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Dealing with the Deficit of Primary Healthcare Workers[1]

Ryan Joseph Martinez[2] and Benjamin Velasco[3]

Introduction

Republic Act No. 7160, or the Local Government Code of 1991, mandates that municipal governments are principally responsible for providing primary healthcare services. However, improvements to these health services have fallen short of expectations. One key factor is the inequitable distribution of human resources for health (HRH), budget appropriation, medical supplies, and modern health facilities. Municipalities have varying policies and experiences in improving the quality of healthcare services.

Still, grassroots initiatives in innovative health projects exist in geographically isolated and disadvantaged areas (GIDAs). Primarily geared toward addressing the shortage of primary healthcare workers in local communities, these initiatives address longstanding inequities and value multisectoral participation. They are also driven and led by community members, and are embedded in the context and needs of the communities they aim to serve. In the context of the pandemic, these values become essential in the recovery of the country from the COVID-19 crisis.

Universal healthcare within the primary healthcare approach

Article II, Section 15 of the 1987 Constitution declares the policy of protecting and promoting the "right to health of the people and instilling health consciousness among them." Meanwhile, President Benigno Aquino III expanded healthcare coverage with the Kalusugan Pangkalahatan (Healthcare for All) through Administrative Order No. 2010-0036. In February 2019, President Rodrigo Duterte signed the Republic Act No. 11223, or the Universal Health Care (UHC) Act.

The UHC Act aims to "guarantee equitable access to quality and affordable health care" (Section 3b) and streamline the processes of government

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2 Ryan Joseph Martinez (rcmartinez2@up.edu.ph) works as a Senior Project Assistant for UP CIDS AltDev.

3 Benjamin Velasco (bbvelasco@up.edu.ph) is an Assistant Professor at the School of Labor and Industrial Relations of UP Diliman and Co-convenor of UP CIDS AltDev.

agencies in delivering services. To achieve this, the law adopts "a framework that fosters a whole-of-systems, whole-of-government, and whole-of-society approach in the development, implementation, monitoring, and evaluation of health policies, programs and plans" (Section 2c).

Primary healthcare encompasses several essential services, covering maternal and childcare, nutrition, and hygiene and sanitation, as well as preventive and promotive health services. The municipal government coordinates with the barangay health stations (BHSs) and the rural health units (RHUs) of each locality as healthcare providers. In areas where access to government services is lacking, civil society fills in the gap. The primary health care approach emphasizes the whole-of-society approach of ensuring "care in the community as well as care through the community" (WHO[4] 2022).

Issues and challenges in human health resources

As a core pillar of universal healthcare, human resources for health (HRH) encompass issues surrounding the shortage of the health workforce. The National Health Human Resource Master Plan of the Department of Health (DOH) outlines key challenges in HRH in the country (DOH 2020). These include: (1) the inadequate number of health workers in the health sector; (2) the inequitable distribution of HRH; (3) the lack of accurate HRH information to guide planning and policy; (4) limited collaboration among stakeholders with multiple roles in the HRH sector; (5) fragmented HRH governance and unclear accountabilities; and (6) policy gaps and poor policy implementation.

In 2016, WHO estimates that Southeast Asia comprises the biggest share in the needs-based shortage of health workers, which amounts to a regional deficit of no less than 6.9 million. Calculations by Alicias-Garen et al. (2019), using available data from DOH in 2016, reveal a deficit of doctors (55,210), nurses (110,424), and midwives (149,300) in both private and public healthcare sectors in the country. This deficit, along with the increased demands for services in public health facilities, often leads to overcrowding and a decline in the quality of such services.

Barangay health workers (BHWs), who act as primary healthcare workers, play a crucial role in access to primary healthcare, especially in GIDAs. In 2019, there were 213,365 active BHWs stationed across 21,273 Barangay Health Stations (BHS) across the country (DOH 2020). These BHS are spread out disproportionately in areas to cover GIDAs, where they act as satellite healthcare stations.

The Philippines is a major exporter of healthcare professionals abroad. The pull factors are the "lucrative" income and employment opportunities, more advanced technological equipment, and training. Meanwhile, the push factors are poor work environment, technology, and "perceived deterioration of political and security situations in the countryside" (Alicias-Garen et al. 2019, 17). The health care system is still "fragmented and inequitable" in terms of the distribution of health resources—both material and human (Alicias-Garen et al. 2019, 8; Dayrit et al. 2018).

