterplan strategies. These relate in particular to the Masterplan's governance and management, establishing collaboration mechanisms, determining the extent of policy support for the strategies, addressing barriers (e.g. funding, time, people) identified during the consultations, disseminating the Masterplan and obtaining buy-in among different stakeholders, creating localized plans, and developing a monitoring and evaluation system. These are proposed to be done in 2020.

A priority in the Masterplan implementation are workforce strategies that will help contain the COVID19 pandemic and protect and ensure the well-being of HRH during this public health emergency and other like it in the future. In the proposed implementation schedule, workforce strategies targeted for 2020 are those that offer alternative learning development approaches, ensure well-being of health workers including compliance with occupational safety and health (OSH) standards and exploring digital health, and ensuring the presence of appropriate skills mix in health facilities. The strategies on creating permanent positions and standardizing positions, competitive compensations, benefits, and incentives will be implemented in the medium-term. However, the strategy is included in the short-term as certain activities need to be started right away. For instance, activities such as broadcasting widely unfilled government and private HRH positions, reviewing existing policies relevant to the creation of positions, etc. are expected to start in the next two years. Initiating activities in the short-term can help ensure its achievement in the medium-term.

The implementation of cross cutting strategies on investments and HRH information systems are targeted for 2021. It is necessary to implement these soonest as the cross-cutting strategies will help improve the successful implementation of the production and other workforce strategies. This is particularly true regarding the timely availability of resources, and access to accurate and up-to-date HRH information.

Indicative cost of the Masterplan

The indicative cost in implementing eighteen strategies under the five strategic objectives covered by the short-term plan is estimated at PHP 8.3 Billion. Of the estimated total indicative cost, 15% of the cost estimate is for production strategies, 82% is for workforce strategies, and 3% is for cross-cutting strategies. This was derived based on cost drivers for activities of each strategy under the strategic objectives for production, workforce and cross-cutting concerns. The main cost drivers identified for each activity are remuneration and operational cost. Remuneration refers to the amount allocated for labor work to carry out an activity, while operational cost is the amount allocated for direct cost (except labor) to implement an activity. This cost estimate does not yet include the cost of projected staffing needs for the short-term.

Governance and accountability

To implement the Masterplan, the current organizational structure of the HRH Network structure (three technical working committees (TWCs) with the themes of HRH Entry, HRH Workforce, and HRH Exit and Re-entry and an Oversight Committee) is proposed to be reconfigured and assume the functions necessary to implement the Masterplan. The Masterplan's strategies can be categorized consistent with the foci of the TWCs: production, workforce, and exit and re-entry. Due to the similar nature of committees and the strategies, each TWC can assume the broad functions of coordination, monitoring and evaluation of the strategies' implementation. The implementation of cross cutting strategies can be taken on by another committee which will be formed for this specific purpose with the same broad functions as the other TWCs. Membership in each TWC will be unique to avoid unduly creating confusion, and additional and/or overlapping workloads for members. However, reconfiguring the TWCs and their functions will entail revisiting the memorandum of understanding among the members of the HRH Network.

The Masterplan adapts the WHO's three components in its accountability framework: governance, results-based management, and an assurance mechanism. Governance of the HRH Masterplan takes place at the national and local levels and spans across planning, implementation, and reporting. The HRH Network and HHRDB will work closely together to manage and coordinate the implementation at the national level while the implementation of the Masterplan at local levels will be led by Provincial/City Health Boards (P/CHBs). The HRH Network and HHRDB will work closely with P/CHBs in the implementation of the Masterplan. Results-based management is embedded in the Masterplan through its logical framework approach (LFA) matrix that has been developed for all strategies across the strategic objectives. For each strategy, activities, outputs, and outcomes have been identified with corresponding indicators. In addition, the stakeholders that will be critical to the attainment of the strategies have been identified. The LFA can become a binding document if the stakeholders formally recognize it as such. The Masterplan is a collaborative endeavor where its successful implementation relies on mutual accountability and responsibility. The last component, quality assurance, can be found in the accountability mechanisms (e.g. Seal of Good Local Governance, DOH Scorecard, Primary Care Scorecard) that have been identified. In addition to scorecards, the P/CPHBs have a key role to play in the accountability framework. Integral to their functions is the exercise of technical and administrative supervision over HRH within their respective territorial jurisdiction. This reinforces the role of local health boards as outlined in the 1991 LGC which is to propose annual budgetary allocations for the operation and maintenance of health facilities and services; and, create committees which shall advise local health agencies on matters such as personnel selection and promotion, grievance and complaints, personnel discipline, operations review, and similar functions.

A critical input to the three components of the accountability framework is the data that will be produced by the Masterplan's monitoring and evaluation system. Besides informing national and local level planning and implementation of the Masterplan, the data will be a critical input into reports about the HRH components of the 2018 UHC law, NOH 2017-2022, the 2017-2022 PDP, and Goal 3 of the SDGs.

Communications plan

To facilitate soliciting inputs and the commitment of a wide range of HRH stakeholders who need to be involved in the Masterplan, a communications plan was developed. The communications plan aims to widely disseminate the Masterplan among stakeholders and the general public, obtain support for the implementation of the Masterplan, and ensure the appropriate implementation especially at the national and local levels. These will be achieved by shaping and delivering key messages using various communication channels and materials that are known to work, and tailoring the messages to resonate with the targeted audience and bring about desired changes.

Monitoring and evaluation

To determine to what extent the theory of change is achieved and to establish its validity, monitoring and evaluation activities will be made integral to the Masterplan. A balanced scorecard (BSC), a widely accepted approach to monitoring and evaluation (M&E), has been crafted for the HRH Masterplan. The BSC includes a set of high-level quantitative indicators across five dimensions and for each of the strategic objectives of the Masterplan that have been identified. These high-level indicators will show the progress towards the accomplishment of the mission and goals of the Masterplan and have been used in the development of indicators for each strategy in the logical framework approach (LFA) matrix.

Philippine Context

Country profile[1]

The Republic of the Philippines, an archipelago situated in Southeast Asia, consists of more than 7,600 islands that are broadly categorized into three geographical divisions: Luzon, Visayas, Mindanao. Over 80% of the population are Catholics and the rest comprise of Muslims, other Christian denominations, Buddhism and other religions. The country's gross domestic product, which was $355.5 billion in 2019,[2] is expected to decline due to COVID19, the first contraction in two decades.[3] In 2020, the estimated population is 109.9 million, of which 54.7% live in rural areas.[4] [5] Literacy rates stand at 98.3%, one of the highest in Southeast Asia.[6] [7] In October 2019, the unemployment rate was at 4.5%.[8] The proportion of the population living below the poverty threshold of PhP10,727 was at 16.6% or 17.6 million Filipinos in 2018.[9]

Filipinos are living longer, from 67 years in 2000 to a projected 72 years in 2020.[10] Non-communicable (NCDs) and communicable diseases were the top 10 causes of mortality in 2016 in the Philippines. NCDs include ischemic heart disease, neoplasms or cancer, cerebrovascular diseases or stroke, hypertensive diseases, diabetes and other heart diseases, and communicable diseases like pneumonia, respiratory tuberculosis and chronic lower respiratory infections. On the other hand, the leading causes of morbidity in 2016 were all communicable diseases such respiratory infection, acute lower respiratory tract infection and pneumonia, except for hypertension. Filipinos bear a triple burden of disease with the high prevalence of communicable disease, increasing NCDs, and from injuries and accidents.[11]

Philippine Health Workforce

The number of HRH who renewed their professional identification cards with the Professional Regulation Commission (PRC) data was 861,891[12] in 2020 suggesting that the health sciences education sector produces enough health workers for the Philippine health system. However, data from National Database of Selected Human Resources for Health Information System (NDHRHIS), Field Health Service Information System (FHSIS), and the Department of Health (DOH) Deployment Program as of 2019 indicate that there are 189,204 HRH or 28% of the total, representing 13 cadres in the health system.[13] The remaining 672,687 HRH or 72% that renewed their PRC ID have unspecified practice.

There are many indicators of the demand for HRH in the local health system. Data from the DOH-Personnel Administration Division (PAD) as of December 2019 show that there are 5,405 unfilled positions in the Department, covering the Central Office, Centers for Health Development retained hospitals and treatment and rehabilitation centers.[14] An estimated 25% of all barangays in the Philippines do not have any health workers.[15] When compared to the World Health Organization (WHO) estimate of 44.5 per 10,000 population needed to achieve coverage of sustainable development goals (SDGs), there is a gap of about 25 HRH per 10,000 population in 2018 in the Philippines. The workload indicators of staffing needs (WISN) study in 2019 estimated requirement of 240,780 physicians, nurses, midwives, and medical technologists in all rural health units (RHUs) and 12,950 nurses and midwives in barangay health stations (BHS) to strengthen primary care services.[16] In response to the COVID19 pandemic, provincial targets established by the DOH include at least: one epidemiology and surveillance officer for every 100,000 population, one contact tracing personnel for every 800 population, Barangay Health Emergency Response Teams (BHERT) for every 1,000 population, and 10 trained testing staff.

Health care services in the Philippines is delivered by a composite of public and private health facilities. Funded mainly by a tax-based budgeting system, PhilHealth capitation, and user fees, the public sector delivers health care through national and local government health facilities. At the national level, the DOH supervises the government retained corporate hospitals, specialty, regional hospitals, and selected primary hospitals, while the Department of National Defense (DND) operates the military hospitals and the University of the Philippines (UP) Manila is in charge of the Philippine General Hospital. Beginning with the devolution of health services in 1991, the provincial governments operate the district and provincial hospitals, and municipal governments provide primary care through rural health units, health centers, and barangay health stations. Highly urbanized cities provide hospital and primary care services through city health centers. The private sector exacts user fees for health care at the point of service.[17] In 2019, there were 1,198 public and private hospitals, 22,613 barangay health stations, 2,596 rural health units, 253 primary care facilities, 674 infirmaries, and 1,906 birthing homes.[18]

Philippine HRH Challenges

There are standalone reports and studies that serve as the basis in the preparation of the HRH Masterplan. These include a Situation Analysis Report, a Strategy Paper, the HLMA Report, and the Policy Omnibus Review Report. From the situation analysis (SA) of the HRH Masterplan, the core problem identified was the lack of fully functional integrated HRH systems including information systems, production and deployment planning, professional development, attractive compensation packages, management and regulation, and

sustainable deployment. Two of its major effects (i.e. inadequate number and inequitable HRH distribution) and four key causes of the core problem will be addressed by the Masterplan.

- Inadequate number of health workers in the health sector. This caused in part by fewer number of graduates in the health sciences due to high attrition rates; the limited number of decent jobs in the health sector; unclear career paths of health workers; the inadequate support for health workers' health, safety, and well-being; and the increasing demand for Filipino health workers in destination developed countries.
- Inequitable distribution of HRH. Factors affecting maldistribution include the inadequate remuneration in low income class municipalities; disparities in salary between private and public sectors, and national and local levels; and the inability of some local government units (LGUs) to absorb health workers such as those who are deployed. In addition, the poor working conditions and the characteristics of the place of assignment that increase their personal risks can affect retention adversely.
- Lack of accurate HRH information to guide planning and policy. The currently available data on the number of health workers in the country is not up to date, comes from *disparate information systems*, and does not accurately reflect the actual numbers. There is no data on health workers that are out of work or unemployed nor data on number of migrants and those who return from working abroad. There is no single integrated source of HRH related data and information.
- Limited collaboration among stakeholders with multiple roles in the HRH sector. Many of the HRH stakeholders operate independently. The HRH Network was established in order to act as an integrating mechanism for discussing issues, policy making and carrying out collaborative decision making, data sharing, and policy implementation, among others. But its effectiveness can still be improved.
- Fragmented HRH governance and unclear accountabilities. The DOH is responsible for the recruitment of health workers at the national level, the Deployment Program, and for DOH retained hospitals. On the other hand, LGUs have the responsibility of staffing field health facilities. Locally recruited HRH are not always adequately compensated, provided benefits or given security of tenure, which can be traced to policy issues such as the personnel services (PS) cap mandated in the 1991 Local Government Code (LGC), and the income of municipalities and provinces. The private sector, while guided by the policies, standards, and programs established by the DOH, operates independently and are not necessarily aligned to DOH directions.
- Lack and poor implementation of policies. There are several policy gaps and issues such as on competency standards and skills mix, effective deployment of HRH, strengthening health leadership and performance management systems, among others. Additionally, there are policy gaps in the development of HRH information systems. There is poor implementation of HRH policies. There is a lack of consistency and strategic coherence in linking critical policies between health, education, labor, and other sectors. Policies emanating from non-health sectors especially the economic and financial sector also impact the HRH sector.

National HRH Masterplan

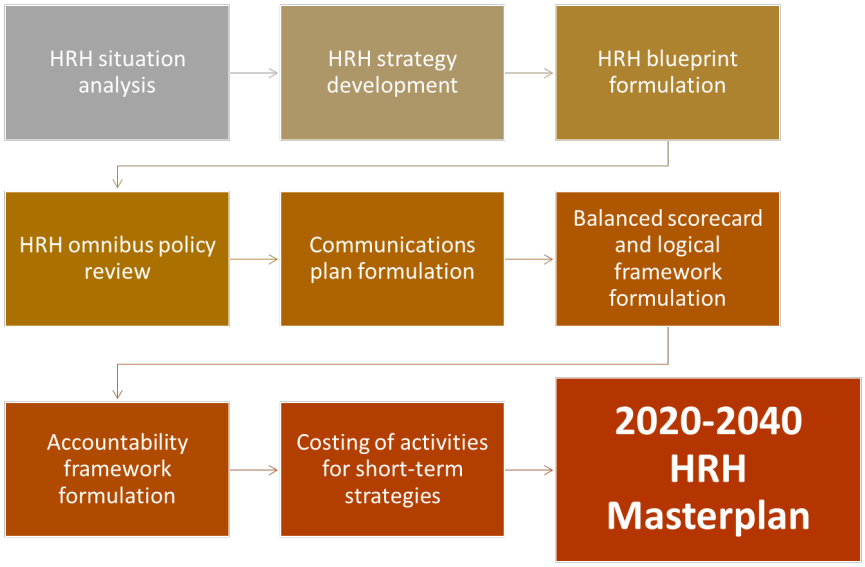
Background and Methodology

The passage of the Universal Health Care (UHC) Law in 2019 is the legal basis that underpins the crafting of the Human Resources for Health Master Plan (HRHMP) 2020-2040. It will serve as an overarching document that guides the whole of society and whole of government to meet the human resources for health (HRH) component of the UHC goals. The HRHMP addresses the need to improve the country's health outcomes and achieve UHC. To do so, it is critical to have a sufficient number of 'appropriately skilled and motivated, equitably distributed and well supported health workers in the system.[19 20]

The HRHMP is aligned with the vision of Filipinos to be among the healthiest people in Asia by 2040 as presented in *AmBisyon Natin 2040*. It is also consistent with the strategic goals of the National Objectives for Health (NOH) 2017-2022 and the Philippine Development Plan 2017-2022, particularly in improving health outcomes, and improved responsiveness of the health system to Filipinos' health needs.

The preparation of the HRH Masterplan involved several major activities: conduct of a situation analysis, strategy development, drafting a blueprint, an omnibus policy review, preparing a communication plan, developing a balanced scorecard and a logical framework approach, formulating an accountability framework, and estimating the indicative costs of the activities of the short-term strategies (Figure 1). Through all this, the HRHMP development was designed to be a co-development endeavor primarily with the DOH-Health Human Resource Development Bureau (HHRDB) and secondarily with the HRH network. Consultations and validation meetings were conducted with the DOH, the HRH network and other stakeholders to derive a consensus on plan inclusions.

Figure 1. Process Diagram on Developing HRH Masterplan



There are several elements in the HRHMP 2020-2040 that distinguishes it from the previous masterplans:

- scenarios that included the impact of public health emergencies and crises for the short, medium, and long term were identified;
- developed assessment criteria that will facilitate the implementation and adaptation of the Masterplan strategies to reflect local situations by local government units (LGUs);
- designed short term, medium term and long-term strategies that align with UHC Act defined structures to improve primary health care delivery through health care provider networks (HCPNs);
- incorporated a strategic communications plan;
- established an accountability framework between and among HRH stakeholders to ensure effective monitoring and evaluation of HRHMP implementation; and,

- it is proposed to be included in the National Economic and Development Authority's (NEDA) medium-term Philippine Development Plan.

Limitations

In developing the HRH Masterplan, the following constraints were encountered:

1. Variance in available data
   In the preparation of the situation analysis, HRH data for 13 cadres was available only for 2018. However, historical data from 1990 to 2018 were available for physicians, nurses, midwives, and medical technologists because this was the scope of USAID's HRH2030 Philippines.
2. Consultations to validate findings of situation analysis and strategies
   The results of the situation analysis and the strategies to address key issues determined in the situation analysis were validated with regional representatives (e.g. health workers from LGUs and barangay health workers (BHWs) representing the grassroots) and the HRH Network through a series of consultations. However, there was limited representation of high level officials from LGUs and the private sector in the consultations.
3. Scenario building
   For the short term, an HRH situation analysis helped define the scenarios. Additional strategies were identified to take into account the impact of projected scenarios of COVID19. For the medium and long-term, assumptions were made such as certain conditions will not have been resolved in the short-term (e.g. triple burden of Filipinos will continue to be an issue). Scenario building was based on the results of a limited review of available literature and existing documents.
4. Omnibus policy review
   - The content assessment used in the policy review did not consider whether policies are still in effect or are implemented in the country
   - International and regional policy instruments, like ASEAN declaration or commitments, that may have influence on the policy environment of Universal Health Care in the country were not included in the policy inventory.
   - 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.
5. Costing of HRH Masterplan activities
   - Assumptions used in the indicative costing only covered the minimum requirement in managing and monitoring the short-term activities identified in the logical framework approach (LFA) matrix.
   - Estimating the cost for remuneration of regular staff and consultant considered the minimum staff composition to manage and monitor each activity. Rates used for costing remuneration requirements is based on National Budget Circular 579 issued on January 2020 implementing the first tranche of the modified salary schedule for civilian personnel in the National Government
   - Estimating the operational cost considered the cost items critical to manage and monitor the activity. Cost of at least 1 critical intervention for each activity was also included.
   - Cost of interventions for production and workforce strategies only considered 4 cadres (doctor, nurse, midwife, medical technologist) due to limitation on data available as basis for cost assumptions
   - Costing of the projected staffing needed to carry out UHC implementation is not included in this report.

Vision, Mission, Goals of the Masterplan

As stated in the UHC Law, the goal of the national 2020-2040 HRH Master Plan is to provide policies and strategies for the appropriate generation, recruitment, retraining, regulation, retention, and reassessment of the health workforce based on population health needs. The HRH Masterplan provides a picture of the current situation of the HRH sector in the Philippines, strategies that will address the issues that impact on the performance of the HRH and health sectors, an accountability mechanism among the HRH stakeholders, and a monitoring and evaluation system that will track the progress of the Masterplan's implementation. The Masterplan development will be progressive, technically, economically feasible and sustainable, and will have sufficient details for implementation and operationalization to guide the health and health related sectors to achieve better HRH management.

Vision

By 2040, all Filipinos shall have access to quality health services, provided by adequate number of competent, highly motivated, people-centered, and compassionate HRH who are enjoying decent work and competitive salaries, in a supportive environment without the need to work overseas.

Mission

Ensure adequate/equitable and sustainable number of compassionate and responsive HRH at all levels to deliver health care through the continuum of promotive, preventive, curative, rehabilitative health interventions.

Goals for HRH Management and Development

- Develop highly skilled and highly motivated health workers
- Ensure adequate and equitable distribution of health workers across the Philippines
- Contribute in improving population health outcomes

Guiding Principles

The HRHMP will espouse the following principles in support of the national initiative towards provision of primary health care (PHC) for all Filipinos. The principles will be embedded in the strategic objectives and strategies of the Masterplan.

- UHC principles including universality, equity, accountability, sustainability, participation, social solidarity, individual and mutual responsibility, transparency, and progressive realization.
- Primary health care principles including equitable distribution, community participation, intersectoral coordination, and appropriate technology.
- Ensuring a healthy, sustainable and productive workforce to improve positive patient experience towards improving population health and reducing cost of care.
- Alignment of strategic directions. The Masterplan is aligned with HRH components of national and international goals and commitments thereby contributing to achieving better health outcomes.
- Continuous monitoring and learning. Feedback is provided and lessons are learned from continuous review and evaluation of the quality, efficiency and effectiveness of the Masterplan's strategies and activities, and the achievement of results in order to improve and strengthen performance.

Theory of Change and Results Framework

As a key initiative that will address the prevailing issues that confront HRH and simultaneously address current critical health issues such as COVID19, the HRH Masterplan posits that: if fit for practice and fit for work HRH with rural background are provided scholarships and developed near their places of origin; provided decent work, learning and development opportunities, and improved working conditions with their protection and well-being in mind; then HRH in the Philippines will contribute to the improvement of the health system performance and to the improvement of individual and population health outcomes (Figure 2). This is the theory of change that underlies the HRH Masterplan. A theory of change is a model of how and why interventions or initiatives are supposed to work or lead to change.[21] [22] [23] [24]

Another way of looking at the theory of change is through the results framework (Figure 3). The Masterplan's strategies are summarized according to the four dimensions of the balanced scorecard which are commonly used when applied to the private sector: customer, internal processes, financing, learning and growth or organizational capacity. Since the strategies are for the country's HRH, partnership and collaboration as a dimension has been added, due to the sector's multi-sectoral nature. Investments, collaborations (e.g. establishing information systems, conducting research, coherent policies among others), and fostering learning and growth among HRH will facilitate the necessary processes (i.e. recruitment and retention, sustainable HRH production, improved productivity and responsiveness) that will lead to adequate and equitable distribution of HRH. This will in turn impact positively on the stakeholders of the HRH sector ultimately leading to improved health outcomes.

Figure 2. Theory of change of the HRH Masterplan

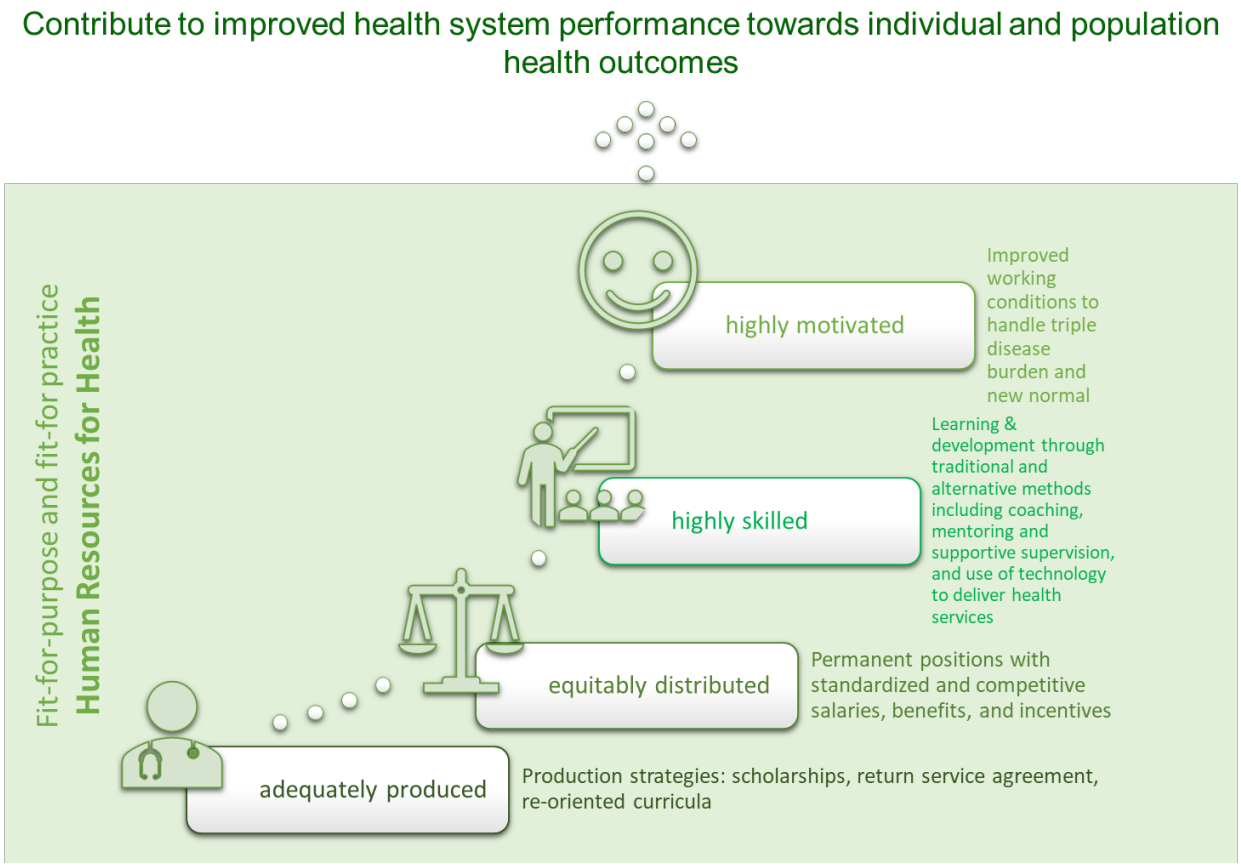
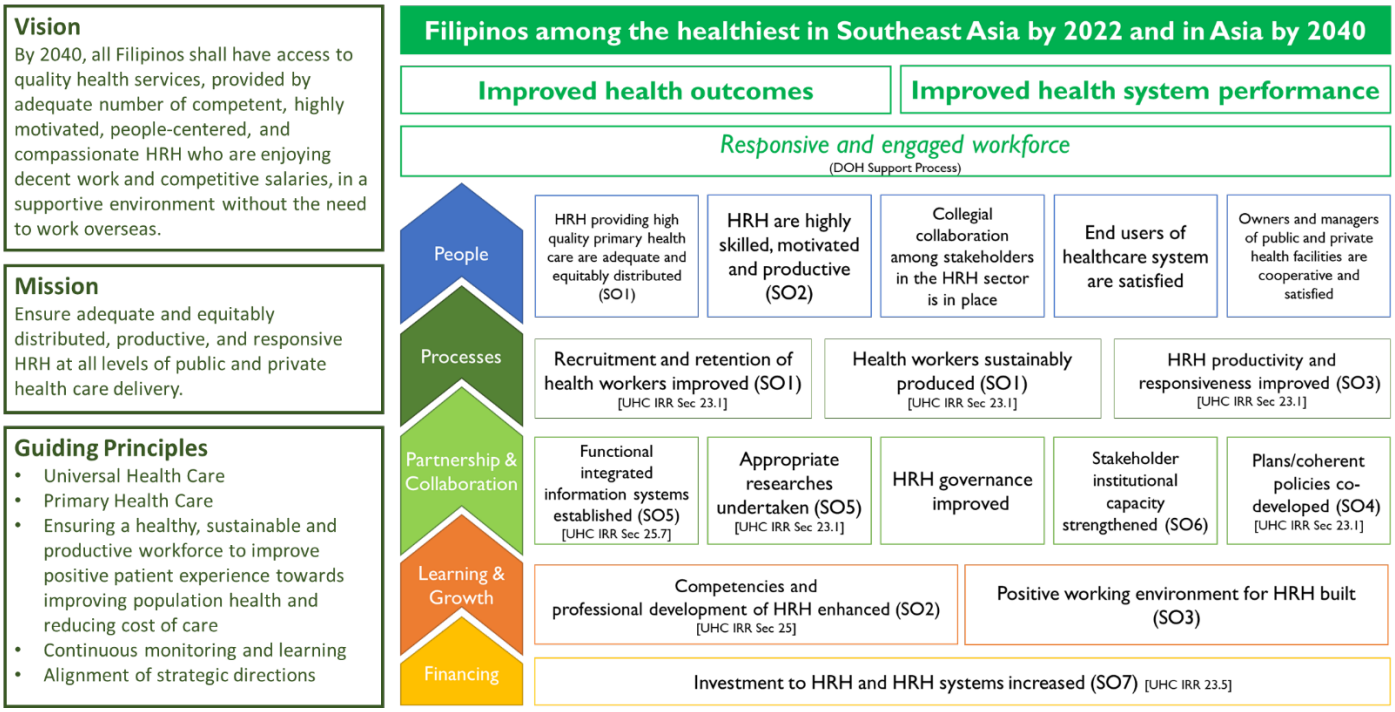


Figure 3. HRH Masterplan 2020-2040 results framework



Source: Based on DOH Balanced Scorecard, AmbisyonNatin 2040 and the Philippine Development Plan 2017-2022

Short term plan (2020-2022)

A. Short term risk-based scenario descriptions

From the HRH situation analysis and a review of COVID-19 related reports, five major scenarios are identified that need to be addressed in the short term of the HRH Masterplan.

