

## Health Human Resource Development

The WHO refers to human resources for health (HRH) as “the people who provide health services to the entire population” (WHO 1993). In the Philippine context, health human resources refer to “health personnel, also called health manpower, and the totality of their skills, knowledge and capabilities for national health development” (DOH 1995). The term also refers to those engaged in the delivery of various health services to promote and maintain the well-being of the people, and thus include “professionals, paraprofessionals, community health workers, support health workers, support personnel and traditional healers” (DOH 1995).

The Philippine Regulation Commission (PRC) tracks the number of registered health professionals, however, there are no existing accurate statistics on health personnel in the Philippines that would account for those who are no longer currently practicing the profession, including the deceased, those who are pursuing other careers aside from their registered profession or those who have immigrated to practice the profession abroad or otherwise. Likewise, there are no existing data that would account for the total number of

support health workers, support personnel or traditional healers in the country.

Health human resource development (HHRD), from the national government perspective, entails the triad of HRH planning, production and management. In this perspective, HHRD incorporates functions that in other sectors would fall in the larger and separate field of human resource management, pertaining to a range of activities from recruitment to deployment, to utilization and retention of health personnel, highlighting the importance of ensuring an adequate national supply of health care providers and retaining them in the service of the country (Rebullida and Lorenzo 2002).

**Table 3.11 Number of Registered Health and Allied Health Professionals Philippines, 2004**

Health Professions	Registered for 2004	Cumulative Total Registered
1. Dentist	1,039	46,360
Dental Hygienist	0	6
2. Medical Technologist	1,558	47,846
Medical Laboratory Technician	96	3,672
3. Midwife	1,818	135,786
4. Nurse	10,013	364,557
5. Nutritionist-Dietician	282	12,107
Dietician	0	1,410
6. Optometrist	56	9,559
7. Pharmacist	1,631	50,748
Chinese Druggist	0	485
8. Physician	2,133	103,891
9. Physical Therapist	1,143	18,388
Occupational Therapist	157	2,159
Physical Therapy Technician	0	78
Occupational Therapy Technician	0	119
10. Radiologic Technologist	253	5,649
X-ray Technician	59	8,403
11. Sanitary Engineer	34	2,339

Source: Professional Regulation Commission, 2004

While the evolution and development of HRH in the Philippines could be traced to the early 1900s with the production of physicians, pharmacists and midwives (1902-1914), dentists (1915) and nurses (1919), the production and development of approximately 10,000-20,000 manpower stock per health professional per year did not vary until the 1950s when the first Filipino doctors and nurses started pursuing specialized training in the United States but eventually ended up finding lucrative job opportunities abroad (Lorenzo and Angluben 1999).

From the 1960's and onwards, there were three major ensuing policy changes that defined a particular phase in the development of HRH in the country.

Since the 1990s, concerns regarding HRH have been increasingly recognized. A HRH plan was made in 1994 but was not implemented as the plan was overtaken by the rapid

changes in HRH trends (e.g. immigration of health workers, globalization, increases in the number of schools, etc.). Hence, the lack of a unifying and comprehensive national plan embracing all health professionals that will look into the needs of HRH poses a major obstacle in HR management and development.

In 2004, activities towards developing a master plan have been underway. A thorough analysis of the HRH situation in the preparation of the HRH Master Plan (HRHMP) showed the following findings:

**Table 3.12 Historical Development of HRH in the Philippines (1960s-onwards)**

Policy Era	Milestones/Characteristics
Primary Health Care Era (1960s-1980s)	<ul style="list-style-type: none"> <li>● Midwives became the second most numerous health professionals (next to nurses), providing primary care not being provided by doctors and nurses in underserved areas</li> <li>● Community-based, step-ladder health curriculum set-up at the UP School of Health Sciences in Palo, Leyte for prospective health workers specially trained to serve remote and underserved areas</li> <li>● DOH established the Innovative Health Sciences Education Partnership Program (IHSEPP) to ensure responsiveness of health sciences education to health needs of the communities</li> <li>● Development and training of community-based primary health workers encouraged by the WHO</li> </ul>
Health System Decentralization Era (early 1990s)	<ul style="list-style-type: none"> <li>● The 1991 Local Government Code devolved the delivery of basic health services to the local government units</li> <li>● Lack of specialty trained physicians and nurses that affected licensing and accreditation of public and private hospitals</li> <li>● Magna Carta for Public Health Workers passed, standardizing basic salaries and additional benefits; widespread demoralization occurred among those working in LGUs that could not provide all the stipulated salary scale and benefits</li> <li>● Fragmentation of healthcare delivery affecting equitable access to quality healthcare</li> </ul>
Health Sector Reform Era (late 1990s, onwards)	<ul style="list-style-type: none"> <li>● Local health systems development is the health sector reform area most affected by human resource management factors</li> <li>● Integration of hospital care with public health services; strengthening of the two-way referral system</li> <li>● Competencies and function of health staff needed to be developed to ensure a seamless health care system</li> </ul>