In addition to migration factors, the COVID-19 pandemic highlighted the deficiency in ability and medical training of workers capable of handling healthcare demands. Better compensation and hazard allowances, coupled with opportunities for educational advancement, could deter migration and improve the overall response of the country's young healthcare workforce (UPPI[5] and DRDF[6] 2020).

However, the concrete manifestations of the National Health Human Resource Master Plan 2020–2040 are yet to be seen. Moreover, the UHC Act mandates the establishment of the National Health Workforce Support System aimed at "addressing [the] human resources needs" in disparate local government units (LGUs) and GIDAs (RA No. 11223, Section 24). Meanwhile, the Scholarships and Training Programs and direct

[4] World Health Organization

[5] University of the Philippines Population Institute

[6] Demographic Research and Development Foundation

deployment of HRH through the Return Service Agreement strive to improve HRH quality and quantity.

Policy proposals to address the deficits in primary healthcare workers

Although issues in the delivery of primary healthcare services are addressed, policy and governance reforms must be enacted using the whole-of-government and whole-of-society approaches, starting from the DOH down to the basic healthcare providers. These include, but are not limited to: (1) ensuring better labor policies and compliance among healthcare employers; (2) better health financing at the local and national levels, which can be appropriated from progressive taxation schemes such as a wealth tax; (3) improved health policy administration and clear objectives from the national action plan; and (4) the localization of these plans to the basic health units.

Data-driven diagnostics of HRH

Still, a prevailing challenge in assessing the country's HRH or workforce system is the incomplete figures in determining the total number of health professionals. By law, the DOH, alongside LGUs, is required to report on respective national and local health workforce statistics. Data on the number of health professionals from the Commission on Higher Education (CHED), Philippine Statistics Authority (PSA), and the Professional Regulation Commission (PRC) should be consolidated and made accessible through Freedom of Information (Executive Order [EO] No. 2, 2016). In addition, the Philippine Overseas Employment Agency (POEA) should also provide a summary of statistics on health workers abroad.

Lastly, a reclassification of the current healthcare system should include not only formal but also informal health workers, such as indigenous healers, community health practitioners, civil society organizations, and nongovernment organizations (NGOs) that fill in the gaps of the current health system. This acknowledges both the importance of citizen health science and the limitations of healthcare in the Philippines. The reclassification entails appropriating support in data collection and management to improve health workforce statistics.

Robust implementation of the UHC Act

Policy recommendations at the legislative level should ensure the robust and exhaustive implementation of the UHC Act of 2020, starting from its basic healthcare units at the barangay and municipal LGU level. Such implementation must also consider the role of civil society and community level health actors. This suggests a paradigmatic shift of the country's health system from a "whole-of-government" approach, which starts from the top to bottom, to a more holistic "whole-of-society" lens, which considers all stakeholders in partnership with government (Tadem et al. 2022, 90).

Various innovative grassroots initiatives suggest ways of expanding opportunities of collaboration, which incorporate grassroots healthcare efforts, and valorize needs-based and evidence-based monitoring and evaluation of health programs. The implementing guidelines of the National Health Workforce Support System could be effectively modeled from the Sorsogon Floating and Mobile Clinic Program. The close coordination of community-driven and -led health initiatives, in collaboration with the provincial government, was essential to its success. In addition, Scholarship and Training Programs could be modeled after the stepladder curriculum of the University of the Philippines School of Health Sciences (UPSHS) in Palo, Leyte. The UPSHS stepladder program, implemented at the community level, opens the opportunity for health education directly to stakeholders. Moreover, it promotes a responsive health program based on the particular and context-specific needs of the community. Thus, people directly benefit from this program, which addressies the shortage of community healthcare providers and professionals at the local level. Tweaking the National Health Workforce Support System and the Scholarship and Training Programs provided for in the UHC (RA 11223, Sections 24–25) can be done at the implementation stage. However, such tweaks can also be institutionalized by amending the UHC using lessons from the Sorsogon Floating and Mobile Clinic and UPSHS.

Although these initiatives respond to the gap in human health resources, they cannot truly resolve its deficits. Even as a whole-of-society approach considers the voice and demands of stakeholders, especially the poor and marginalized living in GIDA, only a whole-of-government approach, where the State plays the central role, can ensure the implementation of the UHC Act.

The biggest gap in UHC implementation is, of course, the problem of funding. DOH's annual budget falls short of the necessary amount to sustain the goal of universal health entitlement. Thus, there is a deficit in required funding to acquire HRH. The budget for health in the General Appropriations Act (GAA) must be progressively and radically increased to attain the target of UHC and support the needed HRH.