1. Filipinos have a triple disease burden: (1) a high prevalence of communicable disease, (2) increasing non-communicable diseases (NCDs), and (3) emerging rates of injuries and accidents.[25] Communicable diseases such as acute respiratory infection, influenza, bronchitis, TB etc., remain dominant as the top leading causes of morbidity in the Philippines. On the other hand, NCDs such as ischemic heart disease, cerebrovascular disease, diabetes, etc. are the leading causes of mortality in the country. Based on data from the Philippine Statistics Authority, the number of road crash related deaths has been showing a year-on-year increase from 2006 to 2015, averaging 4% per year.[26] The Philippines ranks third in the world in terms of exposure to disaster risks and thousands have died from disasters due mostly to trauma, drowning or crush-related injuries.[27]
2. Greater effort should be given to expand the health system capacity.[28] [29] [30] There is a need to scale up hiring of HRH[31] to deal with the triple burden of disease and to prevent and control emerging & re-emerging diseases and health crises, especially at the LGU level. The COVID19 pandemic has highlighted the inadequacies of the Philippine health system particularly in public health emergencies. Recently completed studies has recommended the expansion of the health system capacity including the scaling up of HRH recruitment at the national, regional, provincial and LGU levels. In support of the health system expansion to better respond to COVID19 and without ignoring the triple disease burden of Filipinos, it is critical to respond to the next two scenarios.
3. Use technology where available and feasible[32] to prevent and control emerging & re-emerging diseases and health emergencies.
4. Better information systems yielding substantial data including research, which is key to better decision making and policies, are needed.[33] [34]
5. COVID19's major economic impact is the disruption in the production of goods and services in the country. NEDA estimates zero growth for the economy and possibly a decline due to stoppage in many business operations.[35]

B. Strategic focus in the short term

In response to the current health scenarios that the Philippine health system must respond to, the following strategic foci is being proposed in the short term of the Masterplan:

- Produce adequate number of quality HRH to support national and local health system needs
- Recruit and retain sufficient number of HRH towards attaining equitable distribution of HRH at all levels of the health care system
- Promote decent work and protection for HRH
- Build HRH capacities to deal with triple disease burden, prevent and control emerging & re-emering diseases, and respond to health emergencies
- Establish HRH systems to support strategic health system goals (e.g., HRH governance, information systems, health technologies, etc.)
- Engage policy makers and key stakeholders, at national and local levels, to substantially invest in the health workforce
- Engage community to participate in providing health promotive and disease preventive care for families (by raising awareness and capacity building)

C. Strategies in the short term

Production strategies embed approaches to improving training and retaining future HRH.

- Establish targeted admission practices in higher education institutions (HEIs)
- Educate and train future HRH in or near their places of origin
- Expand scholarships with enforceable return service agreement (RSA) that also offers incentives
- Re-orient curriculum to PHC and integrate public health, rural health courses/ topics, rural exposure/immersion, and use of technology to deliver health services so that health science graduates are responsive to population needs

Workforce strategies focus on improving competencies and professional development, providing competitive salaries and benefits, improving work conditions including the use of technology to deliver health services, and ensuring the well-being of HRH

- Create adequate permanent positions for HRH (including Barangay Health Workers [BHWs] & Barangay Nutrition Scholar [BNS]) in response to health sector needs

- Standardize health workers' positions and competitive compensation, benefits and incentives such as supporting career progression, standardized, decent compensation and benefits, recognition and rewards system to improve job satisfaction and motivation (public and private sectors; national and local)
- Ensure well-being of health workers including protection from emerging and re-emerging diseases (e.g. wellness programs, mental health, etc.)
- Ensure compliance with minimum work environment standards by implementing occupational safety and health (OSH) standards and infection and prevention control initiatives
- Ensure appropriate skills mix and roles/functions present in health facilities
- Develop and implement career paths of health workers across the public and private sector from national to local levels (including recognition and award mechanisms)
- Support career development of volunteer health workers (e.g. BHW, BNS, etc.)
- Enable health workers to obtain appropriate skills, knowledge and attitudes through learning and in-service staff development methods
- Enforce/strengthen the provision of coaching, mentoring, and supportive supervision to health workers

Cross cutting strategies cover improving HRH information systems and conducting research, and increasing investments in HRH and improving fiscal capacity

- Generate resources for HRH from various sources (domestic, international, and other sources)
- Invest in HR systems (education and training, recruitment, deployment and retention, etc.) to meet national and subnational needs
- Develop fiscal capacity to absorb and utilize effectively and transparently both domestic and international resources for HRH systems in the public and private sector
- Strengthen and integrate information systems to ensure up-to-date HRH data and data sharing across the HRH sector e.g. National Health Workforce Registry (NHWR), National Health Workforce Account (NHWA)
- Undertake robust HRH research (including operations and evaluation research and analysis of health labor markets)

D. Implementation plan

This section presents the different components in implementing the short-term plan of the HRH Masterplan that was derived using the logical framework analysis (LFA). LFA was combined with the Balanced Score Card Tool to derive measures and indicators of key strategies.

Strategic objective 1 (SO 1)

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

SO 1 comprises four production strategies in the short-term that embeds retention in order to produce adequate number of HRH and reduce inequitable HRH distribution. The strategies address where future HRH should be educated, the admission guidelines of HEIs, providing scholarships linked to RSAs, and re-orienting the current curricula to emphasize primary health care, exposure and immersion to rural topics and practice, and the use of technology. The development of a new range of skill sets, particularly in the delivery of health services using technology, has been incorporated in the strategy on re-orienting curricula. This is vital in public health emergencies such as the ongoing pandemic.

Stakeholders involved in these set of strategies include Commission on Higher Education (CHED), PRC, HEIs, LGUs, the Congress, professional societies, student groups, and private and public health facilities.

Strategic objective 2 (SO 2)

Create and sustain systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention

Part of the workforce strategies in the short-term, SO 2 focuses on a) improving HRH competencies by enabling them to engage in learning and development through traditional and alternative learning methods including the use of technology, and providing coaching, mentoring, and supportive supervision; and, b) developing the careers of volunteer and professional health workers. The strategies will improve HRH productivity and responsiveness to population needs, in the workplace and promote greater retention.

Stakeholders involved include the DOH, Technical Education and Skills Development Authority (TESDA), PRC, Philippine Statistics Authority (PSA), Department of Interior and Local Government (DILG), LGUs, academe, health facilities, professional associations, public and private health facilities, and other agencies/ institutions that offer programs for volunteer health workers.

Strategic objective 3 (SO 3)

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

SO 3 is composed of short-term strategies on the creation of permanent positions in response to health sector needs and standardizing positions, compensation, benefits, and incentives. The creation of permanent positions will respond to the issue of inadequate HRH in the sector and both strategies will improve job satisfaction and motivation. Three other strategies that will promote job satisfaction and motivation are: ensure the well-being of HRH including their protection, ensure compliance with occupational safety and health standards and infection and prevention control initiatives to improve conditions in the work setting (e.g. telehealth, telemedicine), and ensure that health facilities have the appropriate skills mix. These three strategies will also enable a better response to public health emergencies such as the current pandemic that is COVID19.

Stakeholders involved in these strategies include the DOH, DILG, LGUs, Department of Budget and Management (DBM), Department of Labor and Employment (DOLE), Civil Service Commission (CSC), PSA, HRH Network, Inter-Agency Committee on Environmental Health (IACEH) - Occupational Health Sector and Toxic and Hazardous Substances Sector, University of the Philippines (UP) College of Public Health, UP-Philippine General Hospital (PGH) National Poison Management, province/city-wide health care provider network, professional organizations, and civil society organizations

Strategic objective 5 (SO 5)

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

SO 5 includes short-term strategies on information systems development to ensure up-to-date and accurate information, and the carrying out of HRH-related research. These speak to the need for evidence that will regularly inform decision-making and accountability.

Stakeholders that will be involved include CHED, PRC, DOH, Philippine Overseas Employment Administration (POEA), Commission on Filipinos Oversease (CFO), Department of Information and Communications Technology (DICT), Department of Science and Technology (DOST), LGUs, HRH Network, HEIs, research stakeholders, and the private sector.

Strategic objective 7 (SO 7)

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

SO 7 comprises strategies in the short term that aim to increase investments in HRH and HRH systems and build fiscal capacity in order to respond to current and future population health needs and of health systems.

Stakeholders that will be involved are the Department of Finance (DOF), DBM, DOH, NEDA, PSA, HRH Network, LGUs, the private sector, and international development partners.

LOCALIZING THE MASTERPLAN

Based on evidence drawn from a literature review and validated through national and regional consultations, the strategic objectives and national level strategies were identified for the Masterplan. However, the national strategies cannot be uniformly implemented across the regions and provinces as there are wide variations in local conditions. For instance, many areas in highly urbanized cities have higher access to health services compared with GIDA that have low access and where there are instances when some HRH cadres (e.g. physicians) are not present. In order to address this imbalance, it is proposed that LGUs 'localize' the Masterplan. This can be done by assessing the relevance and feasibility of the Masterplan strategies at the local level. The assessments can be carried out through consultation workshops by the Provincial Health Board with the participation of the HRH Network and HHRDB using a set of criteria (Appendix B). Results of the assessment will inform how the national Masterplan strategies can be adapted best to benefit the health of individuals and local populations.

IMPLEMENTATION SCHEDULE OF MASTERPLAN STRATEGIES

There are necessary preparatory activities for the short-term plan that should be carried out prior to the implementation of the Masterplan strategies. These relate in particular to the Masterplan's governance and management, and its monitoring and evaluation system.

- Establishing governance and management structures including a secretariat. A review of the current Memorandum of Agreement is needed and a formal agreement among the HRH Network members should be reached to establish the Network as **the implementing unit**. The roles of the technical working committees (TWCs) and the Oversight Committee on Masterplan Management and its relationship with the DOH should be clearly defined. Focal persons in each agency / stakeholder must be made available to ensure continuity and consistency.
- Establishing mechanisms and implementing arrangements for stakeholders to work together in implementing and monitoring the Masterplan. Many of the indicators for the outputs and outcomes of the Masterplan strategies are multi-sectoral. The stakeholders' commitment to these will include incorporating HRH in their workplans and budgets and assigning persons to the relevant TWC and actively participating.
- Identifying champions to further the HRH agenda in each HRHN organization. Champions have a clear role to play in ensuring that the Masterplan's short-term strategies are supported by high level stakeholders.
- Determine extent of policy support present for the strategies. The policy omnibus review indicates support for most strategies but unclear to what extent this goes since policy implementation was not included in the omnibus review.
- Refining and establishing the proposed accountability framework (discussed below) and obtaining buy-in from HRH stakeholders.
- Disseminating the Masterplan to different audiences which will be guided by a communications plan.
- Creating localized plans. The Masterplan's strategies were developed for the whole country which does not capture specific local conditions (e.g. health burdens, adequacy of health workers, etc.). Developing several 'local' plans can serve as examples or templates that other provinces can follow.
- Addressing barriers identified during consultations. During the regional and national consultations, the most common barriers raised were availability of funding, time, and people.

The above activities are expected to be implemented in 2020 (

Table 1).

Table 1. Timeline of preparatory activities of the HRH Masterplan

Year	Preparatory activities	Purpose
2020	▪ Review existing Memorandum of Understanding among members of the HRH Network and establish a formal agreement among the HRH Network members including - The Network is the implementing unit of the HRH Masterplan - Reconfiguring structures such as TWCs and their functions - Establishment of a full-time secretariat that will be in charge of the Masterplan's daily implementation and monitoring - Agreement on an accountability framework	▪ Establish governance and management structures ▪ Facilitate the accomplishment of strategies and monitoring of multi-sectoral indicators
	▪ Create mechanisms and implementing arrangements including identification of - Point/focal persons for each agency per strategy - Decision making, communication and other processes - Unique membership in each TWC	▪ Facilitate the processes of collaboration among agencies
	▪ Identify champions to push the HRH agenda	▪ Ensuring transparent governance, availability of resources, and high-level support for strategies
	▪ Identify gaps in policy including extent of implementation	▪ Ensure a supportive policy environment for the HRH Masterplan

Year	Preparatory activities	Purpose
	▪ Implement a communications plan	▪ Disseminate HRH Masterplan and raise support for its implementation
	▪ Develop local HRH plans	▪ Reflect local conditions and ensure implementability at the provincial/city/municipal levels
	▪ Identify financial resources for - setting up and operating the governance and management structures of the Masterplan - implementing the Masterplan strategies	▪ Ensure timely and appropriate implementation of the Masterplan by securing resources that support its implementation

A priority in the Masterplan implementation are workforce strategies that will help contain the COVID19 pandemic and protect and ensure the well-being of HRH during this public health emergency and other like it in the future. In the proposed implementation schedule (

Table 2), workforce strategies targeted for 2020 are those that offer alternative learning development approaches, ensure well-being of health workers including compliance with occupational safety and health (OSH) standards and exploring digital health, and ensuring the presence of appropriate skills mix in health facilities. Note that the creation of permanent positions will be implemented in the medium-term. However, the strategy is included in the short-term as certain activities need to be started right away. For instance, activities such as broadcasting widely unfilled government and private HRH positions, reviewing existing policies relevant to the creation of positions, etc. are expected to start in the next two years. Similarly, the strategy on standardizing positions, competitive compensations, benefits, and incentives will take place in the medium-term. Nevertheless, it is included in the short-term since activities will be initiated to help ensure its achievement in the medium-term.

The implementation of cross cutting strategies on investments and HRH information systems are targeted for 2021. It is necessary to implement these soonest as the cross-cutting strategies will help improve the successful implementation of the production and other workforce strategies. This is particularly true regarding the timely availability of resources, and access to accurate and up-to-date HRH information.

Table 2. Proposed implementation schedule of short-term strategies

Year	Strategy	Activities
Workforce Strategies		
2020	Enable health workers to obtain appropriate skills, knowledge and attitudes through learning and in-service staff development methods [SO 2]	Develop more alternative modes of learning (e.g., e-learning, webinars) on Primary Care in DOH e-Learning platform with CPD units
		Provide access to available face-to-face learning and development programs and providers while earning CPD units
2020	Ensure well-being of health workers including protection from emerging and re-emerging diseases (e.g., wellness programs, mental health, etc.) [SO 3]	Develop health, wellness, and infection prevention and control programs (e.g., mental health, physical health, etc.) for health workers
		Craft policy on health care worker protection (e.g., stigma, bullying), and infection prevention and control measures for emerging and re-emerging diseases
2020	Ensure compliance with minimum work environment standards by implementing occupational safety and health (OSH) standards and infection and prevention control initiatives [SO 3]	Review existing OHS standards and its implementation
		Explore use of available technology to deliver health care services
		Identify alternative work arrangements in cases of public health emergencies

Year	Strategy	Activities
		Review and implement minimum work environment standards (e.g., hazard pay, personal protective equipment (PPEs), short-term accommodations) to prevent and control emerging and re-emerging diseases to protect health workers
2020	Ensure appropriate skills mix and roles/functions present in health facilities [SO 3]	Review current minimum staffing (composition and number) for health service delivery, including needs for workload and public health emergencies, outbreaks, etc.
		Implement WISN findings specifying the ranges for staffing standards based on actual computed workload
		Craft policy on minimum staffing (composition and number) for health facilities for public health emergencies, outbreaks, etc.
		Develop guidelines on HRH standards to ensure optimal response to public health emergencies, outbreaks, etc.
2021	Create adequate permanent positions for HRH (all cadres including Barangay Health Workers & Barangay Nutrition Scholar) in response to health sector needs [SO 3]	Broadcast widely unfilled government and private HRH positions
		Collaborate between the national and local governments to source funds and recruit local HRH to fill necessary vacant positions
		Advocate to LGUs to create positions for HRH
		Review existing policies
2022	Support career development of all health workers including volunteer health workers (e.g., BHW, BNS, etc.) [SO 2]	Review existing capacity building programs for volunteer health workers
		Craft career development paths for volunteer health workers
		Define needed competencies based on roles and functions of job description of volunteer health workers using the competency-assessment tool developed by USAID's HRH2030 Philippines
		Review of roles and responsibilities of BHWs and other health volunteers
		Explore new initiatives such as micro credentialing to be able to provide home-/community-based services
		Strengthen implementation of national certification program (e.g., Barangay Health Services Certification (NCII) under TESDA) for volunteer health workers
2022	Enforce/strengthen the provision of coaching, mentoring, and supportive supervision to health workers [SO 2]	Determine competencies of workplace coaches and mentors and capacitate them as necessary
		Include coaching and mentoring in the learning and development programs
		Design mentoring and coaching programs aligned with area or program needs as needed

Year	Strategy	Activities
2022	Develop and implement career paths of health workers across the public and private sector from national to local levels [SO 2]	Design harmonized career progression paths of HRH in government and private sector
		Provide information on careers in the health sector for potential health workers
2022	Standardize health workers' positions and competitive compensation, benefits and incentives such as supporting career progression, standardized, decent compensation and benefits, recognition and rewards system to improve job satisfaction and motivation (public and private sectors; national and local) [SO 3]	Advocate and capacitate LGUs to allocate sufficient budgets for HRH in accordance with staffing standards
		Request exemption from PS cap and LGU income class-dependent rates for health workers
		Enforce full implementation of Magna Carta for Public Health Workers across national and local levels
		Review/amend provisions under existing laws on compensation and benefits of health workers (e.g., PS limit and Magna Carta to cover private sector HRH)
		Identify compensation packages, benefits and incentives for professional and non-professional health workers that are motivating
		Review of existing benefits and incentives for the public and private sector
		Review of positions classification and job descriptions of public health workers
Cross-cutting Strategies		
2021	Strengthen and integrate information systems to ensure up-to-date HRH data and data sharing across the HRH sector (e.g., National Health Workforce Registry, National Health Workforce Account) [SO 5]	Conduct data mapping to identify data gaps and sources, frequency of data collection, and overlaps, if any
		Utilize the NHWA system as the national repository of HRH data and information
		Identify specific NHWA data modules to be contributed by HRH stakeholders consistent with their mandates
		Provide updated health worker information aligned with agency process (e.g. PRC licensing, POEA exit information, etc.)
		Include a NHWA system of data collection in the processes of agencies collecting HRH data
2021	Conduct HRH research (including operations and evaluation research and analysis of health labor markets) [SO 5]	Formulate HRH research agenda and identify lead groups in the medium term
		Harmonize/integrate HRH development and management research agenda of national agencies
2021	Generate resources for HRH from various sources (domestic, international, and other sources) [SO 7]	Explore co-financing mechanisms between national and local governments
		Funding for local HRH needs (development and management) provided by LGUs and supported, if necessary, by national government with private sector participation

Year	Strategy	Activities
		Explore government subsidies (conditional transfer) for private sector health worker development and management to expand access to health care
2021	Invest in HR systems (education and training, recruitment, deployment and retention, etc.) to meet national and subnational needs [SO 7]	Allocate resources to support HRH in the Local Investment Plan for Health (LIPH)
		Identify sources for funds in areas that are under invested at appropriate levels to support primary health care
		Identify areas in training and education, recruitment, deployment and retention at national and local levels requiring (additional) investments
2021	Develop fiscal capacity to absorb and utilize effectively and transparently both domestic and international resources for HRH systems in the public and private sector [SO 7]	Build capacities of HRH Network and HHRDB for planning, resource management (fiscal management) and analysis
		Develop a system for co-managing resources, such that management directions will be provided by national agencies, and implementation of specific plan of actions will be handled by local government units
Production Strategies		
2022	Educate and train future HRH in or near their places of origin [SO 1]	Identify and support SUCs or high quality HEIs which offer health sciences education in every region
		Determine training hospitals for internship of 12 cadres in all regions
		Reorient health professional curricula to produce responsive health workers equipped with primary care competencies for the region
2022	Establish targeted admission practices in HEIs [SO 1]	Revise admission guidelines in HEIs per region to target indigenous people and local students with rural background who are willing to serve as health workers in their localities
		Promote enrolment of local students including indigenous people who are willing to serve locally for at least 5 years
2022	Expand scholarships that would support the production of needed cadres of health care professionals and health care workers with enforceable RSA that also offers incentives [SO 1]	Use WISN results as basis for providing scholarships in rural areas
		Harmonize public and private scholarships from all sources to boost health sciences program enrolment and produce needed cadres of health workers in rural and GIDA areas
		Strengthen implementation of RSA for HRH (monitoring, non-compliance, identify incentives)
2022	Re-orient curricula to PHC and integrate public health, rural health courses/ topics,	Intensify pre-service education and training on PHC, public health, rural exposure/immersion, and use of technology to deliver health services

Year	Strategy	Activities
	rural exposure/immersion, and use of technology to deliver health services [SO 1]	Advocate for the inclusion of PHC, public health, and rural health topics/ immersion, and use of technology in public and private HEIs
		Utilize flexible learning options (FLOs) in pre-service training of health professionals
		Form a functioning interagency working group to introduce changes to curricula

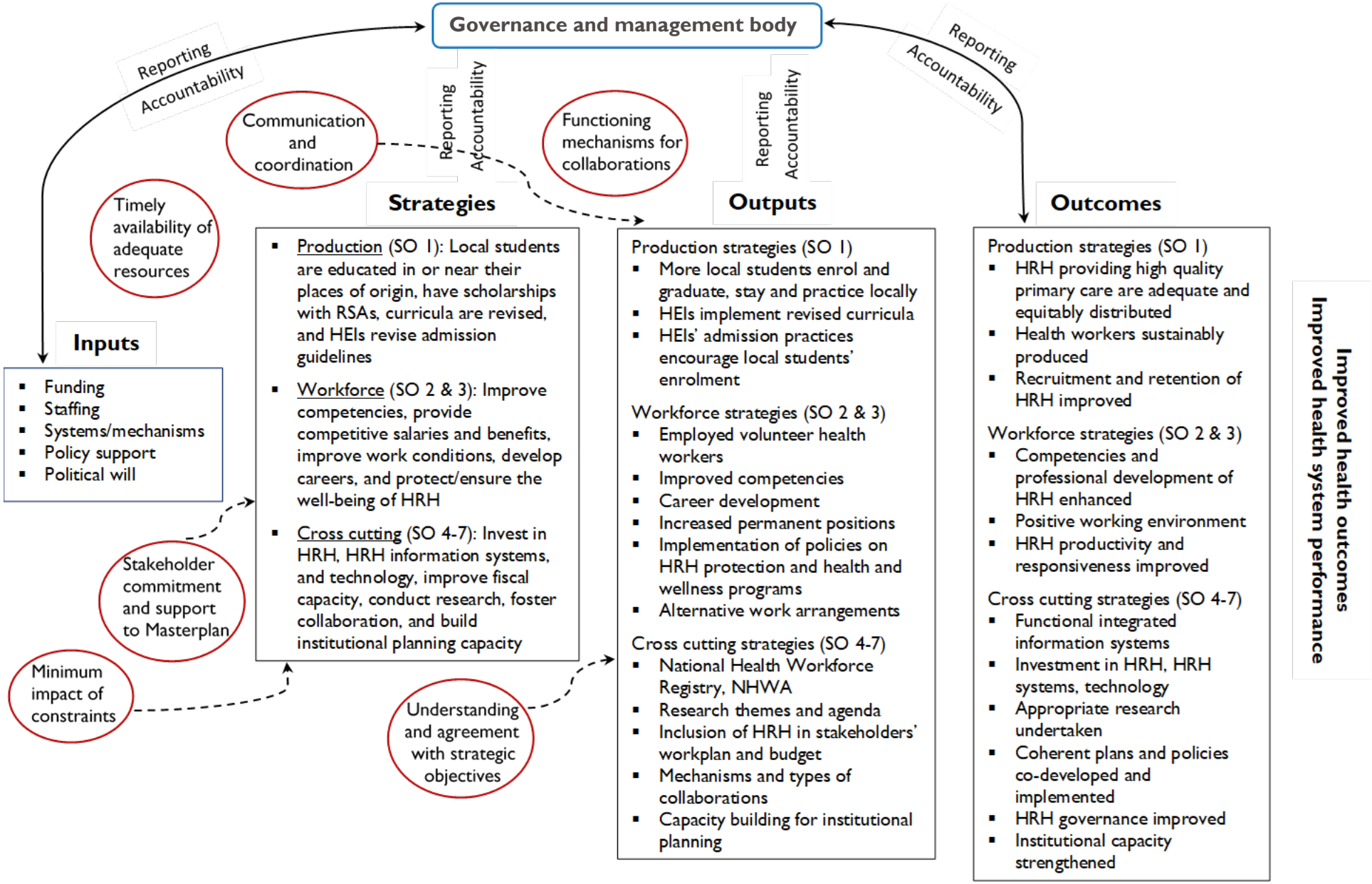
IMPROVING THE IMPLEMENTATION OF THE MASTERPLAN

As a process, the Masterplan's implementation is expected to follow a logical framework (Figure 4). Implementing the Masterplan requires:

- An operational governance and management body
- Inputs consisting of –
  - Indicative estimates of funding needed for the activities of short-term strategies (PhP8.3 Billion)
  - Additional staffing needed, including its cost, is currently being forecasted
  - Policy support is available as presented elsewhere in the report. For instance, the Magna Carta for Health Workers enacted in 1995 has provisions supportive of 5 out of 7 strategic objectives (see Table 10 for details)
  - Even as the development of a Masterplan has legal standing, it is necessary to derive political will and stakeholder buy-in. This will be assisted by the Masterplan communications plan and advocacy.
  - Technical working committees of the HRH Network will be one of the key mechanisms of collaboration. Reporting and accountability systems are integral to the Masterplan's monitoring and evaluation system.

