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Challenges and policy options in health human resource (HRH) compensation, Magna Carta compliance, and salary standardization

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Challenges and Policy Options in Health Human Resource (HRH) Compensation, Magna Carta Compliance, and Salary Standardization

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Louie Iyar L. Dagoy, Yaddah Shalom R. Dollente,
Leif Daryl C. Tan. Clarisa Joy A. Flaminiano,
and Lyle Daryll D. Casas*

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Challenges and Policy Options in Health Human Resource (HRH)
Compensation, Magna Carta Compliance,
and Salary Standardization

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Abstract

This report comprises three papers. In the first paper, we present a comprehensive assessment of the Human Resources for Health (HRH) remuneration system in the Philippines. We examine the current stock of HRH, their economic contribution, and the governance and financing mechanisms that support workforce management. We assess the scope and coverage of HRH-related policies and evaluate the accessibility of welfare services available to healthcare workers. We identify policy and implementation challenges that affect the delivery of these services. To achieve these objectives, we employ a mixed-methods approach, which includes the analysis of multiple administrative datasets and both primary and secondary surveys.

In the second paper, we explore policy options for promoting equitable remuneration in the context of ongoing health sector reforms, particularly the implementation of the Universal Health Care (UHC) Act. We estimate the potential budgetary costs of selected options and draw lessons from other countries that have implemented similar reforms, such as changes in provider payment mechanisms, care integration, decentralization, and performance-based incentives aimed at improving service quality.

In the third paper, we examine the extent to which local government units comply with the Magna Carta of Public Health Workers (MCPHW) over time. We estimate the influence of LGUs' fiscal capacity on compliance levels using a fixed-effects regression model. For this analysis, we use administrative data from the Department of Health, a merged dataset on MCPHW implementation, and supplementary data from various government sources.

Keywords: Human Resource for Health (HRH), remuneration, Magna Carta of Public Health Workers (MCPHW), salary standardization, Philippines

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Underpaid Heroes? A Comprehensive Assessment of Human Resources for Health Compensation in the Philippines¹

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Executive Summary

In this report, we examined the state of the Human Resources for Health (HRH) remuneration system in the Philippines with the following two major objectives. First, we assessed the current stock of HRH, its economic contribution, and the governance and financing mechanisms. Second, we evaluated the scope and coverage of HRH policy and accessibility of existing welfare services for healthcare workers, identifying policy and implementation challenges that affect the delivery of these services. A mixed-method approach was employed to achieve these objectives. We analyzed administrative and survey data and conducted a policy review of government regulations related to HRH. Key informant interviews were conducted with government and health worker group representatives. We conducted a health worker survey administered across eight provinces, gathering responses from generalist medical doctors, specialist medical doctors, nurses, and midwives working in various health facilities (n = 1,033).

Our findings indicate that the health sector accounts for approximately 4% of total employment, with women comprising around 70% of the workforce. HRH remuneration remains low relative to international benchmarks. The HRH system in the Philippines operates through a mix of public and private employment, with 53% of health workers in private institutions. Compensation structures differ significantly between the public and private sectors, influenced by multiple funding sources, including local government income, Magna Carta benefits, PhilHealth reimbursements, and user fees. Significant disparities exist in HRH distribution, with urban centers having over six health workers per 1,000 population, while many rural areas have fewer than one per 1,000. These inequalities are more pronounced for specialist doctors. Notable workload disparities exist between public and private sector health workers, with government health workers experiencing higher patient volumes and staffing shortages.

Regarding HRH welfare, existing policies provide structured compensation through the Salary Standardization Law (SSL) and the Magna Carta of Public Health Workers. However, implementation varies across local governments due to fiscal constraints. Public sector HRH receives additional allowances and benefits, while private sector workers rely mainly on facility-based policies, resulting in lower average salaries and fewer entitlements. Wage disparities between public and private health workers are statistically significant, with public sector workers earning approximately 17.6% more on average. Additionally, labor law compliance in private health facilities remains challenging in meeting minimum wage standards.