*Source: Rebullida and Lorenzo, "Health Human Resource Development: Policies and Effects on the Health Professions", National Institutes of Health, University of the Philippines Manila, 2002*

**Weak and inadequate HRH information system.** There are incomplete or non-existent data on HRH in the private sector, HR distribution, HR employment (domestic and international), and on other relevant aspects of HRH. Furthermore, there is no adequate data on skill and skill mix requirements to justify staffing standards for health facilities and institutions.

**No rational basis for authorizing the opening of health sciences courses as to location, type of programs, number of enrollees, etc.** The high demand for nurses abroad resulted in not only an unusual increase in schools offering nursing but also of medical and allied professionals taking nursing as second course.

**There is an existing distribution imbalance.** Health professionals, especially private practitioners tend to concentrate in urban sites, while an increasing number of them are leaving the country for more lucrative opportunities overseas.

**Inappropriate education and training.** Evaluation of the curriculum of health science professionals revealed that the learning curricula were more content-based than problem or situation-based and that there is an adherence to western educational and health systems leading to mismatch between training and actual practice.

**Unmanaged HRH immigration.** HRH, notably those in the nursing profession as well as sub-professional caregivers, are leaving the country in droves. In the last 3-5 years, we have seen the “second course phenomenon”, wherein health and non-health professionals re-enrolled to obtain nursing degrees due to the perceived increased demand for nurses in the global market.

Of particular concern to the country is the immigration of Filipino workers to first world countries resulting in the loss of millions of skilled and unskilled Filipino workers supposedly a temporary measure to address local employment issues (lack of employment opportunities, underemployment, low wages) but has persisted over the years (Lorenzo et al 2005). Factors identified that account for such phenomenon includes: colonial mentality, economic need, professional and career development, and attraction of a better quality of life or a higher standard of living (Alburo and Abella 2002).

According to the Department of Foreign Affairs, there is an estimated 7.2 million Filipino immigrants all over the world, with overseas deployment rate increasing 5.32 percent annually from 1995-2000 (DFA 2001). The Philippines is the biggest health

service provider of nurses globally (Lorenzo 2005). Not surprisingly, nurses represent the most number of Filipino health professionals leaving the country in favor of top country destinations such as Saudi Arabia, the United States of America and the United Kingdom in the last decade. Other destinations include Libya, United Arab Emirates, Ireland, Singapore, Kuwait, Qatar and Brunei (POEA 2003).

Responses to HRH issues in the past were more often stopgap measures. To address the perennial lack of health workers in far-flung areas, the Department of Health spearheaded the implementation of programs to deploy needed human resources such as:

**Doctors to the Barrios (DTTB) Program** - deployment of physicians in “doctorless” municipalities. With some support from the business sector, DOH provided salary and other incentives to attract doctors to work in hard to reach municipalities. LGUs were required through Memorandum of Agreement (MOA) to provide counterpart support, at the very least, accommodation or equivalent cash allowance.

**Leaders for Health** - a modification of the DTTB Program. This track provides opportunities for a masteral course to doctors assigned in selected regions. This is implemented with funding support from Pfizer and in coordination with Ateneo de Manila Graduate School of Business.

**Rural Health Placement Team** - These are non-medical health professionals assigned in selected underserved areas to complement existing human resource for health. The team consists of nurses, midwives, dentists, medical technologist and others.