The above inputs are fundamental in order to operationalize production, workforce, and cross cutting strategies in the short term. As the strategies are made operational, these are expected to produce outputs which will in time lead to outcomes. For instance, production strategies are expected, with revised HEI admission guidelines, to have a higher proportion of local students who are trained and educated near their place of origin, benefit from the revised curricula, graduate, stay and practice locally. Hence, outcomes will be produced such as improved retention and sustainably produced HRH that can provide primary care. While the processes of generating outputs and outcomes from the inputs and strategies may seem straightforward, in actuality, there are many factors that will affect the creation of desired outputs and outcomes and should be addressed. By no means a complete list, these are the timely availability of the necessary resources for the Masterplan implementation, having excellent communication and coordination among HRH stakeholders at the national and local levels and across HCPNs and P/CWHS, stakeholder commitment and support, understanding and agreement with strategic objectives among stakeholders, functioning mechanisms for collaborations, and the minimum impact of constraints that are beyond the control of the implementers.[36] [37] As shown in Figure 4, most of these impact in the input and strategies stage of the implementation of the Masterplan. Some of these match the barriers identified during the national and regional consultations when the strategies were first proposed and those identified in the LFA. For instance, the need for funding, buy-in particularly from decision makers e.g. local chief executives (LCEs), knowing about the Masterplan, and for collaboration among many stakeholders.

Figure 4. Implementation framework



E. Budget/Resources

This section presents the estimated indicative cost for implementing, managing and monitoring the eighteen short-term strategies identified covering Year 2020 to Year 2022 implementation of the HRH Masterplan.

The indicative cost was identified based on cost drivers for activities of each strategy under the strategic objectives for production, workforce and cross-cutting concerns covered in the short-term plan. The main cost drivers, or factors that trigger change in the cost, identified for each activity are remuneration and operational cost. Remuneration refers to the amount allocated for labor work to carry out an activity, while operational cost is the amount allocated for direct cost (except labor) to implement an activity. Appendix C lists the cost assumptions that underlie the budget estimates.

The indicative cost in implementing eighteen strategies under the five strategic objectives covered by the short-term plan is estimated at PHP 8.3 Billion. Of the estimated total indicative cost, 15% of the cost estimate is for production strategies, 82% is for workforce strategies, and 3% is for cross-cutting strategies.

1. PRODUCTION STRATEGIES

There are four short-term strategies under Strategic Objective 1 (Install systems that will improve recruitment of HRH fit for practice and fit for work to sustainably produce and deploy HRH and to promote greater HRH retention in the health sector leading to adequate and equitable HRH distribution vis-à-vis local health needs) that targets HRH production. Table 3 shows the summary of estimated cost per strategy.

Table 3. Summary of estimated cost, Strategic Objective 1

Strategy	Estimated Cost (in PHP)
1 Educate and train future HRH in or near their places of origin	37,907,742.00
2 Establish targeted admission practices in HEIs	7,933,967.00
3 Expand scholarships that would support the production of needed cadres of health care professionals and health care workers with enforceable RSA that also offers incentives	1,128,948,460.40
4 Re-orient curriculum to PHC and integrate public health, rural health courses/topics, rural exposure/immersion, and use of technology to deliver health services	35,039,294.00
TOTAL	**1,209,829,463.40**

Cost estimates presented in Table 3 considers staff remuneration and operational cost (e.g., events/meetings, transportation, communication, office supplies, etc.) for implementing identified activities for each strategy at the national and regional levels. Large cost drivers in implementing strategies under Strategic Objective 1 are the conduct of conferences or workshops to support HEIs in the region and the scholarship program.

2. WORKFORCE STRATEGIES

Nine short-term strategies under two strategic objectives were included in the short-term plan to support the health workers as they serve as member of the health workforce. Table 4 shows the estimated cost for strategies under Strategic Objective 2 (Create systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention), while Table 5 presents the estimated cost for strategies identified for Strategic Objective 3 (Raise HRH productivity and responsiveness by promoting job satisfaction and motivation at all levels and improve greater HRH retention). In total, the estimated cost for all workforce strategies identified in the short-term plan amounted to PHP 6.86 Billion.

Table 4. Summary of estimated cost, Strategic Objective 2

Strategy	Estimated Cost (in PHP)
5 Support career development of volunteer health workers (e.g., BHW, BNS, etc.)	12,473,100.00
6 Enable health workers to obtain appropriate skills, knowledge and attitudes through learning and in-service staff development methods	6,723,747,156.50
7 Enforce/strengthen the provision of coaching, mentoring, and supportive supervision to health workers	25,096,262.00
8 Develop and implement career paths of health workers across the public and private sectors from national to local levels	28,974,578.00
TOTAL	**6,790,291,096.50**

Cost estimates presented in Table 4 considers staff remuneration and operational cost (e.g., events/meetings, transportation, communication, office supplies, etc.) for implementing identified activities for each strategy at the national and regional levels. Large cost drivers in implementing strategies under Strategic Objective 2 are the conduct of researches and feasibility studies, cost of face-to-face trainings for health workers, cost of e-learning module development, and maintenance cost for the e-learning platform.

Table 5. Summary of estimated cost, Strategic Objective 3

Strategy	Estimated Cost (in PHP)
9 Create adequate permanent positions for HRH (all cadres including including Barangay Health Workers & Barangay Nutrition Scholar) in response to health sector needs	12,289,598.00
10 Standardize health workers' positions and competitive compensation, benefits and incentives such as supporting career progression, standardized, decent compensation and benefits, recognition and rewards system to improve job satisfaction and motivation (public and private sectors; national and local)	23,187,327.00
11 Ensure well-being of health workers including protection from emerging and re-emerging diseases (e.g., wellness programs, mental health, etc.)	3,518,864.00
12 Ensure compliance with minimum work environment standards by implementing occupational safety and health (OSH) standards and infection and prevention control initiatives	10,852,570.00
13 Ensure appropriate skills mix and roles/functions present in health facilities	18,747,659.00
TOTAL	**68,596,018.00**

Cost estimates presented in Table 5 considers the staff remuneration and operational cost (e.g., events/meetings, transportation, communication, office supplies, etc.) for implementing identified activities for each strategy at the national and regional levels. However, the cost estimate in this table **does not yet include** costs of salary and compensation of health workers for Strategy 10, which should be computed based on the result of the staffing projection still being done by the DOH.

3. CROSS-CUTTING STRATEGIES

Five cross-cutting strategies under two strategic objectives were included in the short-term plan to strengthen the health workforce environment. Table 6 shows the estimated cost for strategies under Strategic Objective 5 (Strengthen information systems/data on HRH for monitoring, informing decision making, and ensuring accountability), while Table 7 presents estimated cost for strategies identified for Strategic Objective 7 (Increase investments in HRH and align investments with current and future population health needs and of health systems). In total, the estimated cost for all workforce strategies identified in the short-term plan amounted to PHP 257.87 Million.

Table 6. Summary of estimated cost, Strategic Objective 5

Strategy	Estimated Cost (in PHP)
14 Strengthen and integrate information systems to ensure up-to-date HRH data and data sharing across the HRH sector (e.g., National Health Workforce Registry, National Health Workforce Accounts)	31,679,852.00
15 Conduct HRH research (including operations and evaluation research and analysis of health labor markets)	163,340,135.00
TOTAL	**195,019,987.00**

Cost estimates presented in Table 6 considers the staff remuneration and operational cost (e.g., events/meetings, transportation, communication, office supplies, etc.) for implementing identified activities for each strategy at the national and regional levels. Large cost drivers in implementing strategies under Strategic Objective 5 are the conduct of researches and evaluations and the systems development and maintenance of interoperable HRH information systems.

Table 7. Summary of estimated cost, Strategic Objective 7

Strategy	Estimated Cost (in PHP)
16 Generate resources for HRH from various sources (domestic, international and other sources)	3,611,308.50
17 Invest in HR systems (education and training, recruitment, deployment and retention, etc.) to meet national and subnational needs	45,806,477.00
18 Develop fiscal capacity to absorb and utilize effectively and transparently both domestic and international resources for HRH systems in the public and private sector	13,429,201.00
TOTAL	**62,846,986.50**

Cost estimates presented in Table 7 considers the staff remuneration and operational cost (e.g., events/meetings, transportation, communication, office supplies, etc.) for implementing identified activities for each strategy at the national and regional levels. Large cost drivers in implementing strategies under Strategic Objective 7 are the conduct of regional assessments for training, education, recruitment, deployment requirements, and e-learning module development of resource/fiscal management capacity building.

F. Monitoring and evaluation

In the short term, there will be 17 production, workforce, and crosscutting strategies that will be implemented. Monitoring activities will focus on collecting data for indicators of these short-term strategies and ensuring feedback to strategic and program development to make sure that strategy implementation is on track.

PRODUCTION

Strategic Objective 1: Install systems that will improve recruitment of HRH fit for practice and fit for work to sustainably produce and deploy HRH and to promote greater HRH retention in the health sector leading to adequate and equitable HRH distribution vis-à-vis local health needs

Strategy	Measure
Establish targeted admission practices in HEIs	Increased number of graduates of students from local areas
Educate and train future HRH in or near their places of origin	Proportion of health facilities with graduates of SUCs and high quality HEIs that are responsive to the local needs and practice locally
	Proportion of health facilities that provide holistic/ comprehensive health services
	Reduced patient readmission rates
Expand scholarships with enforceable RSA that also offers incentives	Amount of funding for scholarships per region Sources of scholarships Number of scholars per cadre funded Coverage of scholarships (e.g., tuition fee, miscellaneous fees, living allowance)
Re-orient curriculum to PHC and integrate public health, rural health courses/ topics, rural exposure/immersion, and use of technology to deliver health services	Proportion of health sciences HEIs that have re-oriented curricula to PHC and integrate public health, rural health courses/topics, rural exposure/immersion, and use of technology to deliver health services by CHED region by professional cadre Proportion of health sciences HEIs that produce primary care workers who are practice ready after graduation by region and by cadre

WORKFORCE

Strategic Objective 2: Create and sustain systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention

Strategy	Measure
Support career development of all health workers includeing volunteer health workers (e.g, BHW, BNS, etc.)	Defined health worker career paths by cadre including volunteer health worker
Enable health workers to obtain appropriate skills, knowledge and attitudes through learning and in-service staff development methods	Proportion of responsive and highly skilled HRH providing health services
	Reduced re-admission rates in primary care facilities
	Reduced referral rates in primary care facilities
Provide or expand implementation of coaching, mentoring, and supportive supervision to health workers	Proportion of health facilities with health workers exhibiting enhanced competencies that provide improved health services

Strategy	Measure
Develop and implement career paths of health workers across the public and private sector from national to local levels	Proportion of health workers in the appropriate positions of their career paths based on their competencies and experience

Strategic Objective 3: Raise HRH productivity and responsiveness by promoting job satisfaction and motivation at all levels and improve greater HRH retention

Strategy	Measure
Create adequate permanent positions for HRH (all cadres including Barangay Health Workers [BHWs] & Barangay Nutrition Scholar [BNS]) in response to health sector needs	Proportion of health facilities and health care provider network that fulfilled the staffing standards
	Increased number of HRH employed in health sector with permanent positions especially in rural areas/GIDA
	Increase in funding (Contribution of stakeholders for HRH investment)
Standardize health workers' positions and competitive compensation, benefits and incentives such as supporting career progression, standardized, decent compensation and benefits, recognition and rewards system to improve job satisfaction and motivation (public and private sectors; national and local)	Satisfaction (rating) of public and private health workers on employment terms
	Stable facility HRH complements
	Satisfaction of health workers over competitive compensation, benefits, and incentives received
Ensure well-being of health workers including protection from emerging and re-emerging diseases (e.g. wellness programs, mental health, etc.)	Reduced health worker turnover due to work-related health and illness issues Health compensation package for health workers implemented
Ensure compliance with minimum work environment standards by implementing occupational safety and health (OSH) standards and infection and prevention control initiatives	Satisfaction (rating) of public and private health workers on work environment
	Health worker productivity measures (e.g., reduced absences, infections, etc.)
Ensure appropriate skills mix and roles/functions present in health facilities	Proportion of health facilities that provide proactive and responsive health services
	Reduced patient readmission rates

CROSS-CUTTING

Strategic Objective 5: Strengthen information systems/data on HRH for monitoring, informing decision making, and ensuring accountability

Strategy	Measure
Strengthen and integrate information systems to ensure up-to-date HRH data and data sharing across the HRH sector e.g. National Health Workforce Registry (NHWR), National Health Workforce Account (NHWA)	Number of Functioning information/ intelligence center for HRH established implementing NHWA and the registry
	Presence of tools for decision makers

Strategy	Measure
	Utilization of information by the decision-makers
Undertake robust HRH research (including operations and evaluation research and analysis of health labor markets)	Implemented effective solutions to HRH problems

Strategic Objective 7: Increase investments in HRH and align investments with current and future population health needs and of health systems

Strategy	Measure
Generate resources for HRH from various sources (domestic, international, and other sources)	Fully supported HRH and HRH systems
Invest in HR systems (education and training, recruitment, deployment and retention, etc.) to meet national and subnational needs	Disbursement of funds allocated for investments on education and training, recruitment, deployment and retention of health workers
Develop fiscal capacity to absorb and utilize effectively and transparently both domestic and international resources for HRH systems in the public and private sector	Efficiency measures (use existing DOH indicators)
	Cost-utility/ effectiveness (use existing DOH indicators)

Medium term plan (2023-2028)

The medium-term plan is broadly presented in this document because of the evolving strategic environment that cannot be forecasted accurately. The scenarios and strategic foci are drawn from a combination of the available long-term national plans, such as AmBisyon Natin 2040, Philippine Development Plan, and the need to be better prepared for current population health needs and for emerging and re-emerging diseases and public health emergencies.

A. Medium term risk-based scenario descriptions

Health issues or scenarios identified in the short-term (2020-2022) are not expected to be resolved over two years, which means that the health system will continue to face the following:

1. Filipinos having a triple burden of disease due to continuing increase of NCDs including mental health issues, declining prevalence of communicable disease, and increasing injuries and accidents, and addressing the aging population.
2. The Philippine health system capacity should be enhanced by scaling up hiring of HRH (NEDA 2020) to deal with the continuing issue of triple burden of disease and to prevent and control emerging & re-emerging diseases and health emergencies, especially at LGU level.
3. Use of technology should be developed and expanded to prevent and control emerging & re-emerging diseases and health emergencies, especially at LGU level.
4. Research capabilities should be expanded to locally develop new health solutions needed by the Filipino population to deal with emerging and re-emerging diseases and inform decision making and policies.
5. Climate change and loss of environmental habitat increases the risk of zoonotic diseases incidence[38] and natural disasters.

B. Strategic focus in the medium term

- Sustain production of practice-ready health workforce
- Promote recruitment, and equitable distribution of quality HRH working in underserved areas
- Retain appropriate skill mix in national and submational health systems
- Support career development an advancement of HRH in the health sector

- Enhance HRH competencies to deal with triple disease burden and to prevent and control emerging & re-emering diseases, including strengthening health emergency response teams
- Improve working conditions to motivate health workers to practice in underserved areas
- Optimize existing health workforce
- Increase health literacy of all Filipinos

C. Strategies in the medium term

STRATEGIC OBJECTIVE 1 (SO 1)

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

SO 1 comprise of two production strategies in the medium-term that also embeds retention in order to produce adequate number of HRH and reduce inequitable HRH distribution. In the medium term, strategies launched in the short-term will be sustained, while introducing the following strategies:

- Establish inter-profession education (IPE) and training in universities and institutions
- Provide incentives to HEIs (e.g., tax breaks) to ensure quality graduates and provide scholarship grants

Stakeholders involved in these set of strategies include CHED, PRC, DBM, DOF, HEIs, LGUs, the Congress, professional societies, student groups, and private and public health facilities.

STRATEGIC OBJECTIVE 3 (SO 3)

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

In the medium term, an additional strategy will be implemented along with sustaining the implementation of strategies launched in the short-term. Creating adequate permanent positions and standardizing health workers' positions, compensation, benefits, and incentives, started in the short-term, will continue to be implemented.

- Create adequate permanent positions for HRH (all cadres including BHWs and BNS) in response to health sector needs
- Standardize health workers' positions and competitive compensation, benefits and incentives such as supporting career progression, standardized, decent compensation and benefits, recognition and rewards system to improve job satisfaction and motivation (public and private sectors; national and local)
- Sustain improved health outcomes through standardized care through the implementation of national Clinical Practice Guidelines (CPGs) for priority health conditions.

Stakeholders involved in these strategies include the DOH, professional organizations, and private and public health facilities.

STRATEGIC OBJECTIVE 4 (SO 4)

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

SO 4 focuses on health worker migration policies and programs that should factor in the population health needs of the country, strengthen meaningful private sector regulation particularly in HRH production and employment, and align policies on production, employment, and migration. The nature of these strategies requires close and sustained collaboration and co-development in order to achieve shared goals. Identified strategies are as follows:

- Ensure implementation of health worker migration policies and programs with consideration of the Philippine population health needs
- Strengthen meaningful private sector regulation in HRH production and employment
- Align policies on production, employment and migration involving the education, health, labor, and other relevant sectors

Stakeholders involved in these strategies are HRH Network, CHED, PRC, DOLE, DBM, DILG, CSC, DFA, POEA, OWWA, private and public HEIs and health facilities, professional societies.

STRATEGIC OBJECTIVE 6 (SO 6)

Build the capacity of institutions for effective public policy stewardship, leadership, and governance

In the medium-term, the HRH Network will be strengthened by expanding its membership and improving representation from a wide array of HRH stakeholders. Other short-term cross-cutting strategies on investments in HRH, HRH systems, and technology, improving fiscal capacity, and conducting research will also be continued to ensure that gains are sustained.

Stakeholders involved include the HRH Network, DOH- Centers for Health Development (CHD), regional and provincial HRH offices, LGUs, development partners (e.g., academe, training institutions), and public and private health facilities.

D. Budget/Resources

The budget and resources needed for implementing, managing and monitoring the activities and strategies in the medium-term plan should consider its remuneration and operational cost requirement along with the cost requirement to continue implementing and monitoring the short-term strategies.

As of the time of its writing, the Masterplan includes two production strategies, one workforce strategy, and one cross-cutting strategy identified to be initiated between Year 2023 and Year 2028. Like what was done in the short-term plan, it is recommended to identify the activities that will be implemented in the medium-term plan and estimate the indicative cost requirement prior to implementation. More specific costing can be done during annual planning retreats when current costing parameters can be updated.

E. Monitoring and evaluation

In the medium term, monitoring activities initiated in order to collect data for indicators of short-term strategies will be sustained. In addition, monitoring data for indicators of the following medium-term strategies will be included:

PRODUCTION

Strategic Objective 1: Install systems that will improve recruitment of HRH fit for practice and fit for work to sustainably produce and deploy HRH and to promote greater HRH retention in the health sector leading to adequate and equitable HRH distribution vis-à-vis local health needs

Strategy	Measure
Establish inter-profession education (IPE) and training in universities and institutions	Proportion of program outcomes exhibited by new graduates
	Proportion of all health sciences HEIs utilizing IPE approach to education by cadre, by region
	Assessment scores on performance of new professionals indicate positive patient experience
Provide incentives to HEIs (e.g., tax breaks) to ensure quality graduates	Proportion of high performing HEIs

WORKFORCE

Strategic Objective 3: Raise HRH productivity and responsiveness by promoting job satisfaction and motivation at all levels and improve greater HRH retention

Strategy	Measure
Create adequate permanent positions for HRH (all cadres including BHWs and BNS) in response to health sector needs	Proportion of health workers with permanent positions by cadre by region.
Standardize health workers' positions and competitive compensation, benefits and incentives such as supporting career progression, standardized, decent compensation and benefits, recognition and rewards system to improve job satisfaction and motivation (public and private sectors; national and local)	Measures of variance of salaries, benefits and other incentives across LGUs/ HCPNs by region/province
Sustain improved health outcomes through standardize care through the implementation of national Clinical Practice Guidelines (CPGs) for priority health conditions	Trend of health outcomes over the medium term (7-year period) such as reduced mortality rates, increased life expectancy, etc.
Consistently and evenly implement incentives to improve job satisfaction and motivation such as supporting career progression, standardized, decent compenstion and benefits, recognition and rewards system	Turn over rates of health workers per facility per cadre monitored every quarter

EXIT AND RE-ENTRY

Strategic Objective 4: Foster sustained intersectoral collaboration/co-development to develop responsive and coherent plans and policies among health and non-health agencies and organizations to generate shared goals, synergize functions, and produce collective impact

Strategy	Measure
Ensure implementation of the health worker migration policies and programs in consideration of the Philippine population health needs	Adequate number of HRH for population health needs Compliance with staffing standards per facility type and HPCN

CROSS-CUTTING

Strategic Objective 4: Foster sustained intersectoral collaboration/co-development to develop responsive and coherent plans and policies among health and non-health agencies and organizations to generate shared goals, synergize functions, and produce collective impact

Strategy	Measure
Strengthen meaningful private sector regulation in HRH production and employment	Changes in private sector production and employment practices (e.g., reduction in class size, higher HRH salaries)
Align policies on production, employment and migration involving the education, health, labor, and other relevant sectors	Proportion of aligned implementable policies to total number of HRH-related policies crafted

Strategic Objective 6: Build the capacity of institutions for effective public policy stewardship, leadership, and governance

Strategy	Measure
Strengthen HRH Network as an organization to improve effectiveness and performance	Measures of HRH Network effectiveness (stakeholder satisfaction, extent to which goals are achieved, resource mobilization capacity) and productivity (implementation of policies and programs)

Long term plan (2029-2040)

The long-term plan, which will take place nine years from now is broadly presented because of the evolving strategic environment that cannot be forecasted accurately. The scenarios and strategic foci are drawn from a combination of available long-term national plans, such as AmBisyon Natin 2040, and the need to be better prepared for current population health needs and for emerging and re-emerging diseases and public health emergencies.

A. Long term risk-based scenario descriptions

1. Filipinos have long and healthy lives with access to affordable and good quality healthcare. Health and wellness services are available including primary, secondary, and tertiary care and other products and services (AmBisyon Natin 2040, NEDA).
2. Filipinos are health literate, provided with healthy living conditions, and protected from hazards and risks that could affect their health (UHC Law)

B. Strategic focus in the long term

- Develop highly competent and motivated HRH who are responsive to individual and population health needs
- Retain HRH for the needs of the health system at national and local levels
- Institutionalize governance, financing, regulation and information systems for HRH management and development
- Support progressive investments for HRH
- Provide sufficient resources and srong legislative or policy support to HRH rights, benefits and welfare
- Ensure that Filipinos share accountability for their individual, family and community health outcomes

C. Strategies in the long term

STRATEGIC OBJECTIVE 2 (SO 2)

Create and sustain systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention

In the long-term plan, institutionalizing the short-term and medium-term plan strategies are vital. It is also important to identify and implement appropriate activities to facilitate cooperation among health workers across HCPNs and the development of professional and health worker networks. This strategy will facilitate establishment of community of practice to strengthen coordination/interaction and sharing of information among health workers.

Stakeholders involved include the DOH, LGUs, CHDs, public and private health facilities, professional societies, and health workers and health worker organizations

STRATEGIC OBJECTIVE 3(SO 3)

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

In the long term, strategies launched in the short-term and medium term should be sustained, while introducing, facilitating and regulating an enhanced and more aligned scopes of practice to health workers' function and population health needs.