¹ This research study is funded by Department of Health through the AHEAD-HPSR project.

² JPS is a Project Senior Technical Specialist, LID is a Project Technical Specialist, YSD is a Project Technical Specialist, LDT is a consultant, CJF is a consultant, and VGU is a Senior Research Fellow at the Philippine Institute for Development Studies.

Policy recommendations include the establishment of a national HRH support system to standardize compensation across local governments, the introduction of a Geographically Isolated and Disadvantaged Areas (GIDA) allowance to incentivize HRH deployment in underserved areas, and reforms in PhilHealth's payment mechanisms to integrate performance-based incentives. The government should also expedite the implementation of a global budget system to improve financial predictability and equity in HRH compensation. Addressing these systemic issues will be critical to ensuring a well-functioning HRH system that supports equitable healthcare access across the Philippines.

Keywords: HRH, remuneration, salaries, governance, Philippines

1. Introduction

The remuneration of health workers is essential to health systems as it affects their motivation, performance, morale, and the ability to attract and retain them. In the Philippines, compensation for healthcare workers has become a key government agenda and is central to many policy discussions. In recent years, healthcare workers have faced increased workloads and risks due to the COVID-19 pandemic, prompting widespread public and political support for remuneration reforms.

In addition, the Philippines is in a rapid epidemiological, demographic, and economic transition. These shifts require adjustments in the health system, including the production and management of human resources for health. As the health system shifts toward managing non-communicable diseases (NCDs), integrated care and primary healthcare (PHC) are critical. Demand for inter-professional teams and the role of cadres other than physicians in delivering health services are more important than ever. Also, the country embarks on major health reform under the Universal Health Care Act (UHC), including changes to the provider payment system. These shifts will impact the need for healthcare workers, and the effectiveness of the remuneration system will affect the supply and distribution of health professionals.

This report provides a comprehensive analysis of HRH remuneration policies in the Philippines, including the implementation challenges they face in the context of major health reforms, such as the Universal Health Care (UHC) Act. This report is divided into two major sections. The first section is an in-depth analysis of the HRH system in the Philippines (SO1), specifically the current stock of HRH and their economic contribution. It also outlines the HRH governance and financing of HRH in the Philippines. The second section assesses the challenges in HRH remuneration (SO2). Specifically, the second section will cover the following:

- To review the scope and coverage of existing welfare and services for HRH and its corresponding progress and accomplishments, both in the public and private sectors, at the national and local levels (SO2-a)
- To assess the accessibility of HRH welfare services and actual awareness of welfare rights (SO2-b)
- To define policy and implementation limitations on the delivery of services for HRH welfare (SO2-c)

- To clarify the role and function delineations among NGAs and DOH Offices in implementing policies and providing services for HRH welfare (SO2-c)³
- To provide recommendations concerning the effective delivery and management of HRH welfare services and policies (SO2-d)