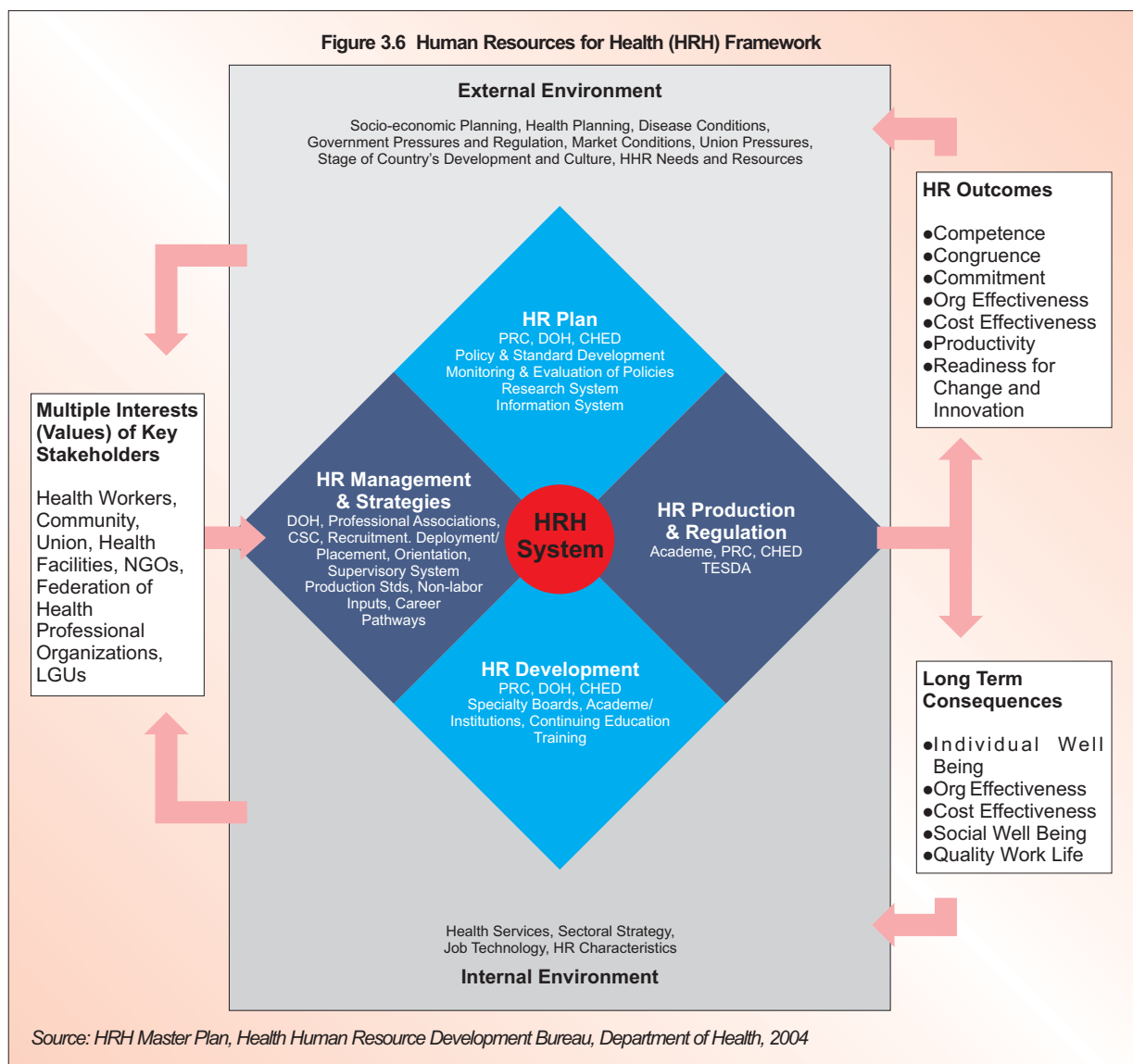
**Specialists to the Province** - The program is sponsored by Unilab and is implemented in coordination with the Philippine Society of Anesthesiologists and the Philippine College of Surgeons. Teams of surgeon-anesthesiologist are fielded in district and provincial hospitals to complement existing health professionals and build the competencies of hospital staffs.

**Residency Consortia** - DOH teaching-training hospitals and medical centers pool together medical specialists in order to provide services in non-teaching and training hospitals and to develop their capability to offer residency programs.

Other means to address the lack of qualified doctors were done through the passage of enabling laws. The current law on midwifery incorporated provisions that would allow midwives, under certain conditions or situations, to perform life-saving procedures,

usually reserved for doctors like suturing of lacerations, giving intravenous fluids, etc. (R.A. 7392, Sec. 23 Art. III).