Stakeholders involved in these strategies include the DOH, LGU, Congress, professional and community-based health worker organizations, civil society organizations, public and private health facilities

STRATEGIC OBJECTIVE 6 (SO 6)

Build the capacity of institutions for effective public policy stewardship, leadership, and governance

In the long term, strategies began in the medium term will be sustained. Additionally, the following strategies will be introduced: building HRH development and management capacity at all levels of the health sector; and establishing, and strengthening where present, quality assurance (QA)/ accountability mechanisms in health facilities. These will build capacity in public policy stewardship and improve leadership and governance.

Stakeholders involved include the HRH Network, DOH-CHDs, regional and provincial HRH offices, LGUs, development partners (e.g., academe, training institutions), and public and private health facilities.

D. Budget/Resources

The budget and resources needed for implementing, managing and monitoring the activities and strategies in the long-term plan should consider its remuneration and operational cost requirement along with the cost requirement to continue implementing and monitoring the short-term strategies.

As of the time of its writing, the masterplan includes two workforce strategies, one exit and re-entry strategy, and four cross-cutting strategies identified to be initiated between Year 2029 and Year 2040. Like what was done in the short-term plan, it is recommended to identify the activities that will be implemented in the long-term plan and estimate the indicative cost requirement prior to implementation.

E. Monitoring and evaluation

In the long-term, monitoring activities initiated in order to collect data for indicators of short- and medium-term strategies will be sustained. In addition, monitoring data for indicators of the following long-term strategies will be included:

WORKFORCE

Strategic Objective 2: Create and sustain systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention

Strategy	Measure
Identify and implement appropriate collaboration activities to facilitate cooperation among health workers across HCPNs and the development of professional and health worker networks	Number of coalitions, networks, alliances or groups that are functional among health workers in HCPNs Number and type of interactions among health workers in HCPN that provide opportunities for learning and support Functional referral system

Strategic Objective 3: Raise HRH productivity and responsiveness by promoting job satisfaction and motivation at all levels and to improve HRH retention

Strategy	Measure
Introduce, facilitate and regulate aligned and enhanced scopes of practice of health workers i.e. task shifting	Improved health worker productivity (efficiency and accomplishments) and satisfaction

Strategic Objective 6: Build the capacity of institutions for effective public policy stewardship, leadership, and governance

Strategy	Measure
Build HRH development and management capacity at all levels of the health sector covering public and private health facilities	Proportion of LGUs with improved HRH development and management systems
Establish/strengthen quality assurance (QA)/ accountability mechanisms in health facilities	Facility performance measures (e.g., referral rates, death rates, recovery rates, etc.)
	Quality assurance certification of health facilities (e.g. ISO)

Governance and Accountability

1. Proposed governance and management structure

At the national level, the HRH Network is proposed to be the implementing unit of the HRH Masterplan and will assume the necessary governance and management functions. Its membership consists of three professional associations, one higher education institution, and 15 government agencies.

At present the goal of the Network is to harmonize the policies and coordinate the action of different agencies, accredited professional organizations, academic institutions, and non-government organizations (NGOs) in the production, welfare, and development of HRH to deliver quality health for Filipinos. Specifically, its objectives are to:

- Ensure that the education and training of HRH is linked to health system needs;
- Ensure that HRH are well motivated and effectively contribute to the health system;
- Ensure that the principles of ethical recruitment of international health personnel are promoted and practiced;
- Engage in national and international partnerships and networks for the management and development of HRH;
- Ensure that HRH planning, and policy monitoring and development are coordinated across different agencies; and
- Protect and upholds the rights of HRH to decent work, social dialogue, and collective negotiations.

The HRH Network organizational structure lends itself well to the implementation of the Masterplan. There are three technical working committees (TWCs) with the themes of HRH Entry, HRH Workforce, and HRH Exit and Re-entry based on the WHO Working Lifespan Strategies (Table 8). These can be reconfigured and assume the functions necessary to implement the Masterplan (Table 9). However, re-arrangement of the working committees will also entail revisiting of MOU among the members of the HRH Network. The Masterplan's strategies can be categorized consistent with the foci of the TWCs: production, workforce, and exit and re-entry. Due to the similar nature of committees and the strategies, each TWC can assume the broad functions of coordination, monitoring and evaluation of the strategies' implementation. The implementation of cross cutting strategies can be taken on by another committee which will be formed for this specific purpose. This committee will have the same functions as the other TWCs. Membership in each TWC will be unique to avoid unduly creating confusion, and additional and/or overlapping workloads for members.

Table 8. Technical Working Committees of the HRH Network

Committee	Theme	Composition
TWC on Entry	Planning, education, and recruitment	One permanent and one alternate member representing each of the designated member government agencies and NGOs
TWC on Workforce	Supervision, compensation, retention, system supports, and lifelong learning and development	
TWC on Exit and Re-entry	Career choice, health and safety, migration and retirement, and reintegration of HRH in the healthcare system	
Oversight Committee	Decision making body	Composed of heads or designates of all member government agencies and NGOs

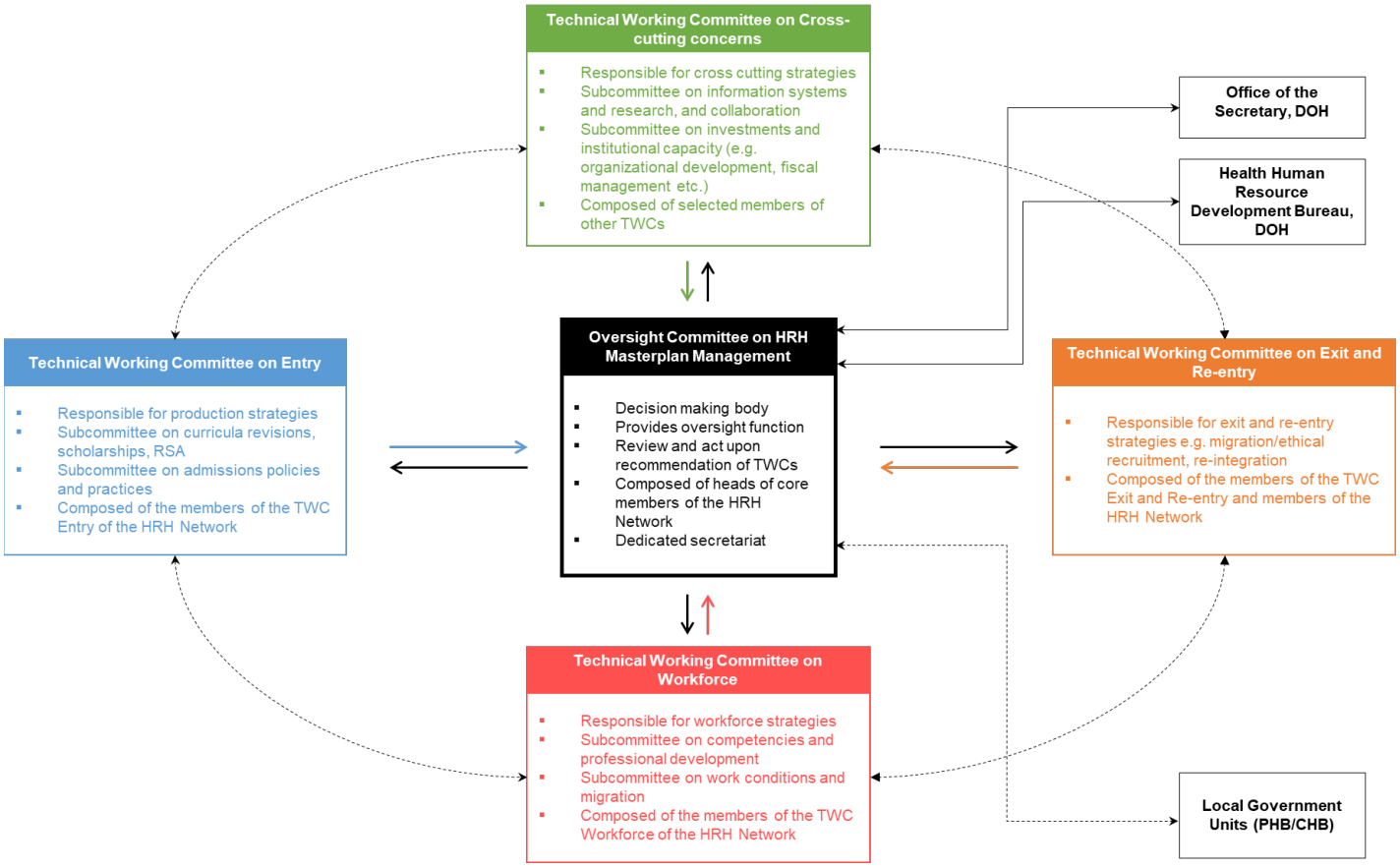
The Oversight Committee on the Masterplan Management will be composed of the heads or designates of all member government agencies and NGOs of the HRH Network. It will function as the decision-making body and provide oversight function to the Network. It will review and act on the recommendations of Technical Working Committees (TWCs) and can create and/or remove committees as necessary. However, it is imperative that the Oversight Committee will be supported by fully functioning secretariat composed of full-time staff as they will act as primary boundary spanners across network members.

Table 9. Proposed Technical Working Committees for the HRH Masterplan 2020-2040 implementation

Committee	Theme/Purpose	Composition
Oversight Committee on HRH Masterplan Management	Decision making body; provide coordination and oversight; review and act upon recommendation of other TWCs	▪ Composed of heads of core members of the HRH Network all members ▪ **Will have a dedicated full-time secretariat**
TWC on Entry	HRH pre-service strategies i.e. on education and training Responsible for production strategies	▪ Will have one subcommittee on curricular revisions, scholarships; and RSA; and, another on admissions policies and practices. Membership will be similar to current TWC Entry of the Network.
TWC on Workforce	All strategies that cover HRH management and development once HRH are in the health workforce Responsible for workforce strategies	▪ Will have one subcommittee on competencies and professional development and another on work conditions (including occupational and mental health) ▪ Membership will be similar to TWC Workforce of the HRH Network
TWC on Exit and Re-entry	HRH strategies on attrition including retirement, migration, re-integration and ethical recruitment Responsible for exit and re-entry strategies	▪ Will have subcommittee on migration ▪ Membership will be similar to TWC Exit and Re-entry of the HRH Network
TWC on Cross-cutting concerns	HRH strategies on information systems, collaboration, policies, investments, and building institutional capacities Responsible for cross cutting strategies	▪ Will have one subcommittee on information systems and research, and collaboration; and, another on investments and institutional capacity ▪ Membership will come from HRH Network members that represent cross cutting issues (e.g. information systems, migration, etc.)

As discussed above, there will be five committees that will comprise the governance and management structure for the implementation of the Masterplan. The structure will not be hierarchical but collegial; committees will be on equal footing to reflect the multi-sectoral nature of HRH development and management (Figure 5). The committees will not work in silos and the Oversight Committee on HRH Masterplan Management will coordinate, provide oversight, and make decisions. The Oversight Committee will regularly report to HHRDB and the Office of the DOH Secretary. It will also work with LGUs through Provincial/City Health Boards and with the proposed Technical Management Committees as they are tasked with HRH development.[39] The committees will play a critical role as mechanisms for collaboration among the many HRH stakeholders.

Figure 5. Proposed governance and management system of the HRHMP 2020-2040



2. Establishing accountabilities

Accountability is an obligation to be answerable for delivering results that were determined through a clear and transparent assignment of responsibility, subject to the availability of resources and constraints posed by external factors.[40] WHO identifies three components in its accountability framework: governance, which is providing strategic direction and leadership for successful accountability; results-based management to deliver on agreed-upon results and operational accountability; and, an assurance mechanism that comprise of enhanced accountability, transparency, and effective management through the provision of integrated assurance mechanisms.[41]

The HRHMP accountability framework (Figure 6) illustrates the three components of accountability. Governance of the HRH Masterplan takes place at the national and local levels and spans across planning, implementation, and reporting. The HRH Network and HHRDB will work closely together to manage and coordinate the implementation at the national level while the implementation of the Masterplan at local levels will be led by Provincial/City Health Boards (P/CHBs). The HRH Network and HHRDB will work closely with P/CHBs in the implementation of the Masterplan. In addition to advocacy work and awareness raising that will be done as

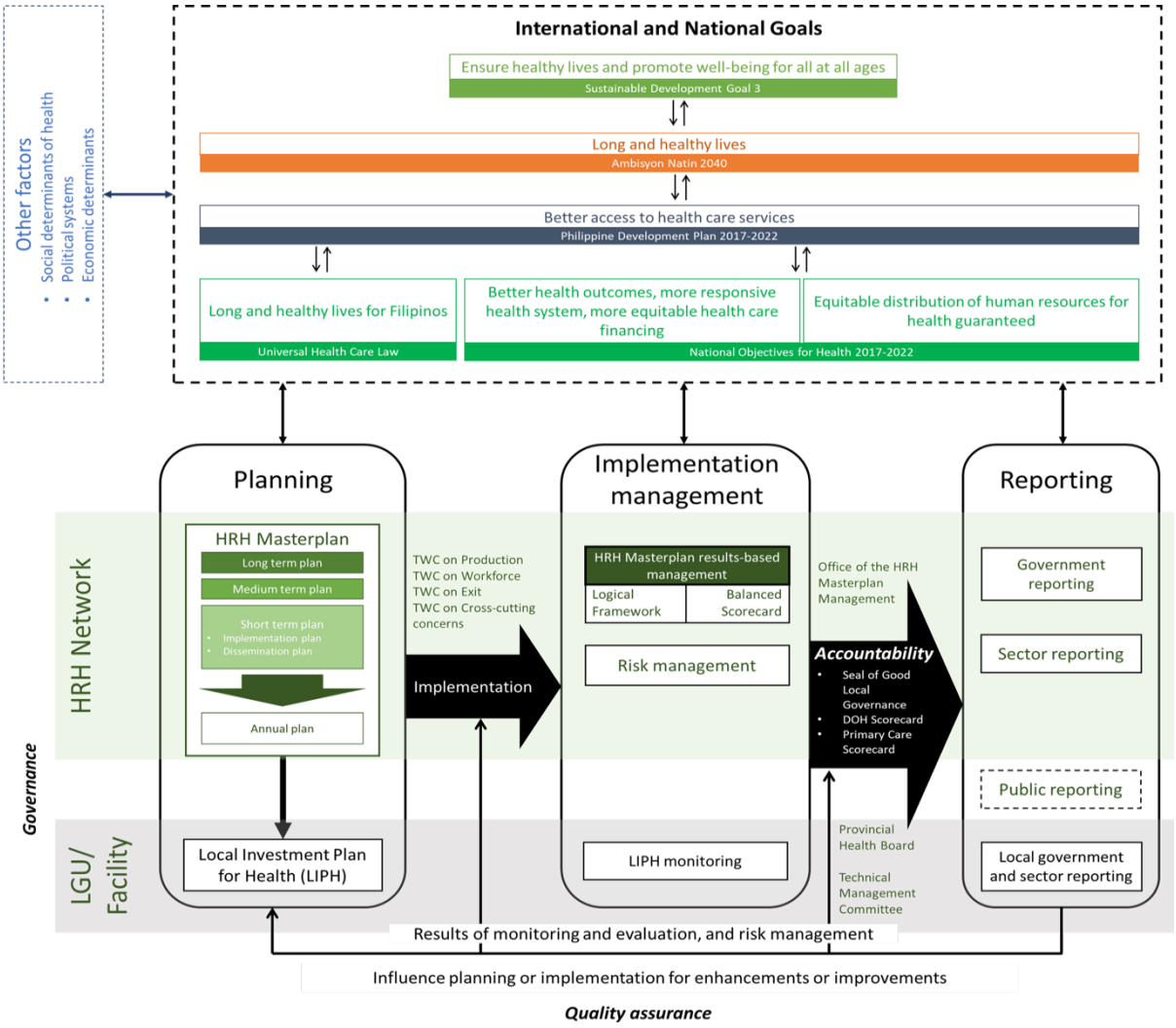
part of the communications plan to gain buy-in from the P/CHBs and other local stakeholders, a policy is proposed to be issued in order to formalize the implementation arrangement between the national and local levels. At the planning stage, the national HRH Masterplan will be adapted to reflect local conditions and incorporated in local investment plans for health e.g. through the addition of budget lines for HRH. Led by TWCs of the HRH Network, national agencies, LGUs, and other stakeholders will be involved in the implementation and monitoring, and reporting of the strategies and activities, making the accomplishment of pre-determined indicators a multi-sectoral effort.

Results-based management is embedded in the implementation of the Masterplan. A logical framework approach (LFA) matrix (Appendix A) has been developed for all strategies across five strategic objectives of the Masterplan. For each strategy, activities, outputs, and outcomes have been identified with corresponding indicators. The indicators are aligned with the Balanced Scorecard indicators that have been devised earlier for the Master Plan. In addition, the stakeholders that will be critical to the attainment of the strategies have been identified. It is necessary to get agreements with and commitments to the results (i.e. indicators) among these stakeholders as the strategies are rolled out. Stakeholders who agreed to the multisectoral performance indicators of the outputs and outcomes per strategy as embodied in the LFA must answer to the governing and management structure (i.e. the HRH Network) of the Masterplan. The Masterplan is a collaborative endeavor where its successful implementation relies on mutual accountability and responsibility.

The quality assurance component of the Masterplan's is evident in the feedback loop of the accountability framework as well as the accountability mechanisms (e.g. Seal of Good Local Governance, DOH Scorecard, Primary Care Scorecard) that have been identified. With the involvement of P/CHBs, the feedback loop will provide evidence that informs the future planning of the Masterplan as well as its implementation. On the other hand, accountability mechanisms will be established between and among HRH Network, regions, and other stakeholders such as LGUs to ensure that HRH are appropriately recruited, developed and managed to provide primary care to the local population. In Figure 6, the mechanisms are represented by scorecards, linked potentially by incentives and sanctions or penalties. The scorecard can be realized and backed by RA 11292 or the Seal of Good Local Governance (SGLG) Act of 2019. The SGLG Act creates a Council where the DOH is a member and will participate in the development of performance indicators for LGUs. An HRH focused performance indicator can be proposed to the Council. An LGU that complies, qualifies, and passes the assessment criteria will be awarded the SGLG and granted the corresponding financial incentive.[42] In addition to scorecards, the P/CPHBs have a key role to play in the accountability framework. Besides their existing functions, they will exercise technical and administrative supervision over HRH within their respective territorial jurisdiction. This reinforces the role of local health boards as outlined in the 1991 LGC which is to propose annual budgetary allocations for the operation and maintenance of health facilities and services; and, create committees which shall advise local health agencies on matters such as personnel selection and promotion, grievance and complaints, personnel discipline, operations review, and similar functions. These will be in accordance with technical and administrative standards and criteria set by the DOH.[43] In addition, the LFA can become a binding document if the stakeholders formally recognize it as such.

A critical input to the three components of the accountability framework is reporting of the data that will be produced by the Masterplan's M&E system. Besides informing national and local level planning and implementation of the Masterplan, the data will provide on how the Masterplan has responded to the HRH components of the 2018 UHC law, NOH 2017-2022, the 2017-2022 PDP, and Goal 3 of the SDGs. This process involves reporting to its national and local stakeholders, and to external development partners.

Figure 6. Accountability framework of the HRHMP 2020-2040



Policy environment and support

For the 2020-2040 HRH Masterplan formulation, it was necessary to define the policy environment that will affect its implementation. The HRH Masterplan must respond to the policy frameworks articulated in international commitments and national goals. These will contribute to the re-shaping of the Masterplan, especially in identifying strategies, activities and targets that it should contain to ensure that there are "appropriately skilled and motivated, equitably distributed and well supported" health workers supporting the health system to improve health outcomes and achieve UHC for Filipinos.[44] [45]

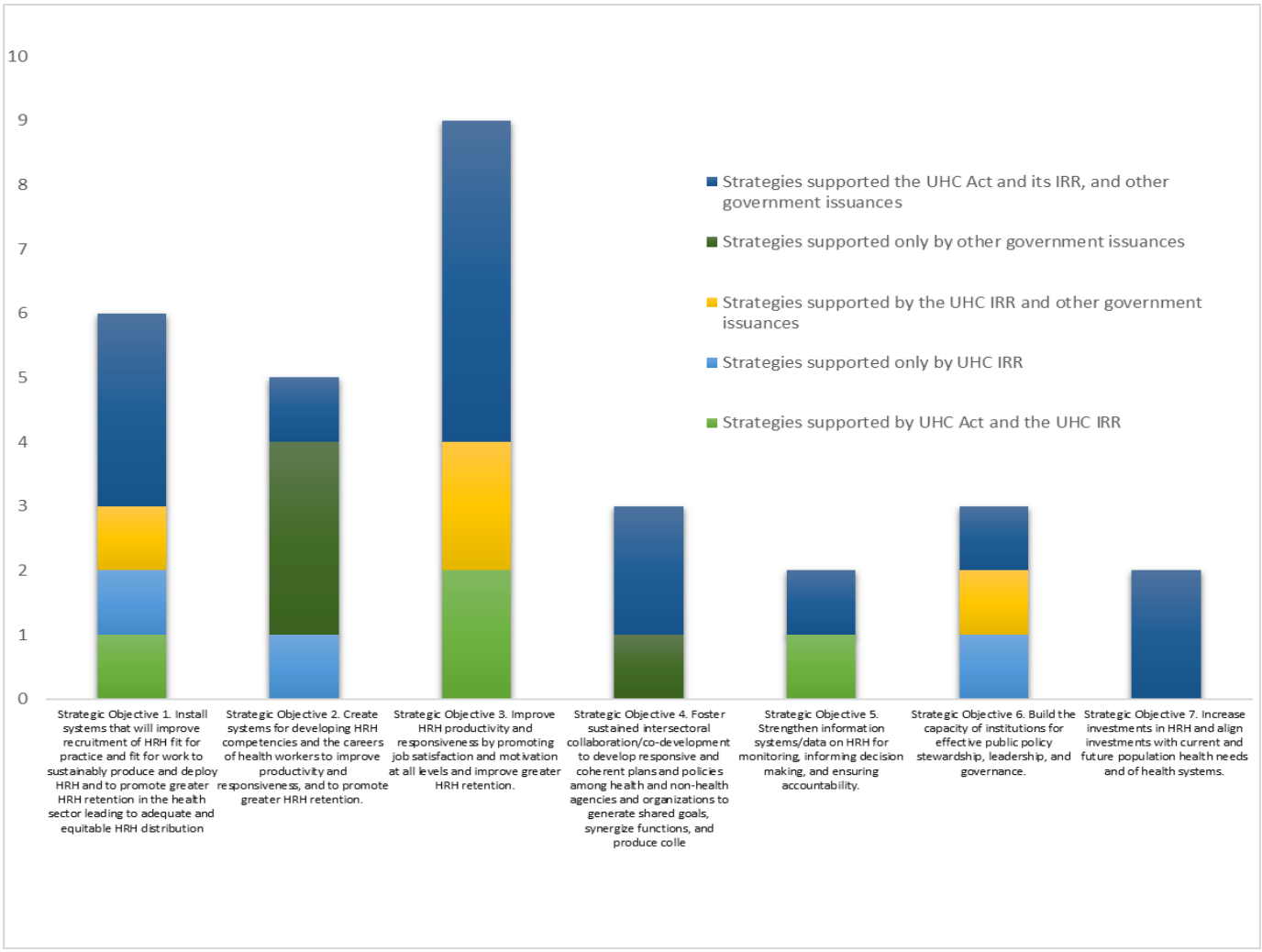
The Philippines commited to achieve desired health outcomes articulated in international agreements like the Millenium Development Goals (MDG) and the Sustainable Development Goals (SDG). In particular, SDG 3, which is specific on health, considers the HRH-related sub-outcome of substantially increasing the health financing and the recruitment, development, training and retention of the health workforce. Furthermore, as a WHO member state, the country is expected to uphold the WHO Global Code of Practice on the International Recruitment of Health Personnel, and consider the WHO Global Workforce Strategy in its planning and policy-making "to improve health, social and economic development outcomes by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce". The Philippines is committed to attain certain health outcomes by 2030. With its signing up to fulfill the High Commission on Health Worker employment and Economic Growth (CHEEG) provisions, the Philippines has professed to increase investments in health workforce employment to contribute to national economic growth.

On the national front, the HRH Masterplan is aligned to the vision of "Filipinos having long and healthy lives by 2040" as stated in AmBisyon Natin 2040. The NOH 2017-2022 also articulated this similarly by envisioning that Filipinos be among the healthiest in Southeast Asia by 2022 and the healthiest among Asians by 2040. Exisiting medium-term plans such as the Philippine Development Plan (PDP) 2017-2022 and the Health Facility Development Plan (HFDP) of the DOH also articulate components supportive of HRH, to which the HRH Masterplan 2020-2040 should be aligned.

The existing policy environment that affects identified HRHMP strategies to address persistent and emerging issues being faced by HRH was observed to be generally supportive.

Figure 7 summarizes the extent of current policy support for the identified strategic objectives of the HRHMP 2020-2040

Figure 7. Policy support to identified HRH strategies per Strategic Objectives



It is important to note that there are 10 short-term, one medium-term, and four long-term strategies across the seven strategic objectives identified in the HRHMasterplan explicitly supported by the UHC Act and its IRR and are likewise supported by policy issuances from the several agencies in the executive branch of the government. There are four 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 three short-term strategies (i.e., Support career development of all health workers including Volunteer Health Workers; Enforce/strengthen the provision of coaching, mentoring, and supportive supervision to health workers; and, Develop career paths of health workers).