2. Methodology

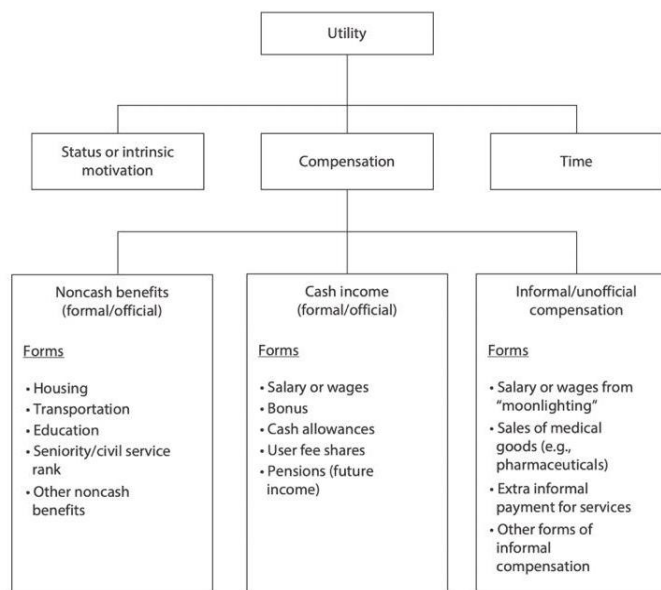
2.1. Analytical framework

To describe the HRH remuneration system in the Philippines and understand the associated implementation challenges, we need to holistically examine the factors that drive healthcare worker utility. In this report, we employed the framework proposed by Jaskiewicz, et al. (2016). This framework posits that the utility of health workers (i.e., job satisfaction and retention) is influenced by multiple factors, with compensation being an important determinant. Compensation can be disaggregated into various components, including cash income, non-cash benefits, and unofficial compensation, each of which contributes differently to overall job satisfaction and workforce retention. In line with this, we will refer to HRH welfare described by Jaskiewicz et al. (2016).

Figure 1 presents a conceptual framework for understanding utility derived from compensation, status or intrinsic motivation, and time. It categorizes compensation into three primary components: non-cash benefits, cash income, and informal/unofficial compensation. **Non-cash benefits**, formally or officially, include housing, transportation, education, seniority-based perks, and other forms of indirect remuneration. **Cash income**, also part of the formal compensation structure, includes salaries, bonuses, allowances, shares of user fees, and future pension entitlements. **Informal or unofficial compensation** may include income from secondary jobs, sales of pharmaceuticals, informal payments for services, and other unregulated forms of income. This framework highlights the multidimensional nature of employee utility, which extends beyond direct financial remuneration to include non-monetary benefits and informal earnings, describing the complexities of incentives in labor markets. Empirical evidence from the healthcare sector shows how non-cash benefits like housing and education are critical in retaining healthcare workers, especially in rural or underserved areas.

³ We did not develop a separate section on this. The SO no. 1 describes the governance of HRH remuneration in the Philippines, which includes the different roles of different national government agencies and local government units.

Figure 1. Framework for Describing the Utility of HRH



Source: Framework of Jakiewicz et al. (2016)

We conducted a literature review on the impact of remuneration on HR-related outcomes (e.g., retention, satisfaction). Empirical studies show that while salary increases may reduce attrition in some cases, non-cash benefits—such as career advancement, training opportunities, and supportive management—play a stronger role in motivating healthcare workers. Informal compensation practices are influenced by economic gaps between sectors, with some studies highlighting pro-social motivations and concerns about rent-seeking behavior and insufficient regulation.

Table 1. Summary of evidence on the potential impact of compensation and non-cash benefits on outcomes

Factors	Author/Year	Methodology	Outcomes
Compensation	(Bimpong et al. 2020)	Narrative systematic review to determine the effect of wages on job satisfaction in the United Kingdom’s NHS.	Health worker pay was found not to influence satisfaction. An increase in wages alone is unlikely to ease the concerns of NHS workers.
	(Antwi and Phillips 2013)	Natural experiment in Ghana	A 10% wage increase decreases annual attrition from the public payroll by 0.9 to 1.8 percentage points among 20–40-year-old workers from professions that tend to migrate.
Non-cash benefits	(Krishnamoorthy, Muthuveloo, and Ping 2020)	Cross-sectional survey in Malaysia	Promotion opportunities, a manageable workload, and a work environment all positively and significantly correlated with nursing retention.