However, in order to address the complex and multi-faceted issues on HRH, a comprehensive approach is needed. This brings into focus the need to institutionalize HRH systems that will ensure that an adequate number of competent health workers who can efficiently and effectively deliver health services are in place where they are needed. HRH systems that have been developed or are being developed include the following: (1) HRH Information System (HRHIS); (2) Job Related Recruitment and Selection System (JRRSS); (3) HR Planning (HRP); (4) Career Development and Management System (CDMS) including individual career planning, establishment of career path, succession planning, and retention planning; (5) Performance Management System



(PMS); (6) Training and Development Needs Analysis (TDNA); and (7) Competency-based Job Description Analysis (CBA). The development of these systems is governed by the HRH Framework that applies to the whole health sector.

There is not a single agency that is responsible for the development and management of HRH in the country thus, a multi-sectoral approach involving various agencies and organizations in the health sector is necessary. Among the agencies involved in HRH are the academe, professional societies, and local governments, the Commission on Higher Education, the Technical Skills Development Authority, the Professional Regulation Commission, the Civil Service Commission, the Departments of Health, Labor and Employment, Interior and Local Government, and Foreign Affairs. LGUs employ more than half of the health workforce and have an important role in the development and implementation of local HRH systems.

<b>Goal: Adequate, competent and committed human resources for health are ensured.</b>			
<b>National Objectives for 2005 - 2010</b>			
<b>Objective</b>	<b>Indicator</b>	<b>Target</b>	<b>Baseline Data and Source</b>
Technical and managerial competence of health professionals are enhanced.	Competency standards developed for HRH (at par with international standards)	Standards are set for managerial competence for supervisory positions in the health sector;  Standards are set for technical competence of health professionals	The set standards were limited to central office (CO - DOH) managers and supervisors  <i>HHRDB, 2004</i>
	Number of managerial and technical staff retooled and retrained on health sector reform priorities and strategies	All provincial health officers and technical coordinators in convergence sites;  All DOH regional directors and technical coordinators;  All DOH central office directors and technical coordinators	Two (2) introductory courses held in 2004  <i>HHRDB, 2004</i>
Implementation of a comprehensive HRH policy framework, strategic plan and systems are strengthened.	Coordinating mechanisms developed among HRH stakeholders	A functional network of government agencies, academic institutions, professional groups, NGOs and private sector involved in HRH is in place	Networks deal with specific HRH aspect, e.g. production (TWG on Medical Curricula) or limited number of stakeholder-members  <i>HHRDB, 2004</i>

National Objectives for 2005 - 2010			
Objective	Indicator	Target	Baseline Data and Source
	HRH systems adopted in Inter-Local Health Zones (ILHZs)	At least five (5) HRH systems are in place in all ILHZs in priority convergence sites	HRH systems are in place in ILHZs in ICHSP areas <i>HHRDB, 2004</i>
HRH distribution and complementation in unserved/underserved areas are ensured.	Percentage of met needs based on request from underserved and/or unserved areas to be provided with health workers	70 percent underserved and/or unserved areas provided with health workers	60 percent underserved and/or unserved areas provided with health workers <i>HHRDB, 2004</i>
	Number of mechanisms to facilitate production of specialists (e.g. residency consortia)	1 residency consortia established	Drafted policy on anesthesia residency consortia <i>HHRDB, 2004</i>
HRH outmigration and retention of returning health workers are addressed.	"Managed HRH Migration" policies and strategies developed and implemented	Comprehensive policies on HRH out-migration and retention of returning health workers developed and instituted	No integrated policies are developed and/or implemented at present <i>HHRDB, 2004</i>

Strategic Thrusts for 2005-2010
<ul style="list-style-type: none"> <li>• Adopting and implementing a <b>comprehensive and multi-disciplinary HRH Plan</b></li> <li>• Developing <b>HRH policies, systems, guidelines and standards</b> responsive to the healthcare needs of the people</li> <li>• Developing <b>policies and strategies to address the out-migration of HRH</b> as well as the <b>retention and utilization of returning health professionals</b></li> <li>• Sustaining <b>incentive mechanisms</b> or schemes for <b>HRH distribution and complementation in underserved areas</b></li> <li>• Making <b>education, training and skills development of HRH more appropriate towards addressing local needs</b> and developing technology-based innovations to optimize capacity building for health service delivery</li> </ul>