Pandemic Impact, Support Received, and Policies for Health Worker Retention: An Environmental Scan

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ABSTRACT

Background and Objectives. The COVID-19 pandemic has brought additional strain to health workers in the Philippines, leading to a significant proportion of them leaving the workforce. The purpose of this study is to explore the impact of the pandemic on health workers, the support that they received and associated challenges; and identify relevant policies for better workplace conditions.

Methods. An environmental scanning method was utilized. Particularly, a literature review and policy scan that were validated through key informant interviews with administrators and frontline health workers from selected urban and rural sites in the three main islands in the Philippines. These were framed into a background note to springboard the discussions during a national policy dialogue participated by representatives from key government organizations, professional organizations of physicians, nurses, and midwives, professional regulatory bodies, hospital administrators, frontline health workers, and donor agencies in the Philippines.

Results. Deaths, burn-out, mental health problems, lack of personal protective equipment and poor allocation of vaccines were reported in the early phases of the pandemic. Support varied across settings but included additional allowance, free meals, accomodation, transportation, training and psychosocial services. Furthermore, pre-pandemic issues such as as low salaries and heavy workload continue to be the main reasons for leaving the workforce or the country. The proposed solutions are as follows: (1) creating policies and strategies for appropriate production, recruitment, and retention of human resources for health; (2) allocating regular permanent positions for both the education and health sector; (3) augmenting and continuation of deployment programs; (3) expanding roles of nurses to push for advanced practice nursing; (4) providing fair compensation along with risk allowances, non-financial incentives, and expanded benefits; (5) supporting mental health wellness by providing an appropriate work-rest balance and safe work environment; (6) providing opportunities for professional development and scholarships with accompanying return-service agreement; and (7) strengthening the reintegration programs for returning overseas health workers.

Conclusion. The pandemic has affected the well-being of health workers and disparities in support were reported due to longstanding workplace issues and policy implementation gaps. Stakeholder commitments require sustained monitoring while policies that are in place and yet to be developed demand stronger support from the government, members of Congress, the private sector, and other key decision-makers.

Keywords: COVID-19, health policy, human resources for health, Philippines, retention

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INTRODUCTION

The demands incurred due to the COVID-19 pandemic resulted in physical and psychological impacts on healthcare workers. Fear of contracting the COVID-19 virus among frontline nurses in the Philippines was reported to be associated with job dissatisfaction, elevated psychological distress, and increased professional and organizational turnover.[1] Similarly, a cross-sectional study among 516 Filipino healthcare workers revealed that 70.7% were found to have anxiety symptoms while 51.0% had depressive symptoms.[2] The demand required in care provision led to burnout and psychological distress of health workers and in turn resignation from the workplace.[2,3] Existing challenges regarding health worker migration, workplace environment, and remuneration of health workers were amplified. In addition, the Philippines is facing medical and nursing shortages and the maldistribution of health workers in the country. Less than 25% of cities and municipalities can meet the WHO recommendation for a health worker-to-population ratio.[4] Of almost all cadres of health workers, more than half reside in the National Capital Region, MIMAROPA, and Central Luzon.[5] Responsive policies are warranted to address pre-existing (e.g., work environment, financial and non-financial incentives, career opportunities, workload, professional autonomy, responsive management, etc.) and pandemic factors insert (e.g. access to full vaccines, personal protective equipment, time off, support for well-being, etc.) influencing the retention and resilience of health workers. Though several studies have reported the experiences of health workers during the COVID-19 pandemic, limited analyses have been made on pre-pandemic and pandemic policies that would be critical should a similar event happen in the future. Therefore, this policy analysis aims to: (1) describe the impact of COVID-19 on health workers, support received and associated challenges (2) examine the policy context around the retention of healthcare workers in the Philippines; (3) analyze the policy options available to support the retention and resilience of HCWs in the Philippines; and (4) develop recommendations for a call to action to support the retention and resilience of healthcare workers in the Philippines.

MATERIALS AND METHODS

This project followed elements of policy research using the environmental scanning method. The environmental scanning method employs a comprehensive mapping of current resources and existing gaps suited to capture contextual factors contributing to health and social issues used to develop resources according to the needs of communities.[6,7] This study utilized formal searching which involves active efforts to seek out information,[8] which further involved data searching and engaging key informants to ensure a comprehensive mapping of the scan.[9] The process consisted of four steps: (1) literature review and policy scan related to the impact of COVID-19 pandemic, pandemic response, and HCWs retention and resilience; (2) key informant interviews (KII) from selected regions of the Philippines; (3) data synthesis on pertinent areas for policy exaction to develop the background note; and (4) implementation of a policy dialogue to engage different stakeholders. The project was implemented from July to November 2022.

Literature Review and Policy Scan

A literature review was conducted by gathering data from electronic databases (PubMed, HERDIN) to describe the impact of COVID-19 on healthcare workers and actions taken to support their resilience and grey literature (N = 51). Policies reviewed included, but were not limited to, the Department of Budget and Management (DBM) circulars on salaries, provision of special risk allowances and non-monetary incentives, protection from exposure, protection of health workers against discrimination, safe health worker to population/patient ratio, and those that concern the migration of health workers.