	(Oladeji et al. 2022)	Discrete Choice Experiment in Ethiopia among Rural Health Extension Workers	Opportunity for continued education and personal development was identified as having the strongest impact on rural health workers' desire to stay.
	(Takemura, Kielmann, and Blaauw 2016)	Discrete Choice Experiment in Kenya among Public Sector Clinical Officers	Opportunity for study leave is the strongest preference among Kenyan COs, higher than even an increase in salaries when influencing rural retention.
	(Lamba et al. 2021)	Discrete Choice Experiment among public health workers across Ethiopia	Non-financial incentives such as supportive management, dedicated training time per year, and good facility quality were top preferences across health cadres.
	(Ojakaa, Olango, and Jarvis 2014)	Cross-sectional survey of primary health care workers in Kenya	Housing, transportation, healthcare benefits of dependents, and career advancement and promotion were identified as factors influencing the motivation and retention of healthcare workers
Informal compensation	(Rispel et al. 2014)	Cross-sectional survey of nurses in South Africa	While financial (higher and weekly pay) reasons play a role in nurses' moonlighting, the strongest reasons were non-financial. These include taking care of patients, the opportunity to learn new skills and relationships with co-workers.
	(Serra, Serneels, and Barr 2011)	Cohort study of nurses and doctors in Ethiopia	Philanthropic and pro-socially motivated health professionals were likelier to work in the non-profit sector than for-profit.
	(Arab et al. 2022)	Qualitative exploratory study on healthcare providers who receive informal compensation	Price differences between the public and private sectors were identified among the economic factors. Additionally, insufficient insurance coverage and low medical salaries were featured. Lack of regulation and monitoring was also identified as a reason for the prevalence of informal payments.

	(Lindkvist 2013)	Quantitative analysis of patient data on informal payments in Tanzania	Results indicate that health workers do not offer higher effort levels despite accepting informal payments. Instead, they offer lower minimum effort levels and are less sensitive to patient conditions. This may point to health workers seeking rent and inducing patients to pay.
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Source: Authors' compilation and analysis of the literature on HRH compensation

2.2. Methodology

This study used a mixed-method approach to answer the set objectives. We used administrative and survey data and policy scanning of government laws to provide an in-depth analysis of the HRH system in the Philippines. **Table 2** summarizes the secondary datasets we analyzed in the study. To address the challenges of implementing the HRH system, including insights into accessibility and coverage of HRH remuneration, we used key information interviews and a healthcare provider survey. We interviewed 19 key informants, including representatives from the DOH, provincial city, municipal health officers, and representatives from HRH associations. From national government agencies, we interviewed four (4) key informants from the relevant offices of the DOH and DOLE as the lead technical agencies on HRH and wage and compensation standard setting in the country. To examine local implementation, we interviewed eight (eight) informants from various levels of local governments. These included provincial health offices, municipal health offices, and LGU health facilities. Lastly, we interviewed six (6) representatives from different levels of HRH associations, including national associations and health facility unions. The survey focused on healthcare providers in all levels of health facilities across multiple municipalities in the selected provincial sites. After computing the sample size, we attempted to employ a two-stage stratified random sampling. We selected a representative sample of healthcare providers from each of the eight (8) study sites. We surveyed 209 generalist medical doctors, 146 specialist medical doctors, 472 nurses, and 204 midwives belonging to facilities ranging from rural health units (RHUs) to level 1, level 2, and level 3 hospitals in their respective provinces.

Table 2. Summary of secondary datasets and sources

Data	Data Processing Steps and Analysis
Health Facility Statistical Reports 2017-2022 (DOH 2023)	Processing: Appended, cleaned, and processed to remove duplicates and address missing values and outliers; merged with other datasets using NHFR code Analysis: Descriptive analysis of volume data; correlation analysis of staffing patterns with economic status variables; productivity analysis Limitations: Lack of non-plantilla (JO, COS, and contractual) staff counts
Hospital Financial Statements 2017-2020 (PIDS 2023)	Processing: Cleaned and processed to remove duplicates and address missing values and outliers; merged with other datasets using NHFR codes and PSGC