Table 10. Legislations and policies with provisions supportive of each strategic objectives

Strategic Objective	Supportive legislation and policy
Strategic Objective 1 Install systems that will improve recruitment of HRH fit for practice and fit for work to sustainably produce and deploy HRH and to promote greater HRH retention in the health sector leading to adequate and equitable HRH distribution vis-à-vis local health needs	• Republic Act 11223 (UHC Act) and IRR • Republic Act 10650 (Open Distance Learning Act) • DOH Administrative Order 2018-0022 • DOH Administrative Order 2006-0014 • CSC Memorandum Circular 1996-26 • DOH Administrative Order 2015-0042 • DOH Administrative Order 2018-0022 • CHED Memorandum Order 2017-15
Strategic Objective 2 Create and sustain systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention	• Republic Act 11223 (UHC Act) and IRR • Republic Act 7883 (Barangay Health Worker Incentives Act) • Republic Act 10912 (Continuing Professional Development Act) • Republic Act 10767 (Comprehensive Tuberculosis Elimination Plan Act) • Republic Act 7305 (Magna Carta for Public Health Workers) • Republic Act 8792 (Electronic Commerce Act) • DOH Administrative Order 2006-0014 • DOH Administrative Order 2014-0042 • Executive Order 1999-102 • CSC Memorandum Circular 2012-6
Strategic Objective 3 Raise HRH productivity and responsiveness by promoting job satisfaction and motivation at all levels and improve greater HRH retention	• Republic Act 11223 (UHC Act) and IRR • Republic Act 7883 (Barangay Health Worker Incentives Act) • Republic Act 7305 (Magna Carta for Public Health Workers) • Republic Act 11058 (Occupational Safety and Health Standards Act) • Republic Act 2382 (Medical Law) • Republic Acts 7164 and 9173 (Nursing Laws) • Republic Act 10862 (Nutrition and Dietetics Law) • Exectuive Order 2016-201

Strategic Objective	Supportive legislation and policy
	• DOH-DBM Joint Circular 2013-1 • DOH-DBM Joint Circular 2014-1 • DOH Administrative Order 2012-0020 • DBM Administrative Order 2011-25 • CSC Memorandum Circular 1997-33 • DOLE Department Order 2018-198
Strategic Objective 4 Foster sustained intersectoral collaboration/co-development to develop responsive and coherent plans and policies among health and non-health agencies and organizations to generate shared goals, synergize functions, and produce collective impact	• Republic Act 11223 (UHC Act) and IRR • Republic Act 7305 (Magna Carta for Public Health Workers) • Republic Acts 8042 and 10022 (Migrant Workers and Overseas Filipinos Act) • CHED Memorandum Order 2012-46 • CHED Memorandum Order 2017-15
Strategic Objective 5 Strengthen information systems/data on HRH for monitoring, informing decision making, and ensuring accountability	• Republic Act 11223 (UHC Act) and IRR • Republic Acts 8042 and 10022 (Migrant Workers and Overseas Filipinos Act) • Republic Act 10844 (Department of Information, Communication and Technology Act) • Republic Act 10175 (Cybercrime Prevention Act) • Republic Act 10173 (Data Privacy Act) • Presidential Decree 442 (Labor Code) • Executive Order 1982-797 • DOH-DOST-Philhealth Joint Administrative Order 2016-2 • DOH Administrative Order 2015-17
Strategic Objective 6 Build the capacity of institutions for effective public policy stewardship, leadership, and governance	• Republic Act 11223 (UHC Act) and IRR • Republic Act 7305 (Magna Carta for Public Health Workers)
Strategic Objective 7 Increase investments in HRH and align investments with current and future population health needs and of health systems	• Republic Act 11223 (UHC Act) and IRR • Republic Act 7305 (Magna Carta for Public Health Workers) • Republic Act 10354 (Responsible Parenthood and Reproductive Health Law) • Republic Act 10912 (Continuing Professional Development Act)

Strategic Objective	Supportive legislation and policy
	• Republic Act 10767 (Comprehensive Tuberculosis Elimination Plan Act) • Republic Act 7883 (Barangay Health Worker Incentives Act) • DOH Administrative Order 2007-34

Given the current policy environment, the translation of provisions from the UHC Act and its IRR to implementation policies and operational guidelines is limited. Some HRH strategies were found to have weak or unclear policy support. Furthermore, existing policies need to be reviewed to ensure that they are aligned to the provisions of the UHC Act and its IRR.

An omnibus policy review was conducted to determine policies that impact HRH development and management that have overlapping and/or opposing intentions and provisions that can affect the successful implementation of the UHC Act. The review showed that there is a growing body of evidence about the policy environment in terms of the health system in the Philippines especially when the dialogue on UHC started. However, there are persisting policy issues that need to be resolved (e.g., institutionalizing interprofessional education, barriers to competitive salaries for health workers, rationalizing staffing standards, revisiting accountability mechanisms, harmonizing governance, etc.). A proposed policy agenda (Table 11) was generated from the review that will facilitate resolution the major issues that spans the working lifespan of health workers, from pre- and in-service training and education, workforce, to exit and re-entry.

Table 11. Proposed policy agenda

Issues	Policy agenda
HRH Production	
Expanding and adjusting inter-professional education (IPE) to the needs for HCPNs and PCPNs	Craft a national policy on IPE to guide collaborative pedagogical approach.
HRH entry, exit & re-entry	
Need to overcome policy barriers in providing competitive salaries and enabling work environment to the health workforce	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	Craft policies to support the re-entry of HRH into the health labor force
Need to operationalize task shifting and task sharing to facilitate teamwork in primary care	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
Need to rationalize staffing patterns and standards based on needs	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	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	Policy agenda
Transitioning HRH governance synchronized with UHC provisions	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	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.
Need to go beyond Gender and Development (GAD) compliance	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.

Communications plan

A communications plan is critical to the effective implementation of the Masterplan. It will facilitate obtaining inputs and commitment of a wide range of HRH stakeholders who need to be involved in the Masterplan. The communication plan aims to:

- Widely disseminate the Masterplan among stakeholders and the general public
- Obtain support for the implementation of the Masterplan
- Ensure the appropriate implementation especially at the national and LGU levels

The objectives will be accomplished by defining key messages, using various communication channels and materials that are known to work from the experience of HRH2030 in the Philippines, and tailoring these as befits the targeted audience to bring about desired changes (Table 12).

Table 12. Key elements of the communications plan

Audience	Key message	Communication channels	Desired change/action
Individuals	▪ With an aging population and emerging and re-emerging diseases, community and personal involvement in improving public health should be encouraged. ▪ The HRH Masterplan will contribute in ensuring that Filipinos will have access to consistent optimal treatment and holistic care. ▪ Adequate number and better quality of health workers mean more and better health services that Filipinos can access to keep and become healthy. ▪ There is no health care without health workers	▪ Mass media channels - Radio, community billboards, posters, press release ▪ Social Media platforms - Facebook, Instagram, YouTube - Prepare social media messages for key stakeholders to share on their personal platforms to repost and thus further amplify messages. ▪ Website - HRH network website and in collaboration with partner agencies and stakeholders ▪ Interpersonal channels - Verbal relay of information among individuals	Awareness building ▪ The first step in an awareness campaign is to understand the knowledge, attitudes and practices of the various user groups. ▪ To influence the behavior of the community, there should be changes in their attitudes, perceptions and behavior. ▪ Awareness-raising campaigns tend to be more successful and have a greater impact when they are conducted by a network ▪ Individuals take responsibility on their health and their family and practice health seeking behavior
Heath care providers	▪ Health facilities can ensure that HRH management is	▪ Healthcare workers Intranet - Internal newsletters	Behavior change

Audience	Key message	Communication channels	Desired change/action
	structured that it complements and strengthens hospital initiatives and the work of staff. ▪ Health facilities should recognize that well managed and developed HRH contribute to personal and societal health and well-being as well as improving the patient experience. ▪ Performance management should be based on a minimum standardized set of competencies that respond to community needs. ▪ Health workers are essential links between the health facilities and the community, strengthening relationships, building trust and supporting health care improvements.	- Central location for resources - Departmental sites - Staff directory ▪ Social Media platforms - Facebook group chat ▪ Interpersonal channels - Verbal relay of information among individuals	- The passage of time is necessary for innovations to be adopted; they are rarely adopted instantaneously. - The message must be widely adopted in order to self-sustain. - Health facility management practice supportive roles to health care providers' career growth and employ recognition system
Policy and decision makers (national and subnational levels)	▪ The HRH Masterplan supports the Philippine Government to create a strategic plan to plan, finance, and implement solutions to address its human resources for health challenges. ▪ The government should strategically invest in HRH as a foundation of an optimal health system that is accessible, accountable, affordable, and reliable. ▪ Ensure effective and robust monitoring and evaluation throughout the policy and implementation of the HRH Masterplan. ▪ In the Philippines, only about 10 percent of the country's health workers serve in rural areas, resulting in maldistribution of HRH and inequities in health services and outcomes in underserved areas.	▪ Government office channels - Communication network between government offices such as e-mails and memos. ▪ Meetings and conferences - Strategic planning - Brainstorming - Policy making	Behavior change - Government use policy instruments to institute change and provide evidence for information campaigns. - Societal support is needed to achieve change i.e. demand for more and competent HRH - Policy and decision-makers promoted enabling policy environment and strategic investments

Audience	Key message	Communication channels	Desired change/action
	▪ Investing in health workers saves lives		
Health System/ facility managers	▪ Ensure effective and robust monitoring and evaluation throughout the policy and implementation of the HRH Masterplan. ▪ Health facilities can ensure that HRH management is structured that it complements and strengthens hospital initiatives and the work of staff. ▪ Health facilities should recognize that well managed and developed HRH contribute to personal and societal health and well-being as well as improving the patient experience. ▪ Performance management should be based on a minimum standardized set of competencies that respond to community needs. ▪ Health workers are essential links between the health facilities and the community, strengthening relationships, building trust and supporting health care improvements.	▪ Government office channels - Communication network between government offices such as e-mails and memos. ▪ Meetings and conferences ▪ Healthcare workers Intranet - Internal newsletters - Central location for resources - Departmental sites - Staff directory ▪ Social Media platforms - Facebook group chat ▪ Interpersonal channels - Verbal relay of information among individuals	Awareness building - The first step in an awareness campaign is to understand the knowledge, attitudes and practices of the various user groups. - To influence the behavior of the community, there should be changes in their attitudes, perceptions and behavior. - Awareness-raising campaigns tend to be more successful and have a greater impact when they are conducted by a network Behavior change - Health facility management practice supportive roles to health care providers' career growth and employ recognition system
General public	▪ The commitment to ensuring universal access to essential health care is, therefore, not only central to the social and economic development of a community but also an important aspect of social equity. ▪ Building an operational partnership with the community, with the goal of improving the health status of the population, is a step beyond participation and involvement.	▪ Mass media channels - Radio, community billboards, posters, press release ▪ Social Media platforms - Facebook, Instagram, YouTube, Vimeo - Prepare social media messages for key stakeholders to share on their personal platforms to repost and thus further amplify messages. ▪ Website - HRH network website and in collaboration with partner agencies and stakeholders ▪ Interpersonal channels - Verbal relay of information among individuals	Awareness building - The first step in an awareness campaign is to understand the knowledge, attitudes and practices of the various user groups. - To influence the behavior of the community, there should be changes in their attitudes, perceptions and behavior. - Awareness-raising campaigns tend to be more successful and have a greater impact when they are conducted by a network

Audience	Key message	Communication channels	Desired change/action
International partners and stakeholders	▪ HRH stakeholders should strategically invest in HRH as a foundation of an optimal health system that is accessible, accountable, affordable, and reliable. ▪ HRH stakeholders will introduce and adopt innovative ways to produce, manage and develop human resources for health to sustain a fit-for-purpose-and-practice health workforce. ▪ Partnership opportunities abound and governments must work with healthcare institutions to encourage and facilitate collaboration between the community and the public sector. ▪ Public-private partnerships establish and recognize the collaboration of the private health sector with services of public utility and can foster respecting basic standards of service delivery. ▪ Building strong partnerships between health professionals provides an opportunity to maximize talents and expertise, while focusing on health care delivery. ▪ Promote integrated and collaborative HRH initiatives (not in silos)	▪ International network - Partner countries (MHO/DOH) - ASEAN, INGOs, NGOs, Agencies ▪ International news media ▪ Websites - HRH network website and in collaboration with partner agencies and stakeholders ▪ Social media platforms - Facebook, Instagram, YouTube, Vimeo - Prepare social media messages for key stakeholders to share on their personal platforms to repost and thus further amplify messages.	Adoption of messages and assist in its dissemination - Deep involvement (buy-in) in the process by a variety of stakeholders tend to generate better outcomes and a greater sense of ownership. - Actively involve partners and stakeholders in the process. - Stakeholders involved in strategic planning will have more interest and investment in the plan's success. - Include representatives of stakeholder groups in discussions for strategic planning to the greatest extent possible - Involve middle level managerial and operational levels in addition to the top level of management In planning and monitoring of HRHMP implementation

Monitoring and evaluation

To determine to what extent the theory of change (see Figure 2) is achieved and to establish its validity, monitoring and evaluation activities will be made integral to the Masterplan. Monitoring is the ongoing process of systematically collecting and analyzing data or feedback on the progress being made towards achieving stated goals and objectives.[46] [47] Evaluation is a systematic, rigorous and independent assessment of ongoing or completed activities, programs or policies, compared to a set of standards, to determine the extent to which objectives are being achieved as a mean to contributing to decision making e.g. improvement of a program or policy.[48] [49] [50]

A balanced scorecard (BSC), a widely accepted approach to monitoring and evaluation (M&E), is a carefully selected set of quantifiable measures derived from strategies organized around financial, customer (people), internal processes (activities), and learning and growth perspectives.[51] A BSC has been crafted for the HRH Masterplan and due to the not for profit nature of human resources for health, partnership and collaboration have been included as additional dimensions. A set of high-level quantitative indicators across five

dimensions of the BSC and for the each of the strategic objectives of the Masterplan have been identified (Table 13). These high-level indicators will show the progress towards the accomplishment of the mission and goals of the Masterplan and have been used in the development of indicators for each strategy in the LFA.

Table 13. Balanced scorecard indicators of the HRH Masterplan

Perspective	Strategic Objectives	Measure
People	Adequate and equitable HRH distribution vis-à-vis local health needs (SO1)	Responsiveness: - provision of proactive health services - reduced readmission rates
▪ Customer value	Satisfied end users of health system	Productivity: - increase in availability of health services - reduction in patients going to secondary/tertiary -level of care
		Health system end user (customer) satisfaction
▪ Satisfaction and/or retention	Collegial collaboration among national agencies and other stakeholders	Types and frequency of collaborations
		Mechanisms for collaboration
	Satisfied and cooperative owners and managers of health facilities	Health worker satisfaction (on employment)
		Reduction of vacancies / duration of vacancy
	Satisfied and cooperative owners and managers of HEIs	Increased # of graduates per cadre and practicing locally
		Improved completion rates (# of graduates/ # of enrolment)
		Proportion of compliant HEIs (# of compliant HEIs/total HEIs in the region)
Process	Improve recruitment of HRH fit for practice and fit for work to sustainably produce and deploy HRH and to promote greater HRH retention in the health sector (SO1)	Increased number of graduates of students from local areas
		Efficiency: Improved retention of local health workers in local health facilities
		Quality: Profile of graduates of SUCs and high quality HEIs are responsive to the needs and practice locally
		Quality: Increased/sustained availability of health services including public health in local health facilities
	Improved HRH productivity and responsiveness (SO3)	Staffing standards fulfilled at the facility and health care provider network level
		Increased HRH employed in health sector with permanent positions especially in rural areas/GIDA
		Low employment turnover; reduced JOs, contractual employment
		Health facilities have appropriate number of permanent positions and filled vacancies
		Proportion of health worker who are aware about HRHMP
		Job satisfaction of public and private health workers
Financial		Fully supported HRH and HRH systems

Perspective	Strategic Objectives	Measure
▪ Financial performance ▪ Effective resource use (Funding source, cost of service, overhead costs)	Increased HRH-related investments which are appropriately managed (SO7)	Increase in funding (Contribution of stakeholders for HRH investment)
		Efficiency measures (existing DOH indicators)
		Cost-utility/ effectiveness (existing DOH indicators)
		Compliance to public financial management system
Learning and growth	Enhanced competencies and careers of health workers (SO2)	Employee satisfaction (career development)
		Defined volunteer health worker career paths
▪ Human capital		Health workers are in the appropriate positions of their career paths based on their competencies and experience
		Improved provision of health services because of enhanced competencies
▪ Culture / Community		Responsive and highly skilled HRH providing culturally appropriate health services
		Improved public health outcomes
▪ Infrastructure & technology	Functional and integrated HRH information systems (SO5)	Access to up to date and accurate information
▪ Governance	Strengthened institutional capacity (SO6)	Improved institutional planning and management capacities
		Proportions of national agencies and LGUs with institutionalized HR management for HRH
Partnership and collaboration	Sustained intersectoral collaboration/co-development of plans and policies (SO4)	Harmonized HRH related policies (personnel services limit in LGUs, financing)

Monitoring activities will be done regularly and focus on data collection for the pre-determined indicators in the LFA and BSC. If and when possible, it will be done in conjunction with the data collection activities and tools that are being done and used by the DOH. Data for the LFA indicators will largely come from national and regional agencies, LGUs, and public and private HEIs and health facilities. These will be summarized and inform the high-level indicators in the BSC, which will indicate the progress of the Masterplan implementation.

There are common evaluation activities that are carried at various stages of an intervention: formative or ex-ante, mid-term or process, and summative or ex-post evaluation. Formative evaluation (monitoring) is usually carried out in the development or implementation stages of an intervention or initiative while summative evaluation (outcome or impact)is done at the end of the intervention or initiative and usually focuses on outcomes.[52] However the nature of an evaluation can be focused on its purpose such as on implementation, improvement-oriented, outcome/impact, and developmental.[53]

While monitoring will be undertaken from the beginning of the implementation of the Masterplan until its completion, evaluation activities are proposed to take place as follows:

Table 14. Timetable for Evaluation Activities

Activity	Coverage	Stage of implementation	Time/Year
Process evaluation	Short term plan	Semi annual and during the short-term plan period	2021 to 2022
Outcome evaluation	Short term plan	Beginning of mid-term	Early 2023
Process evaluation	Mid-term plan	Mid-implementation	End of 2025
Outcome/impact evaluation	Short and mid-term plans	At the end of mid-term	End of 2028

End Notes

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Appendices

Appendix A. Logical Framework Matrix for Short, Medium and Long -term Strategies

Production Strategies

Strategic Objective 1

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

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Goal	1Educate and train future HRH in or near their places of origin	Proportion of health facilities with graduates of SUCs and high quality HEIs that are responsive to the local needs and practice locally	*No data*		Health facility employment records		Congress, CHED, regional HEIs, professional societies, employers: LGUs and private health facilities	2024 - onwards	- Funds for establishing health sciences programs in SUCs and campuses are available - There is policy/political support (Congress, CHED, LGU/LCE) - Availability of schools, training hospitals and affiliation facilities in the area - Availability of competent faculty who are willing to teach in GIDAs/rural areas or where they are needed	
		Proportion of health facilities that provide holistic/ comprehensive health services	*No data*		Health Facility data					
		Reduced patient readmission rates	*No data*		Health Facility data					
Outcomes	Locally produce highly motivated and responsive HRH who will continue to serve for at least 5 years in their locality	▪ increased # of graduates per cadre and practicing locally ▪ Proportion of regions with available supply of local HRH	189,787 HRH Data Source: 2018 HHRDB Data	From forecasting results	Graduation records (CHED)			2024 - onwards	-Alternative learning is accessible	

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Outputs	Local students are enrolled in SUCs or high quality SUCs	Improved completion rates (# of graduates/ # of enrolment)	Enrollees as of 2017 - Nursing: 46,310 - Midwifery: 11,132 - Medicine: 23,763 - Medtech: 32,466 Graduates as of 2017 - Nursing: 12,267 - Midwifery: 3,720 - Medicine: 4,542 - Medtech: 7,307 Source: 2017 CHED data from HLMA dataset	From forecasting results	Graduation and Enrolment records (CHED)			2023		
	Accredited internship/clinical practice programs for 12 cadres established per region	# of interns/trainees by cadre	*No data*	1 internship/clinical practice program per cadre per region				2023		
	Health science courses for 12 cadres offered per region	Proportion of regions with health science courses for 12 cadres	Nursing: All regions Midwifery: All regions Medicine: Except Region 12, CARAGA and MIMAROPA Medtech: All regions Source: 2017 CHED data from HLMA dataset					2023		
Activities & inputs	Identify and support SUCs or high quality HEIs which offer health sciences education in every region	Proportion of regions with HEI having health sciences education present	109 SUCs (min 1 per region but not for all cadres)	All SUCs have responsive curricula for 12 cadres	National and CHED policies and registration			2022		37,907,742.00
	Determine training hospitals for internship of 12 cadres in all regions	Proportion of regions with internship/clinical practice program per cadre in place	*No data*		CHED data			2022		

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
	Reorient health professional curricula to produce responsive health workers equipped with primary care competencies for the region	Proportion of HEIs with responsive curriculum development	*No data*					2022		
Goal	2Establish targeted admission practices in HEIs	Increased number of graduates of students from local areas	*No data* *(Data source: DOH Scholarship program data)*		Admission practices; CHED/HEI issuances		CHED, DOH, regional HEIs	2024 - onwards	- Private schools adjust their admissions guidelines.	
Outcomes	SUCs and HEIs prioritize admissions of IP and students with rural background	Proportion of compliant HEIs (# of compliant HEIs/total HEIs in the region)	*No data*		CHED/HEI monitoring of issuances			2024 - onwards	- Public and private schools can be readily regulated	
Outputs	Increase enrolment of rural and IP students	Proportion of rural and IP students to total enrolment	*No data* *(Data source: DOH Scholarship program data)*	at least 50%	Enrolment records (CHED)			2023	- Coordinate with school officials and family	
Activities & inputs	Revise admission guidelines in HEIs per region to target indigenous people and local students with rural background	Proportion of SUCs/HEIs with admission guidelines target indigenous people and local students with rural background	*No data* *(Data source: DOH Scholarship program data)*					2022	- Policies in place for SUCs and HEIs to prioritize admissions	7,933,967.00
	Promote enrolment of local students including indigenous people who are willing to serve locally for at least 5 years	Proportion of SUCs/HEIs with campaigns to promote enrolment of local students	*No data*					2022		
Goal	3Expand scholarships that would support the production of needed cadres of health care professionals and health care workers with enforceable RSA that also offers incentives	Amount of funding of for scholarships per region	*No data*		Scholarship program data and reports		HRH Network, UNIFAST, DOH, DOST, PRC, CHED, HEIs	2024 - onwards	- There are policies on health sciences program scholarships & RSA with rigorous instruments i.e. incentives and penalties	
		Sources of scholarships	*No data*		Scholarship program data and reports					
		Number of scholars per cadre funded	*No data*		Scholarship program data and reports					
		Coverage of scholarships (e.g., tuition fee, miscellaneous fees, living allowance)	*No data*		Scholarship program data and reports					

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Outcomes	High utilization of health science program scholarships that address HRH gaps in underserved areas	Proportion of graduates with RSAs serving in underserved areas	*No data*		HW Registry, PRC			2024 - onwards	- There is budget for scholarships	
Outputs	Available health sciences program scholarships with RSA for students from underserved areas	Increased number of health sciences program scholarships in underserved areas	Medicine program (for 8 SUCs including UPM and UP-SHS) Nursing program (UPM and UP-SHS) Dentistry (UPM) Midwifery (UP-SHS) Pharmacy (UPM) PT (UPM) OT (UPM) Medtech [Public Health] (UPM) Source: CHED-DBM JMC 2018-1, UPM RSA IRR		Scholarship records			2023	- Students are amenable to longer RSAs.	
Activities & inputs	Use WISN results as basis for providing scholarships in rural areas	Availability of an institutionalized national system of providing scholarship grants in rural areas using WISN results	No institutionalized national system of provising scholarship grants					2022	- WISN is regularly carried out	1,128,948,460.40
	Harmonize public and private scholarships from all sources to boost health sciences program enrolment and produce needed cadres of health workers in rural and GIDA areas	Equitable distribution and comprehensive coverage of health sciences program scholarships in rural and GIDA areas	*No data*					2022		
	Strengthen implementation of RSA for HRH (monitoring, non-compliance, identify incentives)	Proportion of regions implementing and monitoring of an enhanced policy on RSA	CHED-DBM JMC 2018-1, UHC IRR as of 2019					2022		
Goal	4Re-orient curriculum to PHC and integrate public health, rural health courses/ topics, rural exposure/immersion, and use of technology to deliver health services	Proportion of health sciences HEIs that have re-oriented curricula to PHC and integrate public health, rural health courses/topics, rural exposure/immersion, and use of technology to deliver health	*No data*		CHED issuances, health sciences program curricula		CHED, PRC, private sector, HEIs, associations e.g. ADMC, ADPCN	2024 - onwards	- Political will/support is present to introduce and implement revisions in curricula	

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
		services by CHED region by professional cadre								
		Proportion of health sciences HEIs that produce primary care workers who are practice ready after graduation by region and by cadre							- There is budget available for revising curricula.	
Outcomes	HRH graduates have strengthened PHC and public orientation and serving in underserved areas	Proportion of HRH with strengthened PHC and public health orientation serving in underserved areas	*No data*		List of HEIs with graduates who are products of the re-oriented curriculum			2024 - onwards	- The necessary structure for the revision and implementation of curricula is present.	
Outputs	Implementation of revised curricula in HEIs/SUCs	Proportion of HEIs/SUCs with revised curricula	*No data*		HEI records			2023	- HEIs are compliant with curricular revision policies.	
Activities & inputs	Intensify pre-service education and training on PHC, public health, rural exposure/immersion, and use of technology to deliver health services	Proportion of HEIs/SUCs integrating PHC, public health, rural health topics/immersion, and use of technology to deliver health services in curriculum of all health sciences program	*No data*					2022	- The necessary policies are in place and enforceable.	35,039,294.00
		Proportion of HEIs/SUCs producing graduates with new skillset, especially in the application and use of technology in service delivery								
	Advocate for the inclusion of PHC, public health, and rural health topics/ immersion in public and private HEIs	Increased percentage of public health/primary health care related questions in board examinations of health-related courses	*No data*					2022		
	Utilize flexible learning options (FLOs) in pre-service training of health professionals	Number of HEIs using modular, blended learning and e-learning modalities in pre-service training of health professionals	*No data*		HEI reports, CHED policies			2022		

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
	Form a functioning interagency working group to introduce changes to curricula	Enacted agreement (or any binding document) establishing the interagency working group	*No data*					2022		
		Primary health/ public health care included in OBE	*No data*							
		Minimum time of rural exposure/immersion defined in OBE	*No data*							

Workforce Strategies

Strategic Objective 2

Create and sustain systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Goal	5 Support career development of volunteer health workers (e.g, BHW, BNS, etc.)	Defined volunteer health worker career paths	No volunteer health worker career path	Adoption of career paths of volunteer health workers by LGUs	Job descriptions/roles and responsibilities for volunteer health workers Career map for volunteer health workers	Competency assessment	DOH, TESDA, LGUs, DILG, other agencies/ institutions that offer programs for volunteer health workers	2024 - onwards	- There is a policy that supports the career development of volunteer health workers	
Outcomes	Volunteer health workers have career paths in the health sector	Career program for volunteer health workers	No career program for volunteer health workers		Program design			2024 - onwards	- The budget is available for their career development. - LCEs will support the career path of volunteer health workers	
		Proportions of national agencies and LGUs with institutionalized HR management for HRH	*No data*							
	Volunteer health workers will no longer be co-terminus with LCEs.	Proportion of volunteer health workers appointed beyond the LCE term	*No data*		List of volunteer health workers			2024 - onwards	- Structures/processes are in place to support volunteer health workers career development.	