Data Collection and Procedure

To validate and get more in-depth data from the literature review, key informant interviews were conducted with stakeholders from different regions of the Philippines. The participants were selected from provinces and cities, which, according to reports in the literature, indicated good practices in building resilience and retaining health workers. Healthcare workers with direct patient care or administrative roles and employed in their current position from March 2020 to 2022 were eligible for inclusion to allow exhaustive descriptions of their experiences during the pandemic. A semi-structured interview guide was used during data collection with topics on the impact of the COVID-19 pandemic, support rendered for healthcare workers, and challenges and limitations in providing support for healthcare workers. All interviews lasted approximately 30 to 60 minutes and were audio-recorded with the participants' consent. The research was granted an exemption from ethical review based on the criteria for exemption in the National Ethical Guidelines for Research Involving Human Participants 2022.[10]

The research team conducted a total of 25 KIIs from participants in primary care health facilities and public and private tertiary hospitals from selected regions of the Philippines. The interviews were conducted via an online platform in July 2022. Healthcare workers assuming administrative roles were asked about the pre-existing and pandemic-related factors as identified in the project framework, and how they supported their health workers in terms of the identified pre-existing and pandemic factors.

Development of the Background Note

The literature review, policy scan, and content analysis of the KIIs were synthesized into a background note. This was framed for the discussion on the policy dialogue that

summarizes evidence on the impact of the pandemic on frontline healthcare workers in the country, areas where support has been provided and where it is lacking, and options for future policy actions to increase retention of health workers.

National Policy Dialogue

The policy dialogue was held on November 10-11, 2022. The policy dialogue adopts the framework of the International Council of Nurses and the Commission on Graduates of Foreign Nursing Schools (CGFNS) Sustain and Retain in 2022[11] and Beyond Report and the WHO Global Health and Care Worker Compact[12] with predefined topics sorted into two main categories: fostering resilience and promoting retention. Topics for fostering resilience dealt with the pandemic factors enumerated in the framework. On the other hand, promoting retention dealt with the pre-existing factors. The policy dialogue identified priorities ("bundles of linked policies") that can be taken to enhance the retention of front-line health workers and address stressors in their workplaces.

Factors that affect the resilience and retention of health workers include pre-existing and pandemic-related factors. These factors are categorized as those already occurring even before the pandemic and those that became more relevant during the pandemic. These factors also resonate under the policy action areas stipulated in the WHO Global Health and Care Worker Compact. These areas are preventing harm, providing support, safeguarding rights, and inclusivity. The policy dialogue is further guided by the health labor market framework and policy levers for attaining universal health coverage (UHC) which suggests policy actions on production, inflows and outflows of health workers, addressing maldistribution and inefficiencies, and regulating the private sector.[13]

The participants of the policy dialogue include key national government agencies [Department of Health (DOH), Department of Budget and Management (DBM), Department of Labor and Employment (DOLE), and Commission on Higher Education (CHED)], professional organizations (Medicine, Midwifery, and Nursing), members of Congress, public health workers in the local government units, professional regulatory boards, donor agencies, World Health Organization (WHO) and the University of the Philippines Manila College of Nursing as a WHO Collaboration Center for Leadership in Nursing Development.

RESULTS

This section presents the results of the literature review, policy scan, and content analysis of the key informant interviews. Table 1 presents the demographic profile of the participants in the KIIs. Majority of the participants are residing in Luzon, urban areas, and employed in the public sector. Table 2 presents the existing laws, policies, and memorandums supporting HCWs before and during the COVID-19 pandemic.

Impact of the COVID-19 Pandemic on Healthcare Workers

Examining the impact of the COVID-19 pandemic on the many issues surrounding HCWs in the Philippines surfaced the weaknesses of the health system, particularly the human resources for health (HRH). Aside from the direct impact such as deaths, infections, and mental health issues among HCWs, the regional consultations revealed complex and long-term impacts on the different professions as they try to face the continuing challenges imposed by the pandemic. The results underscored the support for HCWs but also surfaced the gaps that support policy recommendations.

Deaths, Infections, and Mental Health Problems

Despite measures to prevent infection among healthcare workers (HCW), among 8,212 COVID-19 cases detected in the Philippines, 24.7% of detected infections and recorded 35 deaths were from HCWs in April 2020.[14] In a screening test performed by San Lazaro Hospital to their 324 HCWs in 2020, eight tested positive, and most were nurses, laboratory personnel, and physicians.[15]

The pandemic also resulted in mental health problems among HCWs. According to a systematic review and meta-analysis,[16] there is an overall high incidence of anxiety (33%) and depression (28%) of COVID-19 not just in the general population but also among healthcare workers, especially among nurses. The heightened level of stress and anxiety was mainly because of the lack of knowledge on managing the COVID-19 virus. As the pandemic progressed, COVID-19 vaccinations were given, and information on management was obtained; health workers reported that stress levels and anxiety also lessened.

Table 1. Profile of Participants in the Key Informant Interviews (n=25)

Characteristics	n	%
Position		
Administrator	12	48
Rank and File	13	52
Type of healthcare worker		
Midwife	3	12
Nurse	13	52
Physician	9	36
Location		
Luzon	17	68
Visayas	4	16
Mindanao	4	16
Setting		
Urban	17	68
Rural	8	32
Sector		
Public	21	84
Private	4	16

Table 2. Laws, Policies, and Memorandums Supporting Health Workers before and during the COVID-19 Pandemic