Critical evaluation of the policy of healthcare devolution

Another policy issue is the devolution of health services to LGUs. It is necessary to review this devolution, given the difficulties posed for perennially financially challenged GIDAs in ensuring HRH and UHC availability. The question of centralizing public healthcare services is imperative, particularly 30 years after devolution in 1992. It is high time to evaluate its outcomes, impact, and stated objectives in light of past experiences and the recent challenges driven by the pandemic.

Although the forthcoming implementation of the Mandanas-Garcia ruling[7] may augment the funds for LGUs, it is still relevant to ask whether devolution is the right policy. The COVID-19 pandemic placed the devolved public healthcare system to the test. This experience should be thoroughly assessed as part of the review of the propriety of healthcare devolution.

Urgent resolution of labor market challenges for the healthcare workforce

Human resource management, addressing the shortage in the health workforce, should tackle longstanding inequities of labor practices in the country. Although the public healthcare workforce stands to benefit from the Magna Carta of Public Health Workers of 1992 (RA 7305), there should be equivalent policies for those working in the private sector. This entails expediting the deliberation and passage of the Magna Carta for Private Health Workers, which should safeguard the benefits and work arrangements of those in that sector.

Attention should also be given to updating policies affecting the health workforce at barangays, grassroots communities, and GIDAs, where access to services is difficult or lacking. A review of the Barangay Health Workers' Benefits and Incentives Act of 1995 (RA No. 7883) is necessary in ensuring better distribution of benefits and incentives for community health practitioners.

To improve policy and regulation, longstanding labor challenges should be assessed. These include employer–employee relations (such as contractualization) and corresponding benefits, the lack of employment opportunities for healthcare providers and professionals, and the comparative disadvantages in terms of wages and benefits between the public and the private health sectors. This requires revisiting existing labor regulations and governance strategies of the Department of Labor and Employment (DOLE) and Civil Service Commission (CSC) with regard to the workforce in respective private and public health sectors. These policies at the agency- and employer-level should consider the broad demands from the labor sector movements.

7 The *Mandanas-Garcia* ruling refers to the Supreme Court (SC)'s final decision on two (2) separate (consolidated on October 22, 2013) petitions filed before the SC: (1) the petition filed by Congressman Hermilando I. Mandanas and other local officials vs. Executive Secretary Paquito N. Ochoa, Jr., et al. (G.R. No. 199802); and (2) Congressman Enrique T. Garcia, Jr. vs. Executive Secretary Paquito N. Ochoa, Jr., et al. (G.R. No. 208488). Both petitions challenged the manner in which the National Government computed the Internal Revenue Allotment (IRA) shares of LGUs. In particular, the petitioners pleaded with the SC to mandate the NG to compute the IRA based on the "just shares" of the LGUs" (DBM 2021, 5). A link to the full ruling is found in the reference list entry, G.R. No. 199802 and G.R. No. 208488 (2019).

Vital consolidation of the local community and indigenous health networks

The deficit in the country's HRH leads to the maldistribution of professional and specialized health assigned in GIDAs. Nonetheless, it is also an opportunity to strengthen local service delivery networks by incorporating and providing training to indigenous healers and community health practitioners, as they are bridges to local communities. Such efforts recognize indigenous knowledge systems and practices as service providers, health promoters, navigators/coordinators, community mobilizers, and health leaders. DOH must recognize these informal health workers and incorporate them into the formal healthcare system through mechanisms, incentives, and budgetary support. For example, they can be deputized as BHWs. This can be done through administrative issuances and executive orders.

Immediate remediation of human resource issues arising from the pandemic

The strain on the health resource capacity brought by the COVID-19 pandemic brings several unique and pressing challenges for the physically worn-out and psychologically stressed health workforce. Hazard pay and subsistence allowance for frontline health workers and BHWs should be deliberated, passed, and immediately distributed. Immunization and preventive health programs for communicable and noncommunicable diseases should be mandated for the health workforce: this is a lesson taken from COVID-19 casualties of health personnel.

In the immediate term, even executive action can actualize hazard pay, subsistence allowance, and other benefits for healthcare workers. In the longer term, it is necessary to amend the Magna Carta of Public Health Workers of 1992 and the Barangay Health Workers' Benefits and Incentives Act of 1995 to incorporate better total compensation. Such will serve as a pull factor to block the hemorrhage of health workers abroad.

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Editorial Office: Lower Ground Floor, Ang Bahay ng Alumni,
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Telephone: 8981-8500 loc. 4266 to 4268 / 8426-0955
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