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Outputs	Adoption of certification program for volunteer health workers by LGUs	Proportion of LGUs employing volunteer health workers with certification	*No data*		List of certified volunteer health workers, TESDA certication program			2023	- LGUs will support the accreditation of volunteer health workers and include them in local priorities.	
	Adoption of career development paths for volunteer health workers	Proportion of LGUs implementing career development paths	0 LGUs		List of LGUs implementing career development paths, LGU annual reports			2023		
Activities & inputs	Review exisiting capacity building programs for volunteer health workers	Availability of a range of capacity building programs for volunteer health workers	*No data*		Reports			2022		12,473,100.00
	Craft career development paths for volunteer health workers	Availability of a feasible career development paths available for volunteer health workers	No career development paths available for volunteer health workers		Career development path for volunteer health worker report			2022		
	Explore new initiatives such as micro credentialing to be able to provide home-/community-based services	Established appropriate certifications (e.g., National Certification Program) for volunteer health workers						2022		
	Strengthen implementation of national certification program for volunteer health workers		*No data*		TESDA Report			2022		
Goal	6 Enable health workers to obtain appropriate skills, knowledge and attitudes through learning and in-service staff development methods	Proportion of responsive and highly skilled HRH providing health services	*No data*		end user (patient and facility) satisfaction	e-learning, competency assessment, LDIMS	PRC, DOH, TESDA, academe, other agencies, health facilities	2022 - onwards	- HRH are allowed time to access learning and development activities. - Support from LCEs to access learning and development activities without incuring absences - The cost of learning and development activities (e.g. conventions) is made affordable with	

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
									sponsorship of health facilities. - There is policy supporting the acquisition of knowledge and skills through various learning and development activities.	
		Reduced re-admission rates	*No data*		facility statistics					
		Reduced referral rates	*No data*		facility statistics					
Outcomes	HRH have up-to-date knowledge, skills and attitudes that is the foundation of high quality practice	Proportion of HRH with improved competencies	No baseline data		Performance evaluation reports, post-training evaluation scores			2022 - onwards	- HRH have access to learning and development activities and opportunities to earn continuing professional development (CPD) units.	
		Proportions of national agencies and LGUs with institutionalized HR management for HRH	No data							
Outputs	HRH regularly access face-to-face accredited learning and development programs or alternative modes of learning while earning CPD units	Increased proportion of HRH with completed trainings and accessing alternative modes like eLearning	No data		list of HRH with completed trainings per year and per region			2021	- There is internet access for quality online learning.	
		Increased investment in training/ competency improvement	No data		LIPH, AOP			2021	- There is a single process that assesses learning and development needs of HRH and oversees learning and development activities attended	
		Number and types of learning and development activities accessed	No data		List of trainings, Training information management			2021		

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
					database in LDIMS					
Activities & inputs	Develop more alternative modes of learning (e.g., e-learning, webinars) on Primary Care in DOH e-Learning platform with CPD units	Presence of Database of alternative modes of learning accessible in DOH e-Learning platform and other learning platforms	No data					2020		6,723,747,156.50
	Provide access to available face-to-face learning and development programs and providers while earning CPD units	Presence of Database of CPD Programs and list of learners per region	No data		Training information management database in LDIMS			2020		
Goal	7 Enforce/ strengthen the provision of coaching, mentoring, and supportive supervision to health workers	Proportion of health facilities with health workers exhibiting enhanced competencies that provide improved health services	No data		end user satisfaction	CMSS	DOH, health facilities, professional associations	2024 - onwards	- All health facilities will integrate CMSS in theeir performance development plans	
Outcomes	HRH have improved knowledge and skills through CMSS	Improved scores in performance management and CMSS tools	*No data*		Performance evaluation reports, assessment tools			2024 - onwards	- Designate supervisors to participate in CMSS	
		Proportions of national agencies and LGUs with institutionalized HR management for HRH	*No data*							
Outputs	HRH have CMSS in public and private sectors at local and national governments	Proportion of HRH with CMSS	*No data*		list of HRH with CMSS			2023	- There are existing tools that may be used in CMSS	
		Time spent for CMSS activities	*No data*		reports					
		Types of CMSS activities	*No data*		reports					
Activities & inputs	Determine competencies of coaches and mentors and capacitate them as necessary	Availability of Capacity building programs for coaches and mentors	*No data*		reports, NHWA			2022		25,096,262.00
		Proportion of coaches and mentors capacitated	*No data*					2022		
	Include coaching and mentoring in the learning and development programs	Proportion of Coaching and mentoring programs accredited for CPD units	*No data*		reports, NHWA			2022		
	Design mentoring and coaching programs aligned with area or program needs as needed	Presence of established coaching and mentoring programs, especially in the public sector	*No data*		reports, NHWA			2022		

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Goal	8 Develop and implement career paths of health workers across the public and private sector from national to local levels	Proportion of health workers in the appropriate positions of their career paths based on their competencies and experience	*No data*		Job descriptions/roles and responsibilities, Career map		DOH, DILG, LGUs, professional organizations, health facilities, CHED, academic partners	2024 - onwards	- The LGUs and the private sector have career progression and specialization programs	
Outcomes	HRH are in appropriate career programs	Proportion of HRH with career paths	*No data*		HR records, NHWA			2024 - onwards	- There is a policy that supports the development of career paths of HRH	
		Proportions of national agencies and LGUs with institutionalized HR management for HRH	*No data*							
Outputs	Implementation of career progression programs in national and local governments, private and public sectors	Number of institutions in private and public sector adopting career progression programs	*No data*		reports, NHWA			2023	- LCEs and health facility management support the development of career paths of HRH.	
Activities & inputs	Design harmonized career progression paths of HRH in government and private sector	Presence of Career progression programs for all health professionals			reports, NHWA			2022	- The income class of the LGUs does not affect the need for development of career paths of HRH.	28,974,578.00
	Provide information on careers in the health sector for potential health workers	Proportion of health workers aware of careers in the health sector			Survey			2022		

Strategic Objective 3

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

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Goal	9 Create adequate permanent positions for HRH (all cadres including Barangay Health Workers [BHWs] & Barangay Nutrition Scholar [BNS]) in response to health sector needs	Proportion of health facilities and health care provider network that fulfilled the staffing standards	*No data*		Staffing list vis-à-vis required staffing per WISN results per facility and health care provider network level	WISN	DOH, DILG, LGUs, CSC, DBM, DOLE, professional organizations, CSOs	2023 - onwards	- There is policy support for the creation of permanent positions. - The budget is available for the creation of permanent positions. - Staffing standards widely disseminated - WISN results available and used basis for creating positions - There is political support for creating permanent positions - NHWA is functional	
		Increased number of HRH employed in Phil health sector with permanent positions especially in rural areas/GIDA	*No data*							
		Increase in funding (Contribution of stakeholders for HRH investment)	*No data*							
Outcomes	Sufficient HRH with permanent positions receiving competetive salaries and benefits	Proportion of health facilities with appropriate number of permanent positions and filled vacancies	9311 vacant positions (count of vacant positions of DOH-CO, regional offices and DOH retained hospitals) Source: Feb 2017 data, DOH-HHRDB		Staffing structure with employment status, salaries and benefits			2023 - onwards	- Health facility websites are functional and capable of disseminating vacancies widely - DOH and LGUs widely disseminate vacancies	
		Proportions of national agencies and LGUs with institutionalized HR management for HRH	*No data* (Permanent positions in DOH and DOH retained hospitals might be available)							
Outputs	Adequate permanent positions with competitive salaries and benefits created for HRH	Increased number of permanent positions in health sector vis-a-vis health sector needs	*No data*		Staffing records, NHWA			2022		
		Decrease in number of health facility personnel occupying job order and/or casual positions	*No data*		Staffing records, NHWA					

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Activities & inputs	Broadcast widely unfilled government and private HRH positions	Proportion of health worker positions filled vis-à-vis the health sector needs	9311 vacant positions (count of vacant positions of DOH-CO, regional offices and DOH retained hospitals) Source: Feb 2017 data, DOH-HHRDB		National database of government (and private) positions for health workers, NHWA			2021		12,289,598.00
	Collaborate between the national and local governments to source funds and recruit local HRH to fill necessary vacant positions							2021		
	Advocate to LGUs to create positions for HRH							2021		
	Review existing policies							2021		
Goal	10 Standardize health workers' positions and competitive compensation, benefits and incentives such as supporting career progression, standardized, decent compenstion and benefits, recognition and rewards system to improve job satisfaction and motivation (public and private sectors; national and local)	Satisfaction (rating) of public and private health workers on employment terms	*No data*		Staff Satisfaction survey		DOH, DBM, DILG, DOLE, CSC	2024 - onwards	- There are funds to provide benefits under the Magna Carta Law	
		Stable facility HRH complements	*No data*					2024 - onwards	- There is political support e.g. LCEs may not want to spend more for HRH.	
		Satisfaction of health workers over competitive compensation, benefits, and incentives received	*No data*		Survey			2024 - onwards	- There are policies to support standardization.	
Outcomes	Consistent implementation of standardized positions, compensation, benefits and incentives across sectors and between local and national governments	Low employment turnover rate; reduced number of health workers occupying job order positions or engaged in contractual employment	*No data*		List of vacancies/filled positions, NHWA			2024 - onwards	- The private sector will support standardization.	
		Proportions of national agencies and LGUs with institutionalized HR management for HRH	*No data*					2024 - onwards	- Private sector supports expansion of Magna Carta to cover Private sector-hired HRH	
Outputs	Standards for positions, compensations, benefits and incentives that are acceptable, feasible and implementable across national and local governments and private sector	Change in standardized positions, compensation and benefits across sectors and between local and national governments	*No data*		Staffing records, compensations and benefits issuances			2023	- Too many players in the Private sector	

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Activities & inputs	Advocate and capacitate LGUs to allocate sufficient budgets for HRH in accordance with staffing standards	Proportion of LGUs enacting budgets supportive of HRH development and management	*No data*		Local budget, AOP			2022	- There is sufficient technical expertise and funds to conduct high quality reviews and craft standards	23,187,327.00
		Proportion of capacitated LCEs	*No data*		Program(s) similar to HLGP					
	Request exemption from PS cap and LGU income class-dependent rates for health workers	Enacted policy/ies that will allow exemption from restrictions of PS Cap and LGU income class-dependent rates	No available policy that will allow exemption from restrictions of PS Cap and LGU income class-dependent rates	Policy exempting restrictions of PS Cap and LGU income class-dependent rates	Revised policy			2022		
		Harmonized HRH related policies (PS cap, financing)	*No data*							
	Explore expansion of Magna Carta to cover private sector HRH	Revision of Magna Carta to cover private sector	Magna Carta does not cover private sector health workers		Revised policy			2022		
	Enforce full implementation of Magna Carta for Public Health Workers across national and local levels	Proportion of compliant health facilities and local governments that implement the Magna Carta provisions	*No data*		List of health facilities and local governments that provides Magna Carta benefits			2022		
	Review/amend provisions under existing laws on compensation and benefits of health workers (e.g., PS limit and Magna Carta to cover private sector HRH)	List of proposed provisions in selected policies that supports health workers	*No data*		Policy reviews, reports			2022		
	Identify compensation packages, benefits and incentives for professional and non-professional health workers that are motivating	Availability of competitive compensation packages, benefits and incentives	*No data*		Staffing structure showing compensation and benefits per facility and health care provider network			2022		
	Review of existing benefits and incentives for the public and private sector	Identified variations in benefits and incentives	*No data*		Report			2022		

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
	Review of positions classification and job descriptions of public health workers	Identified variations in positions and job descriptions	*No data*		Report			2022		
Goal	11 Ensure well-being of health workers including protection from emerging and re-emerging diseases (e.g. wellness programs, mental health, etc.) - (from long term)	Reduced health worker turnover due to work-related health and illness issues	*No data*		health facility reports, agency reports, prevalence/incidence studies, HRH information system statistics		DOLE, DOH, health facilities, HRH Network, C/P-Wide health care provider network	2022 - onwards	- Health workers take advantage of the health, wellness, and infection prevention and control programs	
Outcomes	Improved health and well-being of health workers	Reduced incidence and prevalence of work-related illnesses among health workers	*No data*		health facility reports, agency reports, prevalence/incidence studies, HRH information system statistics			2022 - onwards	- Health facilities have resources for health, wellness, and infection prevention and control programs	
Outputs	Implementation of health and wellness programs for health workers within city-wide and province-wide healthcare provider networks	Proportion of city-wide and province-wide healthcare provider networks implementing health and wellness programs for all health workers	*No data*		health facility reports, agency reports			2021	- Political will of decision-makers to implement policies on health care worker protection, and infection prevention and control in public and private sector	
	Implementation of policies on health care worker protection, and infection prevention and control standards in public and private sector health facilities	Proportion of health facilities implementing policies on health care worker protection, and infection prevention and control in public and private sector	*No data*		health facility reports, agency reports			2021	- Health facilities and decision makers are willing to introduce health and wellness programs for health workers	
Activities & inputs	Develop health, wellness, and infection prevention and control programs (e.g., mental health, physical health, etc.) for health workers	Documented functional health and wellness programs, and infection prevention and control programs	*No data*		health facility reports, agency reports			2020		3,518,864.00
	Craft policy on health care worker protection (e.g., stigma, bullying), and infection prevention and control measures for emerging and re-emerging decisions	Enacted policies on health care worker protection, and infection prevention and control measures	*No data*		Policy documents			2020		

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Goal	12 Ensure compliance with minimum work environment standards by implementing Occupational safety and health (OSH) standards and infection and prevention control initiatives	Satisfaction (rating) of public and private health workers on work environment	*No data*		Routinely collected information on satisfaction		DOH, DOLE, Health Professional societies, health facilities, Inter-Agency Committee on Environmental Health (IACEH) - Occupational Health Sector and Toxic and Hazardous Substances Sector, CSC, UP College of Public Health, UP-PGH National Poison Management	2022 - onwards	- Supporting mechanisms (payment, accreditation) in place	
		Health worker productivity measures (e.g., reduced absences, infections, etc.)			HRIS statistics, NHWA				- Policy supportive to telehealth/telemedicine, alternative work arrangements in place	
Outcomes	Optimal patient load of health workers in health facilities	Proportion of health facilities with optimal patient load considering patient acuity and nature of cases (e.g., infectious, non-infectious, long term, etc.	*No data*		health facility data, HRIS statistics, NHWA			2022 - onwards	- Decision makers support changes in alternative work arrangements	
	Reduced likelihood of health worker exposure to nosocomial and other infections, as well as other health risks	Proportion of health facilities with reduced infections and other health risks among health workers	*No data*		health facility data, HRIS statistics, NHWA			2022 - onwards	- Capacity building to explore and use available technology	
Outputs	Introduce changes in existing OHS standards based on the results of implementation review, and to cover public health emergency scenarios	Proportion of health facilities implementing revised OHS standards	*No data*		health facility report, agency reports			2021		
	Use of telehealth and telemedicine in public and private sector	Proportion of health facilities using telehealth and telemedicine in service delivery	*No data*		health facility and agency reports			2021		
	Introduce changes in work shifts or working time of health workers in public and private sector	Proportion of health facilities implementing changed work shifts for health workers	*No data*		health facility and agency reports			2021		
Activities & inputs	Review existing OHS Standards and its implementation	Gaps from OHS standards implementation review	*No data*		report			2020		10,852,570.00
	Explore use of available technology to deliver health care services	Enacted guidelines on using available technology to deliver health care services	*No data*		Policy documents			2020		
	Identify alternative work arrangements in cases of public health emergencies	Enacted guidelines for alternative work arrangements	*No data*		Policy documents			2020		

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
	Review and implement minimum work environment standards (e.g., hazard pay, PPEs, short-term accommodations) to prevent and control emerging and re-emerging diseases to protect health workers	Available minimum work environment standards on disease prevention and control for emerging and re-emerging diseases	*No data*		Policy documents			2020		
Goal	13 Ensure appropriate skills mix and roles/functions present in health facilities	Proportion of health facilities that provide proactive and responsive health services	*No data*		Health Facility data	WISN	DOH, health facilities, professional organizations, PSA, PHO, C/P-Wide HCPN	2022 - onwards	- Available HRH to be recruited in C/P-Wide - Resources are available to introduce new staffing composition and number for health service delivery	
		Reduced patient readmission rates	*No data*		Health Facility data					
Outcomes	Improved workload distribution among health workers within health facilities in consideration of emerging and re-emerging diseases	Proportion of health facilities with improved workload distribution among health workers	*No data*		Health Facility data			2022 - onwards	- Decision makers are supportive of implementing guidelines on HRH standards	
	Establishment of new health worker cadre/s or roles/functions needed to respond to future health needs including emerging and re-emerging diseases	Improved population and individual health outcomes	*No data*		Health Facility data, PSA, PHO data			2022 - onwards	- Decision-makers use WISN results in developing guidelines on HRH response and policies on minimum staffing composition and number	
Outputs	Introduce new staffing composition and number for health service delivery, including staffing appropriate for regular workload and public health emergencies, outbreaks, etc.	Proportion of health facilities implementing policy on health worker minimum staffing (composition and number)	*No data*		health facility report			2021		
	Implementation of guidelines on HRH standards to ensure optimal response to public health emergencies, outbreaks, etc.	Proportion of health facilities implementing guidelines on HRH standards to ensure optimal response to public health emergencies, outbreaks, etc.	*No data*		health facility report			2021		
		Availability of pool of health workers to respond to emerging and re-emerging diseases	*No data*		Provincial health worker list, HRIS statistics, NHWA					

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Activities & inputs	Implement WISN findings specifying the ranges for staffing standards based on actual computed workload	Proportion of regions implementing staffing based on WISN calculations of workload for all cadres	*No data*		Health facility report, CHD reports			2020		18,747,659.00
	Review current minimum staffing (composition and number) for health service delivery, including needs for workload and public health emergencies, outbreaks, etc.	Gaps on current minimum staffing (composition and number) for health service delivery, including needs for workload and public health emergencies, outbreaks, etc.	*No data*		Report			2020		
	Craft policy on minimum staffing (composition and number) for health facilities in HCPN/SDN for regular health service delivery, public health emergencies, outbreaks, etc.	Enacted policy on minimum staffing (composition and number) for health facilities in HCPN/SDN for regular health service delivery, public health emergencies, outbreaks	*No data*		Policy documents			2020		
	Develop guidelines on HRH standards to ensure optimal response of HCPN/SDN during regular health service delivery, public health emergencies, outbreaks, etc.	HRH standards available for response of HCPN/SDN during regular health service delivery, public health emergencies, outbreaks	*No data*		Policy documents			2020		

Cross-cutting Strategies

Strategic Objective 5

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

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Goal	14 Strengthen and integrate information systems to ensure up-to-date HRH data and data sharing across the HRH sector e.g. National Health Workforce Registry (NHWR), National Health Workforce Account (NHWA)	Number of Functioning information/ intelligence center for HRH established implementing NHWA and the registry	2 (NDHRHIS, IDHRHIS)		Annual reports Tools utilization, national health workforce profile	NHWA	CHED, PRC, DOH, POEA, CFO, DICT, LGUs, CHED private sector, HRH Network	2023 - onwards	- The provisions of Data Privacy Act is well understood by HRH stakeholders and Data Privacy Act will not pose problem for data collection and sharing.	

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
									- There is budget to set up and operate HRH information systems	
		Presence of Tools for decision-makers	*No data*		Annual reports Tools utilization, national health workforce profile					
		Utilization of information by the decision-makers	No data		Policies, policy briefs and reports				- There is political support for setting up the HRH information systems.	
Outcomes	Updated HRH information/data informs decisions and policies	No. and type of HRH process (e.g., recruitment, compensation, etc.) covered of data-informed decisions and policies	0 modules	18 priority NHWA modules	briefs, advisories, policy issuances			2023 - onwards	- A policy will mandate DOH to be the data repository ogHRH information	
Outputs	Functional, integrated and interoperable HRH information systems	Presence of Functional National Health Workforce Registry	0 registry		Reports generated, HRH country profile			2022	- Provide a standard schedule of updating/releasing of data	
		Presence of Functional National Health Workforce Account	NHWA not yet implemented		Reports generated, HRH country profile			2022		
		Availability of HRH country profile	Yes (2018 c/o USAID HRH2030)		Reports generated, HRH country profile			2022		
Activities & inputs	Conduct data mapping to identify data gaps and sources, frequency of data collection, and overlaps, if any	Presence and implementation of a joint agreement among agencies collecting HRH data	*No data*		NHWA			2021		31,679,852.00
	Utilize the NHWA system as the national repository of HRH data and information	Presence of an Interoperable information system across HRH Network and key stakeholders	*No data*		NHWA			2021		
	Identify specific NHWA data modules to be contributed consistent with their mandates	Proportion of relevant stakeholders timely sharing data sets for NHWA	*No data*		NHWA			2021		
	Provide updated health worker information aligned with agency process (e.g. PRC licensing, POEA exit information, etc.)	Presence of Routinely updated health worker information	*No data*		NHWA			2021		
	Include a NHWA system of data collection in the processes of agencies collecting HRH data	Complete data collection aligned with relevant NHWA modules	*No data*		NHWA			2021		

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Goal	15 Conduct HRH research (including operations and evaluation research and analysis of health labor markets)	Implemented effective solutions to HRH problems	No research agenda for HRH		Policy/program and corresponding reports	HLMA, deployment program research, omnibus policy review, health research agenda	DOH, DOST, HRH Network, private sector, HEIs, research stakeholders	2023 - onwards	- The cost of research is budgeted - There is policy supporting the conduct of research. - Research activites are incorporated in health workers' job descriptions. - Health facilities and institutions are held accountable in producing appropriate HRH researches - Time for research is routinely allocated both at the facility and national level - Completed research is widely disseminated and available online	
Outcomes	Understand causes of problems in HRH component of the health system	Number of Identified effective solutions to HRH problems	*No data*		Programs, reports, policy briefs, advisories			2023 - onwards	- A "culture of research" will be promoted.	
	Determine the progress of HRH development and management and its contribution to achievement of health outcomes	Status and progress of HRH development and management at different levels (?)	*No data*		Programs, reports, policy briefs, advisories			2023 - onwards		
Outputs	Develop appropriate HRH research themes for the period (short-, medium-, long-term)	Presence of Research themes for the short-, medium- and long-term	*No data*		reports			2022	- The number of individuals and research facilities engaged in research will increase.	
Activities & inputs	Formulate medium term HRH research agenda and identify lead groups	Presence of a National research agenda for HRH development and management	No data		reports			2021	- There is capacity among stakeholders to do research.	163,340,135.00
	Harmonize/integrate HRH development and management research agenda of national agencies							2021		

Strategic Objective 7

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

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Goal	16 Generate resources for HRH from various sources (domestic, international, and other sources)	Fully supported HRH and HRH systems	2018 PhP: Salaries & benefits: 33.9B Deployment program: 9.6B		government annual and financial reports Program reports		DOF, DBM, DOH, LGUs, NEDA, international development partners, HRH network	2023 - onwards	- There is a policy supporting the generation of resources for HRH from various sources.	
Outcomes	International and other sources complement available resources for HRH systems investment	Increase in HRH funding (Contribution of stakeholders for HRH investment)	*No data*		Budget allocation and funding support from external sources			2023 - onwards	- There is HR line item budget in the LIPH	
Outputs	Resources for HRH and HRH systems made available by national and local governments	Presence of Agreements between national and local government regarding fund sharing	*No data*		Agreements, LIPH, Annual operations plan			2022	- There is sufficient budget allocated for HR at national and local levels	
		Inclusion of HRH in workplan and budget of national and local governments	Yes (Budget)		Agreements, LIPH, Annual operations plan			2022	- Private sector health facilities contribute directly to population health outcome	
Activities & inputs	Explore co-financing mechanisms between national and local governments	Presence of established financing mechanisms	*No data*		Agreements, reports			2021		3,611,308.50
	Funding for local HRH needs (development and management) provided by LGUs and supported, if necessary, by National government	Proportion of LIPH with integrated local HRH investments	*No data*		LIPH			2021		
	Explore government subsidies (conditional transfer) for private sector health worker development and management to expand access to health care	Increased recruitment and retention rates of private health care facility	*No data*		budget and accomplishment reports			2021		
Goal	17 Invest in HR systems (education and training, recruitment, deployment and retention, etc.) to meet national and subnational needs	Disbursement of funds allocated for investments on education and training, recruitment, deployment and retention of health workers	*No data*		government financial/disbursement reports		DOF, DBM, DOH, CHED, LGUs, private sector (e.g., health facility managers), PSA, HRH Network	2023 - onwards	There will be a specific amount allotted to HRH development and management in the LIPH	
Outcomes	Investment plan of HRHMP aligned with national and subnational needs	Presence of Portfolio of investments	*No data*		Investment plan, LIPH			2023 - onwards	- LCEs will prioritize investments HRH	