Policies	Summary/ Highlights of Provision
Policies before the COVID-19 pandemic	
Republic Act (RA) 7160: Local Government Code	Local Government Units (LGUs) formulating and implementing financial plans including health services such as hiring and appropriation of health workers.
RA 7305: Magna Carta of Public Health Workers	Promote and improve the social and economic well-being of the health workers, their living and working conditions, and terms of employment.
RA 6758: Compensation and Position Classification Act of 1989	Ensure appropriate and fair wages for all government personnel, including health workers. The act also stipulated that wages are dependent on the financial capability of the LGUs, which are classified from first-class to sixth-class.
RA 11466: Salary Standardization Law of 2019	Mandates to provide all government personnel a just and equitable compensation in accordance with the principle of equal pay for work of equal value.
RA 9173: Philippine Nursing Act of 2002	This act includes Comprehensive Nursing Specialty Program to upgrade the level of skill and competence of specialty nurse clinicians in the country; Salary where minimum base pay of nurses working in the public health institutions shall not be lower than salary grade 15 prescribed under RA 6758; and Incentives and Benefits such as free hospitalization.
Policies during the COVID-19 pandemic	
Joint Memorandum Circular No. 4 (Department of Budget and Management [DBM], Department of Finance [DOG], and DILG) Policy Guidelines on the Implementation of Certain Provisions of the Bayanihan to Recover as One Act (RA 11494) pertaining to LGUs	Increases the Personnel Services (PS) Cap of LGUs for FY 2020. The PS cap of LGUs for FY 2020 shall be increased by up to ten percent (10%) for first (1st) to third (3rd) income class municipalities, and up to five percent (5%) for fourth (4th) to sixth (6th) income class provinces, cities, and municipalities.
National Budget Circular No. 588	Mandates salary grades of the following: • Doctors (Medical Officer 1 to Medical Specialist 7): ▪ Salary Grade (SG) 16-30: P38,150 to P185,695 • Nurses (Nurse 1 to 7) ▪ SG 15-24: P35,097 to P88,410 • Midwife (Midwife 1 to 6) ▪ SG 9: P22,297
RA 11494: Bayanihan to Recover as One Act	This act includes: COVID-19 Response and Recovery Interventions such as goods (i.e., PPE); DOH shall prioritize the allocation and distribution of the aforesaid goods, supplies and other resources to public health facilities in the regions, provinces, or cities, that are designated as COVID-19 referral hospitals; Private hospitals which have existing capacities to provide support care and treatment to COVID-19 patients; Benefits for healthcare workers (HCWs) such as life insurance, accommodation, transportation, and meals to all public and private health workers; and Compensation for HCWs who have contracted COVID-19. In case of death of the health worker, (P1,000,000); In case of sickness, for a severe or critical case (P100,000), In case of sickness, for a mild or moderate case (P15,000).
Joint Administrative Order No. 2020-001 Department of Health (DOH), Department of Labor and Employment (DOLE), DBM	Authorizes the President to provide compensation to public and private health workers who may contract severe COVID-19 infection while in the line of duty, and who may die while fighting the COVID-19 infection, retroactive from February 1, 2020.
Joint Circular No. 1, s. 2020 November 25, 2020 DBM, DOH	Active Hazard Duty Pay (AHDP) not exceeding P3,000 per month to frontline Human Resources for Health (HRH) whose services are essential in the fight against COVID-19 and are exposed to health risks and hazards due to the pandemic.
Joint Circular No. 2 s. 2020 November 25, 2020 DBM, DOH	COVID-19 Special Risk Allowance (SRA) not exceeding P5,000 per month to public and private health workers (HWs) who are directly catering to or are in contact with COVID-19 patients.
Joint Circular No. 2022- 001 February 10, 2022	Guidelines on the *Grant of One COVID-19 Allowance (OCA)* to Public and Private Health care Workers (HCWs) and Non-HCWs in Health Facilities Involved in COVID-19 Response. COVID-19 benefits shall vary according to risk exposure of the HCW and non-HCW in particular setting: three thousand pesos (P3,000) for low risk, six thousand pesos (P6,000) for medium risk, and nine thousand pesos (P9,000) for high risk.
Advisory No. 47 Series of 2020 Philippine Overseas Employment Administration (POEA) Governing Board No. 09 and Inter-Agency Task Force (IATF) Resolution No. 23 on the Deployment of Health Care Workers Series of 2020	Resolution that temporarily suspends the deployment of heath care workers under the MCS (mission critical skill) to prioritize human resource allocation for the national health care system at the time of the national state of emergency, until the national state of emergency is lifted in the Philippines and until COVID-19-related travel restrictions are lifted at the destination countries.

Table 2. Laws, Policies, and Memorandums Supporting Health Workers before and during the COVID-19 Pandemic *(continued)*

Policies	Summary/ Highlights of Provision
Policies during the COVID-19 pandemic (continued)	
POEA Governing Board Resolution No. 17 Series of 2020 Lifting of the Moratorium on the Deployment of Nurses, Nursing Aides and Assistants, and for Other Purposes (December 7, 2020)	Effective 01 January 2021, the POEA shall impose an annual deployment ceiling of 5,000 new hire HCWs disaggregated by occupation until such time that the IATF may decide to increase such ceiling considering the prevalence of public health emergency caused by the COVID-19 pandemic.
Advisory No. 18 Series of 2022 Annual Deployment Ceiling of New Hired Health Care Workers (March 1, 2022)	The 2021 annual deployment ceiling of new hire healthcare workers (HCWs) for occupations identified by the Department of Labor and Employment as Mission Critical Skills (MCS) shall be further increased to seven thousand (7,000).
RA 11525 COVID-19 Vaccination Program Act (February 26, 2021)	Procurement and Administration of COVID-19 Vaccines and Ancillary Supplies and Services by Local Government Units. LGU shall comply with the science and evidence-based terms and conditions of deployment and inoculation prioritizing the needs of the following special groups: frontline workers in health facilities, senior citizens, and indigent persons.
Philhealth Circular No. 2020-0011 Full financial risk protection for Filipino health workers and patients against Corona Virus Disease (COVID-19)	Health workers regardless of employment status, confined for COVID-19, beginning 1 February 2020 shall be eligible for the COVID-19 benefits for inpatient case management with no co-payment, whether in public or private facility.
Joint Circular No. 2013-1 DBM DOH Revised Organizational Structure and Staffing Standards for Government Hospitals CY 2013 Edition	This circular stipulates the nurse to staff ratio as follows: A ward unit warrants a ratio of 1 supervising nurse (Nurse III) for 50 staff nurses, 1 head nurse (Nurse II) for 15 staff nurses, 1 staff nurse for 12 beds per shift, and 1 nursing attendant per 24 beds per shift. Meanwhile, a critical care unit requires 1 supervising nurse (Nurse III) for 30 staff nurses, 1 head nurse (Nurse II) for 15 staff nurses, 1 staff nurse (Nurse II) for 3 beds per shift, and 1 nursing attendant per 15 beds per shift.
Universal Health Care Act: Implementing Rules and Regulation Republic Act No. 11223. Republic of the Philippines, Manila. 2019. (February 20, 2019), Budget Circular 2009-3 Rules and Regulations on the Grant of the Personnel Economic Relief Allowance at P2,000 per Month. (August 18, 2009) – Personnel Economic Relief Allowance	This shall be given at Two thousand pesos (P2,000) per month, the combined total of the current Five hundred pesos (P500) Personnel Economic Relief Allowance and the One thousand five hundred pesos (P1,500) Additional compensation, to supplement pay due to the rising cost of living.

Exposure from patients, especially during the initial wave of the pandemic, infected HCWs at the point of contact. This resulted in morbidities and deaths that added to the dwindling workforce and compounded the psycho-emotional impact of deaths and sickness from colleagues and their loved ones. The daily encounter with loss, inability to care for themselves and their sick loved ones, physical and emotional exhaustion, and the uncertainty of the pandemic led to moral distress, low morale, and heightened anxiety.

Burn-out

In the Philippines, fear of COVID-19 was found to be connected with job dissatisfaction, elevated psychological distress, and an increase in professional and organizational turnover.[1] In a similar study, more than half of 687 frontline nurses from Central Philippines experienced fear of COVID-19 or *coronaphobia*, 26% responded that they would resign, and 21% expressed that they wanted to leave the profession.[17] In addition, a cross-sectional study among 516 Filipino healthcare workers reported that 71% were found to have anxiety symptoms and 51% had depressive symptoms.[2] Health workers reported a significant increase in workload and experienced understaffing which brought about stress and fatigue. The amount of care needed from health workers has brought burnout and psychological distress to health workers which may result in them leaving the workforce.[2,3]

The regional consultations also reflected on the HCWs' health and workload. HCWs underscored the significant increase in workload following the pandemic. Beyond the influx of patients presenting symptoms, the higher care demands and acuity of patients with COVID-19 contributed to the high workload. HCWs shared that longer duty hours, extensions, and reassignments confounded their exhaustion. Respondents of the regional consultation reported being transferred or rotated from Non-COVID-19 to COVID-19 units to augment existing health human resources. Borderless staffing has brought added stress, especially among those with limited training.

Stigma against Health Workers

On top of psychological stressors brought about by increased workload and psychological stress, HCWs are also subjected to stigma and discrimination which may contribute to feelings of distress.[18,19] Physical and online attacks against our healthcare workers have been reported globally.[20] In the Philippines, some have been evicted from their homes, refused rides on public transport, and not allowed to dine in restaurants due to fear of contracting the virus.[20]

The regional consultations revealed their experiences with stigma. HCWs described experiences of discrimination from families and neighbors, including the communities where they lived and worked. Some shared how barricades were placed to segregate their homes, while others avoided them in fear of acquiring the infection, even being told by their families not to come home. This experience was echoed in reports of harassment and eviction from their homes.[20]

Resignations and Migration of Healthcare Workers

In October 2021, it was noted that about 5% to 10% of nurses working in private hospitals have resigned.[14] In addition, a local news agency reported nursing staff in a certain city had decreased from 200 to 63 or nearly half in a year.[21] Overall, about 40% of nurses in private hospitals have resigned since the pandemic began.[22]

The high nurse-to-patient ratio and low wages were among the common reasons for Filipino nurses to work in other countries. While it gave rise to a global dispersion of Filipino nurses, it also resulted in a low number and unequal distribution of nurses in the Philippines. The HCW-to-patient ratio is another drive for an increased outflow of workers migrating to other countries. Data from WHO show that there were six medical doctors per 10,000 population in the Philippines in 2017, lower than the recommended ratio of 10 doctors per 10,000 population.[23] The doctor-to-population ratio in the country is also lower compared to other Southeast Asian countries, like Vietnam (8 per 10,000), Thailand (8 per 10,000), and Timor Leste (8 per 10,000). The comparable figures in developed countries are 26-40 per 10,000 population. The nurse-to-patient ratio in government institutions is 1:60, some distance away from the DOH's ideal ratio of 1:12.[24] Despite the huge number of health professionals that the country produces every year, there is still a shortage of health workforce employed to meet the standard requirement for the country's growing population. A large factor in this is the continuous out-migration of health professionals. Based on the 2015 census, almost a fifth of the total registered health professionals are working overseas.[25]

Due to fatigue, burn-out, infections and deaths among their ranks, the medical front liners have called for a "timeout" to draw up a better plan to deal with the COVID-19 crisis.[25] Health workforce supply responses during the first phase of the pandemic have focused primarily on increasing overall nurse workforce capacity and shifting more of that capacity to ICU/CCU, highlighting that it is nurses who have provided the critical staff capacity in this area. Health workers were required to work longer hours and/or different shift patterns; redeploying nursing staff from other clinical areas; bringing non-practicing nurses back into the workforce as temporary/voluntary "returners"; deploying student nurses to "front line" work; using temporary/agency staff to work as health personnel; "fast track" integration of international nurses already in the country but awaiting final licensure/registration; and integration of refugees with nursing qualifications.[11] The government has sought to immediately hire 10,000 additional health workers, calling on universities and medical groups to help in hiring more doctors, nurses, and other medical staff.[25] The pandemic has also urged the government to temporarily halt the international departure of workers in 14 health professions, including nursing, for the duration of the nation's COVID-19-related state of emergency,[26] so the country's health system could properly allocate and utilize human health resources. Future applications for healthcare jobs abroad were prohibited; however, it has been lifted, and the government is currently allowing the deployment of 7,000 health workers for 2022.