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
	Investments made produce highest possible contributions to health outcomes	Improved public health outcomes (use existing measures for public health outcomes)	*No data*					2023 - onwards	development and management in this area	
		Cost effectiveness ratios (incremental cost-effectiveness ratio)	*No data*		investment analysis reports, quarterly health reports, PSA data and report			2023 - onwards		
Outputs	Investment decision produce the greatest HR system benefits	Cost-utility analysis ratios Economic rate of return Return of investment	*No data*		investment analysis reports			2022	- Capacity to accomplish economic and financila valuation analysis	
	Establish annual investment priorities and initiatives that include strong HRH systems support	Number of initiatives financed and supported by key stakeholders Annual list of investments	*No data*		LIPH, Annual operations plan, General appropriations			2022	- The policy environment is supportive of HRH investment	
Activities & inputs	Allocate resources to support HRH in the LIPH	HR support budget line item in LIPH	*No data*		LIPH			2021	- Competent governance structure in place to implement investment decisions	45,806,477.00
	Organize advocacy activities and campaigns to engage key stakeholders in investing and supporting HRH development and management initiatives	# and types of advocacy Number of stakeholders reached	*No data*		Reports, Communication materials targeting HRH stakeholders			2021		
	Identify sources for funds in areas that are under invested at appropriate levels to support primary health care	Available sources of funds	*No data*		LIPH, General appropriations			2021		
	Identify areas in training and education, recruitment, deployment and retention at national and local levels requiring (additional) investments	Gaps in investments	*No data*		Report			2021		

	Project Summary	Measure	Baseline	Target	Means of Verification	Existing DOH Initiatives	Stakeholder	Timelines	Assumptions/ Risks	Estimated Cost (in PHP)
Goal	18 Develop fiscal capacity to absorb and utilize effectively and transparently both domestic and international resources for HRH systems in the public and private sector	Efficiency measures (use existing DOH indicators) Cost-utility/ effectiveness (use existing DOH indicators)	*No data*		DOH PGS/ government reports (all levels)		DOF, DBM, DOH, LGUs, private sector (health facilities)	2023 - onwards	- There are policies that support: * development of fiscal management capacities * establishing budget coordination mechanisms across public and private sectors, and national and local levels * co-managing resources across public and private sectors, and national and local levels	
Outcomes	Available resources are maximized for HRH systems in the public and private sector	HRH systems objectives achieved	*No data*		HRH system reports (all levels)			2023 - onwards		
Outputs	Plan, manage and analyze resource utilization routinely (every quarter and annual) in the public and private sectors	Timely utilization (rate) of resources allocated	*No data*		budget vs. expenditure report, budget utilization report			2022	- If quarter utilization of allocated resources is accomplished, annual utilization will be high	
	Establish national and local fiscal system coordination	Presence of Functional coordination mechanism in place between DBM and LGU financial units	*No data*		evaluation report of coordination mechanism accomplishments			2022		
Activities & inputs	Build capacities of HRH Network and HHRDB for planning, resource management (Fiscal fiscal mManagement) and analysis	Proportion of Personnel (private and public sector) trained on planning, resource management, financial/economic analysis	*No data*		HR records, organization file			2021	- There is available learning and development interventions provided to HRH managers at all levels to do planning, resource management, analysis and coordination of financial resources	13,429,201.00
	Develop a system for co-managing resources, such that management directions will be provided by national agencies, and implementation of specific plan of actions will be handled by local government units	Presence of Guidelines on co-managing resources, with clear roles and responsibilities of each actor in the public and private sector	*No data*		Policy guidelines			2021		

MEDIUM-TERM PLAN

Production Strategies

Strategic Objective 1

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

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
Goal	1 Establish inter-profession education (IPE) and training in universities and institutions	Proportion of program outcomes exhibited by new graduates	HEI data, annual reports, PRC data	PRC (data), HEIs, CHED, professional societies, student groups, training hospital/facility (place of assignment)	- Policy support
		Assessment scores on performance of new professionals indicate positive patient experience	Assessment scores and reports		- Assessment tools developed by HRH2030 or other stakeholders will be used
Outcomes	Health sciences graduates are trained to collaborate with various cadres in delivering health care	Proportion of graduates interprofessionally trained	HEI data, annual reports		- HEIs are willing to implement IPE
Outputs	Implementation of IPE guidelines based on needs of HCPNs and PCPNs	Proportion of HEIs implementing IPE guidelines	CHED compliance report?		- Resources (including funds) are available

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
	Implementation curricula integrating IPE based on assessment results	Proportion of HEIs implementing health sciences program with revised curricula integrating IPE	HEI report		- Expertise available to develop IPE curricula
Activities & inputs	Develop guidelines for IPE implementation	Available IPE guidelines	CHED Guidelines, policy issuance		
	Develop curricula integrating IPE	Proportion of health sciences programs with revised curricula integrating IPE	Health sciences program curricula		
	Assess relevance, acceptability and feasibility of IPE in existing health sciences education	Gaps in IPE on existing health sciences education	Report		
Goal	2 Provide incentives to HEIs (e.g., tax breaks) to ensure quality graduates	Proportion of high performing HEIs	HEI annual reports, CHED data	CHED, PRC, DBM, DOF, LGUs, HEIs,	- Adapt CHED criteria for high performing HEIs
Outcomes	Improved quality of graduates	Performance of graduates as health professionals based on competency assessment	Competency assessment scores, NHWA data		- Performance standards for professionals by cadre are developed and available
		Improved board passing rates	PRC data		
	Improved performance of HEIs offering health sciences program	Improved completion rates comparable to ASEAN standards	CHED data, HEI data		- HEIs are willing to improve quality of graduates
Outputs	Implement effective financial or non-financial incentive packages for HEIs	Available financial or non-financial incentive packages for HEIs	HEI annual reports, CHED report		

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
		Proportion of HEIs granted appropriate incentives	HEI report		
Activities & inputs	Identify appropriate financial or non-financial packages for HEIs to ensure quality	Proposed evidence-based effective incentives and incentive mechanisms for HEIs	HRH Network-TWC Entry Report		- Funds and other resources are available
	Explore implementation of HEI incentive mechanisms and good practices from other countries				
	Review existing incentives and incentive mechanisms for HEIs (including SUCs)				Policy support

Workforce Strategies

Strategic Objective 3

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

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
Goal	3 Create adequate permanent positions for HRH (all cadres including Barangay Health Workers [BHWs] & Barangay Nutrition Scholar [BNS]) in response to health sector needs	Proportion of health facilities and health care provider network that fulfilled the staffing standards	Staffing list vis-à-vis required staffing per WISN results per facility and health care provider network level	DOH, DILG, LGUs, CSC, DBM, DOLE, professional organizations, CSOs	- There is policy support for the creation of permanent positions. - The budget is available for the creation of permanent positions.

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
					- Staffing standards widely disseminated - WISN results available and used basis for creating positions
		Increased number of HRH employed in Phil health sector with permanent positions especially in rural areas/GIDA	NHWA		- There is political support for creating permanent positions
		Increase in funding (Contribution of stakeholders for HRH investment)	LIPH, agency annual plans and reports		- NHWA is functional
Outcomes	Sufficient HRH with permanent positions receiving competetive salaries and benefits	Proportion of health facilities with appropriate number of permanent positions and filled vacancies	Staffing structure with employment status, salaries and benefits		- Health facility websites are functional and capable of disseminating vacancies widely
		Proportions of national agencies and LGUs with institutionalized HR management for HRH	Agency and LGU reports		- DOH and LGUs widely disseminate vacancies
Outputs	Adequate permanent positions with competitive salaries and benefits created for HRH	Increased number of permanent positions in health sector vis-a-vis health sector needs	Staffing records, NHWA		

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
		Decrease in number of health facility personnel occupying job order and/or casual positions	Staffing records, NHWA		
Activities & inputs	Revise outdated policies, and those with gaps, and develop new policies, as needed	Amended and new policies supporting the creation of new permanent positions	Policies		
	Identify sources of funding of new permanent positions	Inventory/list of funding sources and mechanisms for permanent positions	LIPH, agency reports		
	Advocate to LGUs and key stakeholders to create permanent positions for HRH	# and types of advocacy Number of stakeholders reached	Communication materials targeting HRH stakeholders		
Goal	4 Standardize health workers' positions and competitive compensation, benefits and incentives (public and private sectors; national and local)	Satisfaction (rating) of public and private health workers on employment terms	Job satisfaction ratings/ surveys	DOH, DBM, DILG, DOLE, CSC	- There are funds to provide benefits under the Magna Carta Law - There is political support e.g. LCEs may not want to spend more for HRH. - There are policies to support standardization.
		Stable facility HRH complements	Employment records, list of vacancies		
		Satisfaction of health workers over competitive compensation, benefits, and incentives received	Job satisfaction ratings/ surveys		

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
Outcomes	Consistent implementation of standardized positions, compensation, benefits and incentives across sectors and between local and national governments	Low employment turnover rate; reduced number of health workers occupying job order positions or engaged in contractual employment	Health facility reports, employment records		- The private sector will support standardization.
		Proportions of national agencies and LGUs with institutionalized HR management for HRH	LGU, CHD, DOH reports		- Private sector supports expansion of Magna Carta to cover Private sector-hired HRH
Outputs	Standards for positions, compensations, benefits and incentives that are acceptable, feasible and implementable across national and local governments and private sector	Change in standardized positions, compensation and benefits across sectors and between local and national governments	Policy, HR reports		- Too many players in the Private sector
Activities & inputs	Advocate for amendment of existing government issuances and existing laws affecting compensation and benefits of health workers	Amended issuances and laws affecting compensation and benefits of health workers	Policy		- There is sufficient technical expertise and funds to conduct high quality reviews and craft standards
	Advocate passage of a Magna Carta covering private sector HRH	Revision of Magna Carta to cover private sector	Policy		
Goal	5 Sustain improved health outcomes through standardize care through the implementation of national Clinical Practice Guidelines (CPGs) for priority health conditions	Trend of health outcomes in a 7-year period (e.g., reduced mortality rates, increased life expectancy)	health statistics, PSA data	Professional organizations, health facilities, PSA, DOH	- Buy-in of professional societies in developing and updating CPGs and clinical pathways of priority health conditions

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
Outcomes	Improve health outcomes related to CPG and clinical pathway compliance	Proportion of health facilities and health professional cadres compliant with CPGs and clinical pathways for priority health conditions	DOH data		- Political support from WHO, DOH and professional societies
Outputs	Ensure feasibility and acceptability of CPGs and clinical pathways for priority health conditions	Proportion of health facilities that adopt and sustain the use of CPGs and clinical pathways for priority health conditions	Health facility reports to DOH, professional organization data,		- Resources available from professional societies in developing and updating CPGs and clinical pathways per cadre
	Adoption of new and updated CPGs and clinical pathways for priority health conditions				- Additional resources from development partners and DOH
Activities & inputs	Advocate adoption of new and updated CPGs and clinical pathways for priority health conditions	Levels of awareness and adoption	CPG and clinical pathway utilization survey results		
	Disseminate widely the new and updated CPGs and clinical pathways for priority health conditions				
	Develop (where none) and update (if outdated) CPGs and clinical pathways for the priority health conditions based on HTA results	Percentage of health conditions with new and updated evidence based CPGs and clinical pathways	HTA reports and professional organization publication of CPGs		

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
	Review of existing national CPGs and clinical pathways implemented in the country for priority health conditions (comminicable, non-communicable, emerging/re-emerging diseases)	Inventory of CPGs and clinical pathways for priority health conditions			
	Use of digital health worker decision support accessible via mobile devices				

Entry and re-entry, and Cross-cutting Strategies

Strategic Objective 4

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

	Project Summary	Indicators	Means of Verification	Stakeholder	Assumptions/ Risks
Goal	6 Ensure implementation of the health worker migration policies and programs consider the Philippine population health needs	Adequate number of HRH for population health needs	National statistics, PSA, NHWA	POEA, DFA, OWWA, DOH, LGUs, professional societies, private sector (recruitment agencies, hospital association), development partners, destination country representative	- Political support and agency stakeholder buy-in
Outcomes	Sustainable migration of HRH to strengthen the capacity of the health system	Proportion of active Filipino health worker migrants to total active health workforce	Facility-based statistics, HCPN data, NHWA		- Resources in reviewing BLAs and ASEAN MRAs provisions, and other international commitments, and monitoring compliance
Outputs	BLAs and ASEAN MRAs provisions, and other international commitments more	Proportion of BLAs/ international commitments with provisions	Reports		- Low likelihood of health worker pushback

	Project Summary	Indicators	Means of Verification	Stakeholder	Assumptions/ Risks
	beneficial to Philippine interest (e.g., more economic opportunities, student exchange or scholarship opportunities)	aligned with meeting population health needs			
	Implementation of new policies and programs, and enhanced migration policies	Proportion of cadres complying to enhanced migration policies	Reports		
Activities & inputs	Advocate for individual health workers to cooperate with changes in migration policies and program that will manage migration to sustainable levels	Number of health workers reached through advocacy activities	Reports		
	Develop new policies or programs, when necessary, that will bridge the identified gaps in current migration policies and programs to manage migration to sustainable levels	New policies or programs	Congress archives, DOH-HPDPB reports		
	Strengthen existing migration policies (set conditions for migration, monitoring, compliance, penalties/incentives) to manage migration to sustainable levels	Revised policies	Congress archives, DOH-HPDPB reports		
	Review implementation and impact of bilateral agreements (BLAs), ASEAN MRAs, commitments in WHO ethical recruitment and other commitments to manage migration to sustainable levels	Gaps and potential benefits to the country	Reports		
Goal	7 Strengthen meaningful private sector regulation in HRH production and employment	Changes in private sector production and employment practices (e.g., reduction in class size, higher salaries)	Reports	Private sector HEIs and health facilities, PRC, DOH, CHED, DOLE, professional societies	- Private sector and stakeholder buy-in regarding regulation

	Project Summary	Indicators	Means of Verification	Stakeholder	Assumptions/ Risks
Outcomes	Encourage outcome-based (e.g., sustainable migration) self-regulation in the private sector	Proportion of private sector health facilities participating in self-regulation	Statistics, PSA, NHWA		- Resources available to review current system of regulation, provide incentives and monitor compliance
Outputs	Implement enhanced private sector regulation system and incentives/penalties	Available self-regulation mechanisms	Reports		- Policy support available
Activities & inputs	Identify incentives/penalties for private sector to achieve rational and quality HRH production and employment	Set of incentives/penalties package	Policies and programs		
	Review current system of private sector regulation i.e. identify areas where private sector regulation is needed	Gaps in private sector regulation	Reports		
Goal	8 Align policies on production, employment and migration involving the education, health, labor, and other relevant sectors	Proportion of aligned implementable policies to total number of HRH-related policies crafted	Reports, NHWA, Reports from policy units of collaborating agencies	HRH Network, CHED, PRC, DOLE, private and publlic HEIs and health facilities, professional societies, DBM, DILG, CSC, DFA, POEA, OWWA	- Buy in from stakeholders to review and align policies and guidelines
Outcomes	Produce HRH required by health, labor, and other relevant sectors	Proportion of regions with adequate HRH based on needs	Regional reports (DMO generated)		- Resources for review process, implementation and monitoring of aligned policy and guidelines
Outputs	Effectively implement aligned policies on production, employment and migration involving the education, health, labor, and other relevant sectors at the regional and provincial level	Proportion of regions and provinces complying with aligned policies and guidelines promulgated	Reports, NHWA, Reports from policy units of collaborating agencies		- Political support in implementing policies and guidelines

	Project Summary	Indicators	Means of Verification	Stakeholder	Assumptions/ Risks
Activities & inputs	Craft policy agenda and implementation guidelines that aligns production, employment and migration involving the education, health, labor, and other relevant sectors	Number of aligned policies and guidelines promulgated	NHWA, HPDPB reports, reports from the policy units of collaborating agencies		
	Form a national and regional functioning interagency working group to align policies on production, employment and migration involving the education, health labor, and other relevant sectors		Organogram, reports showing the agency collaboration working groups		
	Review implementation of existing policies on production, employment and migration involving the education, health, labor, and other relevant sectors	Gaps in policy implementation	reports		

Strategic Objective 6

Build the capacity of institutions for effective public policy stewardship, leadership, and governance

	Project Summary	Indicators	Means of Verification	Stakeholder	Assumptions/ Risks
Goal	9 Strengthen HRH Network as an organization to improve effectiveness and performance	Measures of HRH Network effectiveness (stakeholder satisfaction, extent to which goals are achieved, resource mobilization capacity) and productivity (implementation of policies and programs)	HRH Network reports, HRH Network members' annual reports	HRH Network, HRH Network members, LGUs, grassroots organizations, private sector, non-government organizations, professional societies	- Policy support to legitimize organizational development and build organizational capacity of HRH Network
Outcomes	HRH Network has more active role in leading HRH development and management	Increased number of HRH Network driven policy issuances and decisions	Joint issuances, HRH Network issuances and agreements		- Sharing of resources encouraged
	Expand membership of the HRH Network to include involvement of diverse set of stakeholders	Harmonized HRH related policies (PS cap, financing)	Joint issuances, HRH Network issuances and agreements		- Resources are available
Outputs	Better representation of HRH stakeholders due to broader membership	Proportion of member organizations participating in policy development, decision-making and resource mobilization	Agency reports		- Stakeholder (including grassroots organizations and LGUs) buy-in
Activities & inputs	Advocate for more active participation of HRH Network core members	Attendance to HRH Network activities	Attendance sheets		

	Project Summary	Indicators	Means of Verification	Stakeholder	Assumptions/ Risks
	Advocate active participation of grassroots organizations and LGUs				
	Identify gaps in stakeholder involvement to maximize HRH Network governance and management	Gaps in stakeholder involvement	Report		

LONG-TERM PLAN

Workforce Strategies

Strategic Objective 2

Create and sustain systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
Goal	1 Identify and implement appropriate collaboration activities to facilitate cooperation among health workers across HCPNs and the development of professional and health worker networks	Number of coalitions, networks, alliances or groups that are functional among health workers in HCPNs	Reports from professional and health worker groups, studies	DOH, public and private health facilities, LGU, professional societies, health workers, HCPNs, Development management officers (regional and provincial)	- Resources available for organizing and sustaining outreach activities
		Number and type of interactions among health workers in HCPN that provide opportunities for	Reports from professional and health worker groups, studies		
		Functional referral system	Health facility reports		
Outcomes	Establish community of practice (COP) among HRH	Proportion of regions with established COP	Profesional association and other reports		- Policy support to organize outreach activities available
Outputs	Establish monitoring system of outreach indicators	Monitoring data available routinely	Reports		
	Implement technologies that will strengthen interaction and coordination among HRH, especially in GIDA	Proportion of regions implementing technologies in strengthening interaction and coordination of HRH	Reports, health facility reports		- Reliable and stable connectivity (internet and mobile) available, especially in GIDA

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
	Organize inter-professional groups/network, health worker networks and other outreach activities, especially in GIDA	Proportion of HRH participating inter-professional outreach activities	Profesional association and other reports		- Buy-in of stakeholders (including community-based health worker groups and professional societies)
Activities & inputs	Develop effective outreach coordination among health workers across HPCNs	Indicators of effectiveness and efficiency of outreach coordination	Profesional association and other reports		
	Explore technologies that can facilitate coordination, networking and interaction among health workers, especially in GIDA	Functional digital platform	Reports, health facility reports		
	Determine and design appropriate activities that facilitates cooperation and learning among health workers, especially those in GIDA	Number of collaborative activities organized	Profesional association and other reports		

Strategic Objective 3

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

	Project Summary	Measure	Means of Verification	Stakeholder	Assumptions/ Risks
Goal	2 Introduce, facilitate and regulate aligned and enhanced scopes of practice of health workers i.e. task shifting	Improved health worker productivity (efficiency and accomplishments) and satisfaction	Facility performance measures	DOH, professional and community based health worker organizations, Congress, civil society organizations, LGU and private health facilities	- Stakeholder buy-in on enhancing scope of practice
Outcomes	Increase HRH job satisfaction and motivation	Decreased HRH turnover	Health facility records		- Political support and endorsement to changes in scopes of practice
	Effective delivery of primary care by improving HRH teamwork	Reduced workload pressures	Patient experience assessment scores (HRH, patient and institution satisfaction measures)		- Relationships among health worker groups/organization is congenial
Outputs	Implement new and aligned health professional laws reflecting enhanced scopes of practice	Proportion of health workers practicing enhanced scope of practice	Survey results of implemented enhanced scopes of practice		- Major conflicts among health care professional groups addressed
Activities & inputs	Update scopes of practice of professional and community-based HRH cadres	Proportion of professional laws with updated scope of practice	Updated scopes of practice and omnibus HRH practice act		- Resources available to conduct review of health worker functions and responsibilities
	Review functions and responsibilities of health workers per facility and per cadre		Report		

Cross cutting Strategies

Strategic Objective 6

Build the capacity of institutions for effective public policy stewardship, leadership, and governance

	Project Summary	Indicators	Means of Verification	Stakeholder	Assumptions/ Risks
Goal	3 Build HRH development and management capacity at all levels of the health sector covering public and private health facilities	Proportion of LGUs with improved HRH development and management systems	NHWA, HHRDB/HRH Network reports	HRH Network, LGUs, development partners (e.g., academe, training institutions), public and private health facilities, DOH-CHDs, regional and provincial HRH offices	- Political support to institutionalize HR management especially at LGU level
Outcomes	LGUs and other stakeholders capacitated in HRH development and management	Proportion of LGUs with enhanced capacity for HRH development and management	NHWA, HHRDB/HRH Network reports		- Buy in from stakeholders to improve HRH development and management capacities
Outputs	Improved HRH development and management capacity	Proportion of LGUs with LIPH considerations responding to province-wide and city-wide HRH needs	Local investment plans for health		
	Contextualized HRH development and management to be responsive to province-wide and city-wide HRH needs				- Available expertise to provide capacity building in HRH development and management
	Implement HR plan (including HR/personnel chart, job description of all positions, HR systems, HRIS, competency level and qualification, succession planning)	Proportion of LGUs at the provincial and city level formulating and implementing HR plan	Reports		- Funding and manpower to implement HR plan

	Project Summary	Indicators	Means of Verification	Stakeholder	Assumptions/ Risks
Activities & inputs	Design and implement capacity building activities	Number of LGU that participated in capacity building activities	Capacity building reports		- Resources to assess, implement and monitor capacity building in HRH development and management
	Review HRH development and management capacity of LGUs and other stakeholders	Gaps in LGU and stakeholder HRH development and management capacity	LGU and stakeholder reports		- HRH development and management office is present at the regional and provincial level
	Support transition of programmatic HRH management to province-wide and city-wide HRH management systems	Available integrated HRH development and management in city-wide and province-wide health systems	HHRDB and regional reports		
	Assess HRH management and development maturity level	LGU HRH management and development maturity level	Reports		- Expertise on assessing HRH management and development maturoty levels
Goal	4 Establish/strengthen quality assurance (QA)/ accountability mechanisms in health facilities	Facility performance measures (e.g., referral rates, death rates, recovery rates, etc)	Statistics, PSA, health and nutrition survey	DOH (HHRDB, HFSRB), professional societies, public and private health facilities, HRH Network, PhilHealth	- Policy support for establishing national QA system for facilities
		Quality assurance certification of health facilities (e.g., ISO)	Reports		

	Project Summary	Indicators	Means of Verification	Stakeholder	Assumptions/ Risks
Outcomes	Improved quality of care and enhanced patient experience	Reduced readmission rates	Statistics, PSA, health and nutrition survey		- Resources to review, implement and monitor strengthened QA
		Patient experience assessment score	Results from patient experience assessment		- Patient experience framework is implemented
Outputs	Implement updated and revised standards of care	Compliance with standards of care	Health facility reports		- Stakeholder buy-in and participation to implement QA interventions in the LGU and health facilities
Activities & inputs	Develop mechanisms for health service delivery quality assurance focusing on HRH and patient accountability per cadre, per health facility, and at HCPN level	Available QA and accountability mechanisms per cadre, per health facility, and at HCPN level	HRH Network TWC Reports		
	Review existing standards of care to determine gaps and impact on health outcomes by cadre	Gaps in standards of care and impact on health outcomes by cadre	HRH Network TWC Reports		- TWGs will be formed to review and recommend updates on existing standards of care

Appendix B. Assessing strategies to localize the national HRH Masterplan

Rationale

Based on evidence drawn from a literature review and validated through national and regional consultations, national level strategies were identified for the Masterplan. However, the national strategies cannot be uniformly implemented across the regions and provinces as there are wide variations in local conditions. For instance, highly urbanized cities have higher access to health services compared with GIDA that have low access and where there are instances when some HRH cadres (e.g. physicians) are not present. In order to address this imbalance, it is proposed that LGUs 'localize' the Masterplan through consultation workshops.