Despite the challenges during lockdowns, health teams, especially in rural areas, were able to find alternative ways to deliver services and adapt to the restrictions. Barangay health workers (BHWs) and public health nurses played a more active role in the local health system; they delivered prescription medicines and family planning commodities to patients' homes, scheduled vaccination visits, and did prenatal check-ups at the barangay level.[27] A reinforcement of the referral system was employed to avoid unnecessary rural health unit (RHU) visits. Many have also shifted to telemedicine using dedicated hotlines and radio consultations. Some used social media to disseminate information regarding COVID-19.

Recruitment of health workers, especially nurses, was also problematic as narrated by hospital administrators. The recruitment of nurses has been made even more difficult with international borders opening and restrictions to travel easing up. Despite the issuance of a deployment cap, the issue of recruitment of nurses due to migration still stands.

Borderless staffing, as described by respondents to be the assignment of HCWs in clinical areas outside their specialization, was rampant during the pandemic in response to the lack of HCWs. This situation was alarming to the HCWs, especially the nurses, since they would be assigned to an area where they had little to no training. The anxiety and stress of being transferred to a different area also led to an increase in the resignation rates of nurses.

Despite sustained efforts to contribute to the pandemic response, HCWs resigned or did not renew their contracts. Their resignations resulted in in-country migration from private to government-run hospitals, out-migration to other countries, and leaving the profession or practice altogether. The regional consultations explained and underscored similar reasons that HCWs have primarily left institutions due to: (1) inadequate remuneration to compensate for the risks, (2) the fear of getting infected, and (3) burnout. The meager salary was reported among those serving in private hospitals at as little as P8,000/month compared to the government-run hospitals at P33,575. The fear of infection was crippling for the more aged HCWs and those on the frontlines who may get infected and pass on the infection to their loved ones. Lastly, respondents anchored their burnout experiences on the extreme workloads, hazards, anxiety, and moral distress.

In-migration from private to public institutions stemmed from the stark difference in salary despite the relative exposure risks and workload. Out-migration, particularly among nurses, was more amplified when the foreign demand increased with the promise of better compensation, workload balance, and higher take-home pay. The increased resignations further aggravated the workload for those HCWs left in service as healthcare practice became increasingly less attractive to potential new hires.

Policy Implementation Gaps

The Local Government Code Republic Act (RA) 7160 implementation depends on the classification of municipalities, cities, and provinces based on their annual income resulting in budget restrictions in compensation of HCWs, while RA 7305 Magna Carta of Public Health Workers stipulates a salary scale or grade prescribed by the Compensation and Position Classification Act of 1989. Entry-level nurses from a first-class province city should receive [Philippine Peso (P)] P35,097 [Salary Grade (SG) 15], while the same nurse from a fifth-class city should receive 80% of the stipulated rate, which is P28,078. Nurses from sixth-class municipalities receive P22,813, which is only 65% of the rate. The variance in salary despite laws instituted is due to the financial capability of the respective LGUs.[28] RA 11466 Salary Standardization Law of 2019 covers HCWs both from the public and private sectors, however, the private sector is compensated below the national wage average. In contrast, physicians, especially those with specializations, are considered the highest paid health workers in the country.[29] According to Occupational Wage Survey 2018 of the Philippines Statistics Authority, the average monthly wages of health professionals indicated that physicians receive an average salary of P33,592, nurses receive P14,942, while midwives receive P12,630. It is also noted in the National Budget Circular No. 572 that only physicians are within the prescribed salary rate, while nurses and midwives are below the prescribed salary rate. Lastly, RA 9173 Philippine Nursing Act of 2002, despite the mandated minimum base pay of SG 15, salary discrepancies between nurses in the public and private sectors are still evident. Government-hired nurses receive a monthly average of P13,500, while nurses hired in the private sector receive a monthly average of P10,000.[30]

The Joint Memorandum Circular No. 4 (DBM, DOF, DILG) Policy Guidelines on the Implementation of Certain Provisions of the *Bayanihan* to Recover as One Act (RA 11494) pertaining to LGUs[31] increased of personnel services cap of 10% for first to third class provinces, cities, and municipalities and 5% for fourth to sixth class provinces, cities, and municipalities, enabling LGUs to pay proper wages to health workers, and hire additional personnel. This led to easing the workload of HCWs, supporting their health and well-being, and enabling them to take respite.

The *Bayanihan* to Heal as One Act[32] prioritizes the needs of the HCWs by ensuring that they are well provided with their basic needs (meals, accommodation, transportation) and compensation. The Joint Circulars of the DBM and DOH guide different agencies, both public and private, to guarantee that health workers receive active hazard duty pay, special risk allowance, and distribution of PPE. The latest guideline, One COVID-19 Allowance, sets varying amounts depending on the risk exposure of the health workers. However, delays in releasing the allowances and discrepancies in the amounts proved to be another hurdle that health workers face.[15]

POEA Governing Board Resolution No. 17 Series of 2020 Lifting of the Moratorium on the Deployment of Nurses, Nursing Aides and Assistants and for Other Purposes[33] and Advisory No. 18 Series of 2022 Annual Deployment Ceiling of New Hired Health Care Workers[34] was critiqued for the imposed deployment ban, supposed to increase retention of HCWs, due to its possible unconstitutionality and effect on the Philippine economy[14]. The temporary suspension has been lifted, and the government allowed the deployment of 7,000 health workers, a favorable increase compared to the 5,000-deployment cap in 2021.