Objectives

1. To present the national Masterplan strategies that addresses key HRH issues
2. To determine the relevance and feasibility of the national strategies to address key HRH issues in local areas/regions

Outputs

1. National Masterplan strategies adapted to address local health issues; and
2. Consensus on the localized Masterplan

Stakeholder participation

Group	Expected contribution
HRH Network, HHRDB	▪ Co-lead the organization of the consultations ▪ Co-facilitate discussions with stakeholders ▪ Co-documenter of the consultations
DOH Regional Offices (ROs)	▪ Participate in the discussion of issues and strategies ▪ Assist in organizing consultations
Provincial Health Boards	▪ Participate in the discussion of issues and strategies ▪ Determine the relevance and feasibility of the national strategies to local health and socio-economic conditions
Representatives of health facilities and local population	▪ Participate in the discussion of issues and strategies ▪ Provide inputs on relevance and feasibility of the national strategies to local health and socio-economic conditions

Methodology

There will be two activities in each of the consultation workshops: (a) a short presentation of the Masterplan, and (b) small group discussion. The presentation will highlight the key HRH issues at the national level and the strategies that will address these. It is important to remind participants that while the major HRH issues are presented, each comprise of smaller issues. The small group discussion will provide a venue for discussion of local HRH issues. The relevance and feasibility in the context of local health issues and socio-economic conditions will be determined.

Participants will be divided into groups. Each group will respond to the following questions:

1) Are the national strategies relevant and feasible?
2) Are there other HRH issues that should be addressed? What strategies should address these other issues?

To elicit inputs and provide structure to the discussions, the following criteria will be applied as each strategy is discussed.

Criteria	Definition	Scale Used
Relevance	The strategy can effectively address HRH issues in our municipality/ province/region.	1 = Low 2 = High
Feasibility (acceptability)	Capable of being carried out by different factors below: 1. Has time 2. Budget 3. People 4. Policies 5. Structures 6. Cultural/political factors Note: Presumes that strategy is acceptable if feasibility is being explored. Acceptability shall mean sufficient to serve the purpose	1 = Low feasibility (has 1-3 factors) 2 = Highly feasible (has 4-6 factors)

A plenary session will be conducted after the small group work to share the results of discussions as well as solicit feedback and insights.

Appendix C. Cost Assumptions for Short-term Strategies

1. Production strategies

Key assumptions used to estimate the cost indicated in Table 7 are as follows:

Remuneration requirements

a. There will be a designated team to manage and monitor implementation of activities (at national and regional level) consisting of 1 manager (SG 22), 1 technical staff (SG 18) and 1 support staff (SG 14). Monthly cost is approximated using government rate and based on the identified salary grade.
b. Activities to be implemented at the national level will have a one regional staff (SG 18) as counterpart to cascade and monitor activities in the regions. Monthly cost is approximated using government rate using the same salary grade as that of a technical staff
c. Some activities have identified engagement of consultant/expert as additional human resource for some activities identified. Monthly cost is approximated using government rate at SG 26.

Operational cost considerations

a. Cost for implementing activities include meeting costs, transportation costs, communication costs and costs for office supplies needed by the implementation team to cover each activity's approximated duration
    ii. Meeting cost per person for both internal and external stakeholder meetings approximated using the meal rate indicated in Executive Order no. 77 s. 2019
    iii. Communication cost approximated cost for local calls[1], cell cards and mail/courier service[2]
    iv. Transportation cost estimates cost for land trips for site visits, trips for meetings outside office, and other local land trips
    v. Office supplies approximated a standard monthly budget allocation
b. Cost for a 2-day conference per region is included to cover possibility of convening higher education institutions in the regions. Costing considers the costs for meal per person, venue rental and conference kits
c. Scholarship program is one of the key interventions included in the costing assumption for production strategies. It covers 4 cadres (medicine, nursing, midwifery, medical technology)[3] computed based on the following assumptions:
    i. WISN results used to compute for the total number of health workers delivering primary care in rural health units and barangay health stations
    ii. 100% of vacancies in rural health units and barangay health stations based on attrition[4] as the basis for number of scholars
d. Cost of feasibility studies exploring at least one flexible learning option for pre-service education per cadre was estimated at PHP 2,000,000.00 per study

2. Workforce strategies

Key assumptions used to estimate the cost indicated in Table 8 and Table 9 are as follows:

Remuneration requirements

a. There will be a designated team to manage and monitor implementation of activities (at national and regional level) consisting of 1 manager (SG 22), 1 technical staff (SG 18) and 1 support staff (SG 14). Monthly cost is approximated using government rate and based on the identified salary grade.
b. Activities to be implemented at the national level will have a one regional staff (SG 18) as counterpart to cascade and monitor activities in the regions. Monthly cost is approximated using government rate using the same salary grade as that of a technical staff
c. Some activities have identified engagement of consultant/expert as additional human resource for some activities identified. Monthly cost is approximated using government rate at SG 26

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[1] Using published rates from PLDT, one of the major telecommunications companies in the Philippines
[2] Using published rates from LBC, one of the major courier service providers in the Philippines
[3] Only these four cadres were covered by available WISN study covering rural health unit and barangay health stations in the country. The cost requirement to cover the scholarship program for the remaining eight cadres will still need to be computed.
[4] Attrition rate for doctors, midwives and nurses is based on estimated total annual attrition rate for doctors, midwives and nurses (maximum estimate) from middle income countries from a 2017 study by Castro Lopes *et al.* Attrition rate for Medical Technologist is based on rate declared in the HRH Masterplan 2005-2030 and the Philippine HRH country profile published by WHO in 2013

d. This costing does not include computation of total salary and compensation cost of health workers needed based on staffing projection

Operational cost considerations

a. Cost for implementing activities include meeting costs, transportation costs, communication costs and costs for office supplies needed by the implementation team to cover each activity's approximated duration
   ii. Meeting cost per person for both internal and external stakeholder meetings approximated using the meal rate indicated in Executive Order no. 77 s. 2019
   iii. Communication cost approximated cost for local calls[5], cell cards and mail/courier service[6]
   iv. Transportation cost estimates cost for land trips for site visits, trips for meetings outside office, and other local land trips
   v. Office supplies approximated a standard monthly budget allocation
b. Cost in developing e-learning modules considered the following assumptions:
   i. Estimated cost of e-learning module development based on HRH2030's experience in engaging private sector partners in developing e-learning modules (with an average of PHP400,000.00 per module which includes script, storyboard and final production)
   ii. E-learning module development for the following:
      - Health worker capacity building per health program: 4 e-learning modules[7] will be developed for each health program[8]
      - E-learning modules for developing coaching and mentoring competencies: 2 modules for mentoring and 2 modules for coaching
c. Cost for e-learning platform maintenance for 1 year (including updates and systems maintenance, staff training) approximated at PHP 500,000 per month
d. Cost for conducting feasibility study for alternative modes of learning and development program (aside from face-to-face training and e-learning) where cost is approximated at PHP 2,000,000.00 per study
e. Cost for conducting career path development studies for the 12 cadres[9] is approximated at PHP 2,000,000.00 per study
f. Approximated cost of face-to-face training covering 4 cadres (medicine, nursing, midwifery, medical technology) computed based on the following assumptions:
   i. WISN results used to compute for the total number of health workers delivering primary care in RHU and BHS
   ii. Cost of training per person is estimated based on sum of training cost from government and private training providers per person with each person having access to two 3-day trainings per year[10]

3. Cross cutting strategies

Key assumptions used to estimate the cost indicated in Table 10 and Table 11 are as follows:

Remuneration requirements

a. There will be a designated team to manage and monitor implementation of activities (at national and regional level) consisting of 1 manager (SG 22), 1 technical staff (SG 18) and 1 support staff (SG 14). Monthly cost is approximated using government rate and based on the identified salary grade.
b. Activities to be implemented at the national level will have a one regional staff (SG 18) as counterpart to cascade and monitor activities in the regions. Monthly cost is approximated using government rate using the same salary grade as that of a technical staff
c. Some activities have identified engagement of consultant/expert as additional human resource for some activities identified. Monthly cost is approximated using government rate at SG 26

[5] Using published rates from PLDT, one of the major telecommunications companies in the Philippines
[6] Using published rates from LBC, one of the major courier service providers in the Philippines
[7] 1 module each for doctor, nurse, midwife and medical technologist
[8] There are 50 health programs published in the DOH website
[9] 12 cadres of health workers: doctor, nurse, midwife, medical technologist, physical therapist, occupational therapist, respiratory therapist, radiology technologist, nutritionist-dietician, pharmacist, dentist, optometrist
[10] Derived from PSA's Annual Training Cost by Employment Size and Training Provider, Philippines: 2013

Operational cost considerations[11]

a. Cost for implementing activities include meeting costs, transportation costs, communication costs and costs for office supplies needed by the implementation team to cover each activity's approximated duration
   iii. Meeting cost per person for both internal and external stakeholder meetings approximated using the meal rate indicated in Executive Order no. 77 s. 2019
   iv. Communication cost approximated cost for local calls[12], cell cards and mail/courier service[13]
   v. Transportation cost estimates cost for land trips for site visits, trips for meetings outside office, and other local land trips
   vi. Office supplies approximated a standard monthly budget allocation
b. Cost for software development and deployment of an interoperable information system for NHWA was estimated based on industry standard for developing HR software cost[14]
c. Cost for information system maintenance for 1 year (including updates and systems maintenance, staff training) approximated at PHP 500,000 per month
d. Cost to fund conduct of HRH-related research for at least 10 operations researches, 5 evaluation researches and 1 labor market research approximated to be PHP5,000,000 per research
e. Cost of conducting HRH policy related research, where it is assumed that each member agency/organization of the HRH Network[15] will have at least 1 operations research and 1 evaluation research, was estimated to be PHP 2,000,000.00 per research
f. Cost for conduct of regional assessments (at least once a year) on training and education, recruitment, deployment and retention were approximated at PHP 500,000.00 per assessment

[11] Subsidy for private sector health worker development and management is an identified intervention. However, cost is not yet identified because of limited information on how cost can be approximated
[12] Using published rates from PLDT, one of the major telecommunications companies in the Philippines
[13] Using published rates from LBC, one of the major courier service providers in the Philippines
[14] Industry standard cost from https://existek.com/blog/how-much-does-custom-hr-software-development-cost/
[15] Currently have 20 member institutions per 2016 MOA

Appendix D. Costing matrices for Short-term Strategies

PRODUCTION STRATEGIES

Activity Description			Cost considerations		Subtotal
Strategic Objective	**Strategy**	**Activity**	**Remuneration**	**Operational cost**	
Strategic Objective 1 Install systems that will improve recruitment of HRH fit for practice and fit for work to sustainably produce and deploy HRH and to promote greater HRH retention in the health sector leading to adequate and equitable HRH distribution vis-à-vis local health needs	1 Educate and train future HRH in or near their places of origin	Identify and support SUCs or high quality HEIs which offer health sciences education in every region	10,208,925.00	11,162,336.00	21,371,261.00
		Determine training hospitals for internship of 12 cadres in all regions	3,402,975.00	1,494,232.00	4,897,207.00
		Reorient health professional curricula to produce responsive health workers equipped with primary care competencies for the region	11,157,858.00	481,416.00	11,639,274.00
	2 Establish targeted admission practices in HEIs	Revise admission guidelines in HEIs per region to target indigenous people and local students with rural background	3,163,384.50	808,112.00	3,971,496.50
		Promote enrolment of local students including indigenous people who are willing to serve locally for at least 5 years	2,669,558.50	1,292,912.00	3,962,470.50
	3 Expand scholarships with enforceable RSA that also offers incentives	Use WISN results as basis for providing scholarships in rural areas	5,104,462.50	1,118,668.00	6,223,130.50
		Harmonize public and private scholarships to boost health sciences program enrolment in rural and GIDA areas	2,450,371.50	1,114,461,391.40	1,116,911,762.90
		Strengthen RSA (implementation, monitoring, non-compliance, identify incentives)	4,900,743.00	912,824.00	5,813,567.00
	4Re-orient curriculum to PHC and integrate public health, rural health courses/ topics, rural exposure/immersion, and use of technology to deliver health services	Intensify pre-service education and training on PHC, public health, rural exposure/immersion, and use of technology to deliver health services	3,267,162.00	542,216.00	3,809,378.00
		Advocate for the inclusion of PHC, public health, and rural health topics/ immersion in public and private HEIs	3,667,512.00	1,181,432.00	4,848,944.00
		Utilize flexible learning options (FLOs) in pre-service training of health professionals	1,633,581.00	24,273,608.00	25,907,189.00

Activity Description			Cost considerations		Subtotal
Strategic Objective	**Strategy**	**Activity**	**Remuneration**	**Operational cost**	
		Form a functioning interagency working group to introduce changes to curricula	200,175.00	273,608.00	473,783.00
TOTAL			**51,826,708.00**	**1,158,002,755.40**	**1,209,829,463.40**
Percent			4%	96%	100%

WORKFORCE STRATEGIES

Activity Description			Cost considerations		Subtotal
Strategic Objective	**Strategy**	**Activity**	**Remuneration**	**Operational cost**	
Strategic Objective 2 Create and sustain systems for developing HRH competencies and the careers of health workers to improve productivity and responsiveness, and to promote greater HRH retention.	Support career development of volunteer health workers (e.g, BHW, BNS, etc.) [Medium-term: Professionalizing volunteer health workers]	Review existing capacity building programs for volunteer health workers	200,175.00	50,536.00	250,711.00
		Craft career development paths for volunteer health workers	1,258,083.00	4,131,608.00	5,389,691.00
		Explore new initiatives such as micro credentialing to be able to provide home-/community-based services	600,525.00	4,815,824.00	5,416,349.00
		Strengthen implementation of national certification program for volunteer health workers	600,525.00	815,824.00	1,416,349.00
	Enable health workers to obtain appropriate skills, knowledge and attitudes through learning and in-service staff development methods	Develop more alternative modes of learning (e.g., e-learning, webinars) on Primary Care in DOH e-Learning platform with CPD units	17,874,162.00	96,866,824.00	114,740,986.00
		Provide access to available face-to-face learning and development programs and providers while earning CPD units	600,525.00	6,608,405,645.50	6,609,006,170.50
	Enforce/strengthen the provision of coaching, mentoring, and supportive supervision to health workers	Determine competencies of coaches and mentors and capacitate them as necessary	4,536,093.00	764,388.00	5,300,481.00
		Include coaching and mentoring in the learning and development programs	10,208,925.00	1,528,776.00	11,737,701.00
		Design mentoring and coaching programs aligned with area or program needs as needed	929,304.00	7,128,776.00	8,058,080.00

Activity Description			Cost considerations		Subtotal
Strategic Objective	**Strategy**	**Activity**	**Remuneration**	**Operational cost**	
	Develop and implement career paths of health workers across the public and private sector from national to local levels	Design harmonized career progression paths of HRH in government and private sector	4,545,873.00	24,131,608.00	28,677,481.00
		Provide information on careers in the health sector for potential health workers	266,829.00	30,268.00	297,097.00
Strategic Objective 3 Raise HRH productivity and responsiveness by promoting job satisfaction and motivation at all levels and improve greater HRH retention.	Create adequate permanent positions for HRH (including Barangay Health Workers [BHWs] & Barangay Nutrition Scholar [BNS]) in response to health sector needs	Broadcast widely unfilled government and private HRH positions	3,399,354.00	764,388.00	4,163,742.00
		Collaborate between the national and local governments to source funds and recruit local HRH to fill necessary vacant positions	2,416,938.00	70,804.00	2,487,742.00
		Advocate to LGUs to create positions for HRH	4,536,093.00	764,388.00	5,300,481.00
		Review existing policies	266,829.00	70,804.00	337,633.00
	Standardize health workers' positions and competitive compensation, benefits and incentives such as supporting career progression, standardized, decent compenstion and benefits, recognition and rewards system to improve job satisfaction and motivation (public and private sectors; national and local)	Advocate and capacitate LGUs to allocate sufficient budgets for HRH in accordance with staffing standards	4,536,093.00	764,388.00	5,300,481.00
		Request exemption from PS cap and LGU income class-dependent rates for health workers	2,416,938.00	70,804.00	2,487,742.00
		Explore expansion of Magna Carta to cover private sector HRH	266,829.00	70,804.00	337,633.00
		Enforce implementation of Magna Carta for Public Health Workers across national and LGU health facilities	10,208,925.00	1,528,776.00	11,737,701.00
		Review/amend provisions under existing laws on compensation and benefits of health workers (e.g., PS limit and Magna Carta to cover private sector HRH)	266,829.00	70,804.00	337,633.00
		Identify compensation packages, benefits and incentives for professional and non-professional health workers that are motivating	266,829.00	70,804.00	337,633.00
		Review of existing benefits and incentives for the public and private sector	1,033,005.00	50,536.00	1,083,541.00
		Review of positions classification and job descriptions	1,433,355.00	131,608.00	1,564,963.00
	Ensure well-being of health workers including protection from emerging and re-emerging diseases (e.g. wellness	Develop health, wellness, and infection prevention and control programs (e.g., mental health, physical health, etc.) for health workers	266,829.00	70,804.00	337,633.00

Activity Description			Cost considerations		Subtotal
Strategic Objective	**Strategy**	**Activity**	**Remuneration**	**Operational cost**	
	programs, mental health, etc.) - (from long term)	Craft policy on health care worker protection (e.g., stigma, bullying), and infection prevention and control measures for emerging and re-emerging decisions	2,765,319.00	415,912.00	3,181,231.00
	Ensure compliance with minimum work environment standards by implementing Occupational safety and health (OSH) standards and infection and prevention control initiatives - (from long term)	Review existing OHS Standards and its implementation	266,829.00	70,804.00	337,633.00
		Explore use of available technology to deliver health care services	2,765,319.00	739,660.00	3,504,979.00
		Identify alternative work arrangements in cases of public health emergencies	2,765,319.00	739,660.00	3,504,979.00
		Review and implement minimum work environment standards (e.g., hazard pay, PPEs, short-term accommodations) to prevent and control emerging and re-emerging diseases to protect health workers	2,765,319.00	739,660.00	3,504,979.00
	Ensure appropriate skills mix and roles/functions present in health facilities (from medium-term)	Review current minimum staffing (composition and number) for health service delivery, including needs for workload and public health emergencies, outbreaks, etc.	10,208,925.00	1,528,776.00	11,737,701.00
		Craft policy on minimum staffing (composition and number) for health facilities for public health emergencies, outbreaks, etc.	2,765,319.00	739,660.00	3,504,979.00
		Develop guidelines on HRH standards to ensure optimal response to public health emergencies, outbreaks, etc.	2,765,319.00	739,660.00	3,504,979.00
TOTAL			**100,003,533.00**	**6,758,883,581.50**	**6,858,887,114.50**
Percent			1%	99%	100%

CROSS-CUTTING STRATEGIES

Activity Description			Cost considerations		Subtotal
Strategic Objective	**Strategy**	**Activity**	**Remuneration**	**Operational cost**	
Strategic Objective 5 Strengthen information systems/data on HRH for	14 Strengthen and integrate information systems to ensure up-to-date HRH data and data sharing across the HRH sector	Conduct data mapping to identify data gaps and sources, frequency of data collection, and overlaps, if any	4,900,743.00	815,824.00	5,716,567.00

Activity Description			Cost considerations		Subtotal
Strategic Objective	**Strategy**	**Activity**	**Remuneration**	**Operational cost**	
monitoring, informing decision making, and ensuring accountability	e.g. National Health Workforce Registry (NHWR), National Health Workforce Account (NHWA)	Utilize the NHWA system as the national repository of HRH data and information	3,267,162.00	16,630,216.00	19,897,378.00
		Identify specific NHWA data modules to be contributed consistent with their mandates	943,267.50	73,988.00	1,017,255.50
		Provide updated health worker information aligned with agency process (e.g. PRC licensing, POEA exit information, etc.)	3,709,992.00	298,944.00	4,008,936.00
		Include a NHWA system of data collection in the processes of agencies collecting HRH data	943,267.50	96,448.00	1,039,715.50
	15 Conduct HRH research (including operations and evaluation research and analysis of health labor markets)	Identify specific HRH research agenda and lead groups	2,244,420.00	80,126,608.00	82,371,028.00
		Align HRH development and management research agenda of national agencies	885,339.00	80,083,768.00	80,969,107.00
Strategic Objective 7 Increase investments in HRH and align investments with current and future population health needs and of health systems.	16 Generate resources for HRH from various sources (domestic, international, and other sources)	Explore co-financing mechanisms between national and local governments	400,350.00	122,232.00	522,582.00
		Funding for local HRH needs (development and management) provided by LGUs and supported, if necessary, by National government	2,450,371.50	412,912.00	2,863,283.50
		Explore government subsidies (conditional transfer) for private sector health worker development and management to expand access to health care	200,175.00	25,268.00	225,443.00
	17 Invest in HR systems (education and training, recruitment, deployment and retention, etc.) to meet national and subnational needs	Allocate resources to support HRH in the LIPH	4,532,472.00	1,036,184.00	5,568,656.00
		Organize advocacy activities and campaigns to engage key stakeholders in investing and supporting HRH development and management initiatives	3,267,162.00	572,048.00	3,839,210.00
		Identify sources for funds in areas that are under invested at appropriate levels to support primary health care	1,633,581.00	278,608.00	1,912,189.00
		Identify areas in training and education, recruitment, deployment and retention at national and local levels requiring (additional) investments	400,350.00	34,086,072.00	34,486,422.00

Activity Description			Cost considerations		Subtotal
Strategic Objective	**Strategy**	**Activity**	**Remuneration**	**Operational cost**	
	18 Develop fiscal capacity to absorb and utilize effectively and transparently both domestic and international resources for HRH systems in the public and private sector	Build capacity for planning, resource management (Fiscal Management) and analysis	5,777,487.00	3,837,336.00	9,614,823.00
		Develop a system for co-managing resources, such that management directions will be provided by national agencies, and implementation of specific plan of actions will be handled by local government units	3,267,162.00	547,216.00	3,814,378.00
TOTAL			**38,823,301.50**	**219,043,672.00**	**257,866,973.50**
Percent			15%	85%	100%

Appendix E. About the HRH Network

The HRH Network Philippines integrates agency efforts to harmonize HRH policy directions and coordinate the action of its members in the development of an adequate, globally competent and sustainable health workforce that can contribute significantly to the attainment of universal quality health care for Filipinos. It has been recognized as the first inter-agency collaborative network for HRH in Asia.

In 2006, the Department of Health (DOH) spearheaded the creation of the HRH Network Philippines which is composed of 18 multi-sectoral government agencies and non-government organizations bound by a signed Memorandum of Understanding. These agencies and organizations are as follows:

- Association of Deans of Philippine Colleges of Nursing
- Association of Philippine Medical Colleges
- Bureau of Immigration
- Civil Service Commission
- Commission on Filipinos Overseas
- Commission on Higher Education
- Department of Budget and Management
- Department of Health
- Department of Labor and Employment
- Department of Interior and Local Government
- National Economic and Development Authority
- Overseas Workers Welfare Administration
- Philippine Nurses Association
- Philippine Overseas Employment Administration
- Professional Regulation Commission
- Public Services Labor Independent Confederation
- Technical Education and Skills Development Authority
- University of the Philippines Manila

The HRH Network Philippines is further organized into three Technical Working Committees namely: Entry (education, training, pre-deployment), Workforce (working conditions and productivity), and Exit and Re-entry (migration and re-integration). The Network regularly meets (once every quarter) to conduct various discussions on collaboration, issues, and updates on the HRH situation in the country.

Throughout the years, the HRH Network Philippines has helped shape national policies, programs, systems, and initiatives towards realizing the Philippine's HRH Master Plan and the adjacent international and national plans and commitments, which combined, provide the anchoring schema to respond to workforce needs such as production, training, recruitment, distribution, compensation, and standardization.

The HRH Network Philippines has several initiatives and accomplishments, including the development of various researches and policies on HRH. Some of the initiatives and accomplishments are as follows:

- Organized eight fora since its establishment. The last forum was held in 2017 with the theme: "Keeping Momentum: Accelerating Progress towards Sustainable Human Resources for Health for National Development and Universal Health Care".
- Developed multi-stakeholder country reports on the monitoring of the World Health Organization (WHO) Global Code of Practice every three years since 2012.
- Engaged in the development of bilateral and multilateral labor agreements and has an active participation in the ASEAN meetings of Committee on Services for discussion on Mutual Recognition Arrangements and other economic cooperation agreements with HRH implications.
- Developed two HRH information systems: 1. National Database for HRH Information System (NDHRHIS) which provides statistical information on HRH distribution by geographical location, sex, gender, age, type of facility ownership (private/government) and 2. Integrated Database System for HRH Information System (IDSHRHIS) which captures processes, stores and reports information on HRH from production to deployment to migration, re-entry, and retirement.
- Guided the development of seven researches on HRH and multisectoral HRH policies. Amongst the latest policies developed by the Network are DOH-CHED Joint Administrative Order (JAO) No. 2013-0034 "Affiliation of Higher Education Institutions with Hospitals and Other Health Facilities for Training of Students in Health Professional Education" and DOH-PRC JAO No. 2015-01 "Policies and Guidelines on the Conduct of Medical Residency and Fellowship Training Program for Foreign Medical Professionals in the Philippines"

Furthermore, the HRH Network Philippines had collaborative work and projects with the USAID's HRH2030 Philippines, and WHO for the development and implementation of National Health Workforce Accounts, Workload Indicators of Staffing Needs, Health Labor Market Analysis, and National HRH Master Plan 2020-2040.

Accompanying Documents

Document Title	Description
HLMA Report	A printed report containing the result of the health labor market study conducted by USAID's HRH2030/Philippines
Situation Analysis	A printed report describing the current situation of, and issues faced by HRH in the Philippines
Strategy paper	A printed report containing the result of the strategy development process completed by USAID's HRH2030/Philippines for the Masterplan 2020-2040 HRH
Blueprint	A printed report presenting the overview of the situation analysis and the strategies identified for the HRH Masterplan 2020-2040
Omnibus Policy Review Report	A printed report containing the result of the HRH omnibus policy review conducted by USAID's HRH2030/Philippines
Policy briefs	A compilation of policy briefs on: • Investing and financing human resources for health as a strategy to attain health outcomes • Enhancing Health Workforce Distribution and Retention to Improve Access to Health Care Services • Migration of human resources for health