Support for Health Workers during the Pandemic

The following section details the efforts made by both public and private sectors in providing support to healthcare workers during the pandemic.

Provision of Personal Protective Equipment (PPEs)

The provision of PPEs has significantly improved from the time when the pandemic started. On top of supplies provided by the government, civil society groups and organizations have joined to provide support to frontline workers in the Philippines. Donations of cloth-based washable masks in lieu of the conventional disposable masks, face shields improvised out of acetate sheets and foam, and tailored reusable hospital protective gowns from waterproof fabrics.

Vaccination

Healthcare workers were given priority in the distribution of the COVID-19 vaccination during the pandemic. Department Memorandum No. 2021-0484 by the Philippine Department of Health specifically designated workers in frontline health services as Priority Group A.1, deeming them those with high priority in obtaining the vaccine.[35] The current vaccination coverage for healthcare workers in the Philippines as of October 2022 is around 96.6%, with 61.1% having received their first booster dose.[36]

Training of Health Workers on Infection Control

Infection prevention and control was strengthened by developing modules and conducting online training to healthcare workers and even community settings. Building population vigilance is hoped to bring down risk of acquiring the disease and healthcare utilization. Laboratory access also played a significant role in identifying, treating, and isolating patients positive from COVID-19. Indeed, the expanded testing capacity increased detection and enforced timely

isolation curbed the spread of infection in communities. The DOH together with partner agencies conducted a series of webinars to share vital information on managing and preventing COVID-19.

Controlling Disease Transmission

Direct and indirect measures were undertaken to support frontline healthcare workers especially during the peak of the COVID-19 pandemic. To reduce the caseload of hospital personnel, quarantine measures were developed. The IATF on Emerging Infectious Diseases outlined different levels of restrictions across the regions of the country. This action was premised on the concept that limiting movement of people will help contain the spread of the disease. This resulted in a decrease in hospital utilization rate that reached limits at the outset of the pandemic. Further, this provided health workers a reprieve and an opportunity for those exposed to COVID-19 to recover and return to duty. Surveillance and contact tracing were also amplified. It helped understand the disease dynamics and track the chain of infection, settings, places, and events where transmission has occurred in high numbers.

Psychosocial Support Services

Participants of the regional consultations reported the presence of psychosocial support and mental health services in their facility. For example, one facility had regular mental health assessments for health workers and appropriate interventions were given based on this. Others provided peer counseling to those in distress. Time-off was reportedly given to health workers after a specific length of rotation. Some were also granted flexible time to be at work while others retained their normal schedule albeit with the presence of relievers in the event of understaffing. Those who experienced burnout were also given time off.

Information Campaigns against Stigma and Misinformation

During the height of the pandemic, the DOH launched various information campaigns through various platforms, including social media, which aimed to increase awareness toward the ongoing COVID-19 pandemic and to eradicate the stigma among frontline health workers associated with the virus. One such program was the *DOH B.I.D.A. Solusyon sa COVID-19*, which aimed to remind the public regarding the guidelines for minimum health standards and to verify information received regarding the virus, encouraging everyone to take part in preventing the spread of COVID-19.[37]

Financial and Non-financial Incentives

Policies for financial incentives were enacted through the *Bayanihan* to Heal as One Act in 2020. Apart from ensuring basic needs, additional allowances and hazard pay were included. The special risk allowance amounted up to P5,000 per month for those working in contact with COVID-19 patients.[38] This was followed by the One COVID Allowance (OCA) which ranged from P3,000 to P9,000 depending on the level of occupational risk.[34,39] Hospital administrators and nursing supervisors in the regional consultations reported that they have provided sign-up bonuses ranging from P50,000 to P100,000 for new hires.

The DOH also issued Administrative Order No. 2020-0054 which implemented guidelines on providing life insurance, accommodation, transportation, and meals to health workers under the "*Bayanihan* to Recover as One" Act.[40] With this, various non-financial incentives were given to health care workers at the height of the pandemic as a means to compensate for the burden they bear at work. These included free meals, transportation, and lodging facilities to lessen their burden due to their working hours, as well as traveling to and from home. Accommodation was also given to those who had lengthy shifts lasting for days in COVID-19 referral facilities to ensure the safety of their families and reduce the risk of infection. Free transportation for frontliners was also expanded to areas outside Metro Manila courtesy of the Department of Transportation.[41]

Human Resource Augmentation and International Deployment Caps

To augment existing HRH, the DOH established guidelines on HRH deployment under the national health workforce support system through AO No. 2020-0038.[42] This allowed for the recruitment of temporary health workers such as doctors, nurses, and allied health professionals to address the increasing healthcare demands brought by the pandemic.

The pressing need for workers in essential services during the acute phases of the pandemic caused the government to temporarily halt the international departure of workers in 14 health professions, including nursing, for the duration of the nation's COVID-19 related state of emergency.[26] This action alleviated some pressure on the country's health system to allocate and utilize human health resources as needed. This freeze was temporary and was lifted in early 2022, and the government is currently allowing the deployment of 7,000 health workers for 2022.

Challenges and Limitations in the Support for Healthcare Workers

During the earlier part of the pandemic, PPEs, access to vaccines, and institutional responses were initially a problem. As the country enters the 3rd year of the pandemic, health workers and administrators reported that these have been less problematic than before. However, the pre-existing issues in health worker retention (i.e., low salaries, migration of health workers, etc.) have continued to pose challenges.

Low Salaries among Nurses and Delayed Release of Risk Allowances

One of the reasons that nurses leave the country is the relatively low salary.[14] Table 3 shows the monthly wages of

different health professionals, specifically, general medical practitioners, dentists, nurses, and midwives. The 2018 Occupational Wages Survey (OWS) indicates that most health professionals receive a monthly wage that is below the national average at around P18,000 as of 2018 level. Dentists and General Medical Practitioners received wages higher than the national average of P18,108 compared to nurses and midwives whose salaries suggest that they are living just above the poverty threshold of P12,082 monthly, based on the 2018 per-capita poverty threshold level for a household with five members.[43]

Unequal Salaries between Health Workers in the Public and Private Sectors

To note, an entry-level nurse working in a public hospital starts with a monthly salary of about P33,575 (about US$670), while those working in private hospitals may start with as little as P8,000 (about US$160). These may not be enough to cover the cost of living in the Philippines. In terms of the One COVID Allowance (OCA), the amount of allowance varies depending on the risk exposure of the health workers. Delays in releasing the allowances and discrepancies in the amounts proved to be another hurdle that health workers faced.[15]

High Health Worker-to-Patient Ratio

A high nurse-to-patient ratio was one of the common reasons for Filipino nurses to migrate to other countries, which resulted in a low number and unequal distribution of nurses in the Philippines.[14] According to the Philippine Nurses' Association (PNA), the nurse-to-patient ratio in government institutions is 1:60, some distance away from the DOH's ideal ratio of 1:12.[24] It was also reported that there were six medical doctors per 10,000 population in the Philippines in 2017 compared to the recommended ratio of 10 doctors per 10,000 population and overall lower compared to other Southeast Asian countries.[25]

Lack of Regular, Permanent Positions

Despite the presence of deployment programs, many local government officials reported that they are unable to give the health workers regular, permanent positions. In the public sector, this is in part due to the budget cap on personnel services expenses placed upon local government units. For example, one LGU can only spend 45% of its total budget for all its personnel including health workers. Anything beyond this cap is prohibited. Hence, if the LGU has a small budget, it has very limited fiscal space to allot for permanent positions. Those in the private sector reported lack of funds as the main challenge to hiring more health workers.

Lifting of Deployment Cap

The migration of nurses, physicians, and other health care workers abroad was already evident in previous years. During the initial stages of the pandemic, health workers were barred from leaving the country to ensure that there was no shortage in health personnel to combat the ongoing health crisis. By November 2020, the temporary ban was lifted allowing for the deployment of medical workers abroad.[44] However, with the end of the ban came the deployment cap allowing only around 5,000 workers to go overseas. The deployment cap has been continuously lifted, with the most recent being 7,500 as of October 2022.[45] Regardless of the cap, there is still a continuous migration of health workers, minimizing retention and continuing the depletion of human resources for health especially in disadvantaged areas of the country.

DISCUSSION

The COVID-19 pandemic exposed the existing weaknesses and limitations of the health system in the Philippines, particularly the health human resources issues on adequate staffing and skills mix, protection, and workplace safety, as well as investment in education and training of healthcare workers. Some policy levers were identified to address the identified issues and challenges that influence the production, recruitment, and retention of health workers.

Policies on production encompass the issues of scholarships and return service agreements for health sciences. Policies on recruitment should be cognizant of the inflows and outflows of health workers, issues of maldistribution and inefficiencies, and regulation of the private sector. This includes the continuation of healthcare workers' deployment programs, additional permanent positions in the health system, and the reintegration of healthcare workers. Policies on retention should consider both the demand, and the leadership and governance. Demand is affected by the rules of the labor market and its dynamics to deal with the inefficiencies and inequities in the system. Leadership and governance may influence the impact of demand and supply. Infrastructure upgrades are possible solutions to improve service delivery and expand the capacity to hire more healthcare workers. Workplace safety and security, valuing and recognition may add to the weight of retaining workers.

Policies on Production

Scholarships and Return Service Agreements for Health Sciences Students

Government-sponsored scholarships and return service agreements for the health sciences program influence the production of healthcare workers. This has been proven by programs, such as the Rural Health Midwives Placement Program (RHMPP) and the Pinoy MD Program under the Republic Act (RA) 10687 Unified Student Financial Assistance System for Tertiary Education (UniFAST) Act,[46] which increases access to tertiary education and aims to encourage enrollment in health science courses, particularly in midwifery and medicine programs, to increase health professionals in geographically isolated and disadvantaged

areas (GIDA). Another is the Doktor Para sa Bayan Act (RA) 11509, that was established as a Medical Scholarship and Return Service (MSRS) program to ensure one physician for every municipality in the country.[47] Enhancing policies on scholarship-based RSA may also improve effectiveness in the retention and distribution of HRH most especially in disadvantaged areas.

Policies on Recruitment

Continuation of Deployment Programs

To support LGUs due to their limitations in hiring and retaining HRH, the DOH Deployment Program was implemented, mandating the securing of positions to hire and deploy health professionals and health workers under the National Health Workforce Support System (NHWSS),[48] and funded through the General Appropriations Act.

Enhancing the implementation and continuation of the program as per HRH 2030, DOH can map staffing needs through workload indicators for staffing needs (WISN), strengthen regional implementation through training and designation of committees as well as include community-oriented leadership and management.

Creation of Additional Regular Permanent Positions

The creation of regular permanent positions may help in addressing issues in retention among health workers. This can be supported by the Bayanihan to Heal as One Act allotting P1.7 billion for HRH hiring, P433 million of which was used for the processing of approved health personnel for hiring and providing a one-time sign-up bonus of P50,000 to P100,000 to newly employed health workers during the pandemic. Despite these initiatives, several challenges remain such as reclassification of financial resources from regular positions which makes it imperative that these opportunities be established to provide a sense of job security for workers.

Reintegration of Healthcare Workers from Abroad and those Out of Practice

Reintegration programs and policies help in maximizing the gains of employment overseas while providing a safety cushion for those overseas should they return to the country regardless of reason to make reintegration and reemployment easier for them. As of December 2021, there are 617,898 licensed nurses, 121,688 nurses have unspecified location of practice, 3,905 are out of practice, and 316,405 are migrant health workers.[49] Most OFWs have temporary migration cycles due in part to short-term and temporary contracts, they would return to their countries of origin. The National Reintegration Program promotes the delivery of sustainable reintegration services to returnees of OFWs, especially those who experience forced repatriation due to unexpected events.[50] However, there are still inadequate legal frameworks supporting reintegration, such as re-licensing professionals.

Table 3. Monthly Wages of Selected Health Professionals

Profession	Salary (in Philippine peso)
Dentistry	P28,123
General Medicine	P35,592
Midwifery	P12,630
Nursing	P14,942

Policies on Retention

COVID-19-related Risk Financial Incentives

During the pandemic, special financial incentives were granted to health workers. The Joint Circulars by the Department of Budget and Management (DBM), Department of Health (DOH), and Department of Labor and Employment (DOLE) guided different public and private agencies to guarantee that health workers receive active hazard duty pay, special risk allowance, access to physical protective equipment (PPE), and One COVID-19 Allowance (OCA) which stipulated that benefits shall vary according to risk exposure of the health care workers (HCW) and non-HCW in particular settings.

The *Bayanihan* to Heal as One Act has provided support to HCWs during the pandemic in the forms of equipment and hazard pay. During the enhanced community quarantine in 2020, P47 million was allocated for the funding of Special Risk Allowances. HCWs who contracted severe COVID-19 infections while on duty received P100,000 each, while qualified beneficiaries of departed HCWs received compensation of P1 million each.[51] Although these were mandated, several healthcare workers reported that they are still waiting for their allowance or unaware if it was ever granted to them.

Salaries of HCWs

Policies such as the RA 7305 (Magna Carta for Public Health Workers)[52] which ensures that government public health workers receive minimum salaries across all government facilities and the implementation of the Modified Salary Schedule for Local Government Personnel under RA No. 11466 that increased the salaries of government workers[53] helped retained the HCWs in the government sector. However, while these policies may influence the retention of newly hired health workers, more competitive overseas employment would still push the migration of healthcare workers.

The lack of similar policies for the HCWs in the private sector has led to the movement of HCWs, particularly nurses in private healthcare facilities to government facilities despite the heavy workload and less than desirable workplace environment. Through dialogue with the private sector, increasing the entry-level pay of health workers may assist in their retention. A recent example of action towards this was how the *Makabayan* bloc in the House of Representatives had filed House Bill No. 4599 or the Salary Increase for Nurses

Act, aiming to set a minimum monthly salary of P50,000 for nurses in both public and private institutions.[54]

Provision of Non-financial Incentives

A policy option presented by HRH 2030 pushes for the provision of non-financial incentives that complement the salaries and benefits to be provided in the Universal Health Care Law. Non-financial incentives include leave benefits, recognition, and award mechanisms, compensatory day-off, team building activities, and support for continuing education.

As indicated in section 34 of the Magna Carta for Public Health Workers, continuing education is one of the non-financial incentives that health workers have access to upgrade their position and compensation.[52] Health workers who benefit from this professional advancement could have a contract with their agency to be granted study leave.[55] Non-financial incentives during the pandemic were mainly the provision of training on the management and treatment of COVID-19. As compared to face-to-face academic conferences, an online platform was utilized mainly during the pandemic for training of health workers.

An overall improvement in organizational management, systems, and communication will also be of great benefit towards health workers. Retention of the incentives given during the pandemic would also help to further engage workers. HRH 2030 cites this course of action as being a factor in improving motivation and ensuring health workers feel valued, thus increasing retention.[56] Furthermore, this was also shown to be feasible in terms of technicality and finance as there will be no large cost upfront and these benefits are already being given in other sectors in the Philippines, making them easily replicable.

Career Mobility and Leadership Positions

Career mobility including leadership positions may also influence retention of HCWs. Pushing for Advanced Practice Nursing in the Philippines may help in securing job placement and widening career options for nurses as to promote retention and provide career advancement opportunities within the country.

Ethical Recruitment and Migration Management

Addressing the reasons for health workers leaving the country is critical to their retention. Moreover, a dialogue on mechanisms that will benefit both origin and destination countries is essential in the migration of health workers. This may include bilateral negotiations on ethical recruitment considering the needs of both countries.

CONCLUSION AND RECOMMENDATIONS

Targeting the main outcomes, HCW retention and resilience requires well-designed and responsive policies implemented to address the root causes of threats to HCWs and practice settings. Results of the environmental scan including the policy dialogue echoed the impact of the COVID-19 pandemic on the HCWs. Despite limitations in the study methodology such as inferences of factors affecting resilience and retention of HCWs, the results presented a comprehensive mapping of HRH situation before, during, and after the COVID-19 pandemic. The findings recognize the compounded effects of threats to personal and psychological safety leading to anxiety, depression, and psychological distress. These threats are rooted in discrepancies and inadequate remuneration, limited hiring incentives, and unhealthy work environments that drive HCW migration.

Thus, this document calls on policymakers for coordinated actions to address the spectrum of production, recruitment, and retention to support our HCWs through the following recommendations: (1) continuation of scholarships with accompanying return service agreements; (2) continuation of government deployment programs; (3) creation of additional regular permanent positions; (4) setting standard minimum salary for nurses in the private sector; (5) sufficient and timely provision of financial and non-financial incentives; (6) reintegration of health workers from abroad and non-practicing into the workforce; (7) career mobility and leadership positions; and (8) ethical recruitment of professionals across countries.

Statement of Authorship

All authors certified fulfillment of ICMJE authorship criteria.

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