	<p>Analysis: Descriptive analysis of the salary and compensation data by hospital ownership and service capability and its ratio to revenue</p> <p>Limitation: No disaggregated data on salary per profession or cadre</p>
National Health Facility Registry 2024 (DOH 2024b)	<p>Processing: Processed to remove duplicates and fix formatting issues; merged with other major datasets</p>
Occupational Wages Survey 2014, 2018, & 2020 (PSA 2024b)	<p>Processing: Cleaned and processed to remove duplicates and address missing values; merged with the ASPBI and NHFR datasets to determine hospital ownership</p> <p>Analysis: Descriptive analysis of volume data, base salary across various sectors and health cadre</p> <p>Limitation: Accessible only within the PSA data enclave; limited years of data</p>
Annual Survey of Philippine Business and Industry 2020 (PSA 2023b)	<p>Processing: Cleaned and processed to remove duplicates and address missing values; merged with the OWS and NHFR datasets</p> <p>Analysis: Descriptive analysis of compensation, expenditures, operational income, and revenue across all sectors</p> <p>Limitation: Accessible only within the PSA data enclave</p>
Labor Force Survey 2010-2023 (PSA 2023e)	<p>Processing: Appended and processed to check for duplicates and completeness of variables</p> <p>Analysis: Descriptive analysis of volume data and basic pay; Pooled OLS Regression</p>
Poverty Statistics and Small Area Estimates 2015, 2018, & 2021 (PSA 2023a)	<p>Processing: Appended and merged with other major datasets</p> <p>Analysis: Correlation analysis of poverty incidence with PS spending on health and density data</p>
Philippine Standard Geographic Code 2024 (PSA 2024a)	<p>Processing: Processed to fix formatting issues for easier handling; merged with other major datasets</p>
Census on Population and Housing 2020 (PSA 2023c)	<p>Processing: Merged with other datasets</p> <p>Analysis: Correlation analysis of health expenditures per capita and volume data per 1000 population with the economic status variables</p>
LGU Scorecard on Health 2014-2022 (DOH 2024a)	<p>Processing: Appended, cleaned, and processed to remove duplicates and address missing values and outliers; merged with other datasets</p> <p>Analysis: Descriptive analysis of magna carta compliance and its correlation to LGU health spending and revenue</p> <p>Limitation: Lacks specificity on which magna carta benefits are provided and whether these are provided fully or merely meeting the compliance requirements</p>
LGU Annual Regular Income 2009-2022 (DOF-BLGF 2024a)	<p>Processing: Appended, cleaned, and processed to remove duplicates and address missing values and outliers; merged with other datasets</p>

	Analysis: Correlation analysis of magna carta compliance and LGU revenue
LGU Capital Outlay and Personnel Services Expenditures 2017-2023 (DOF-BLGF 2024b)	Processing: Appended, cleaned, and processed to remove duplicates and address missing values and outliers; merged with other datasets Analysis: Descriptive analysis of LGU PS expenditure
LGU Health, Nutrition, and Population Control Expenditures 2017-2023 (DOF-BLGF 2024c)	Processing: Appended, cleaned, and processed to remove duplicates and address missing values and outliers; merged with other datasets Analysis: Descriptive analysis of LGU health expenditures; correlation analysis of the health PS expenditure with economic health
LGU Statement of Receipts and Expenditures 2009-2022 (DOF-BLGF 2023)	Processing: Appended, cleaned, and processed to remove duplicates and address missing values and outliers; merged with other datasets Analysis: Correlation analysis of the share of PS to total LGU total operating income and health PS per capita
Philippine National Health Accounts 2023 (PSA 2023d)	Analysis: Descriptive analysis of HRH salaries and a share of total current health expenditure
PIDS COBP-CATCH Healthcare Provider Survey (Conda et. al forthcoming)	Analysis: Descriptive analysis of HRH monetary and non-monetary compensation, trainings, and motivations

Source: Authors' illustration of the secondary quantitative datasets utilized for the study

3. Human Resources for Health in the Philippines (SO1)

In this section, we present an in-depth analysis of the HRH system in the Philippines, focusing on the composition of HRH within the overall economy, its governance, financing, and the current stock of healthcare workers

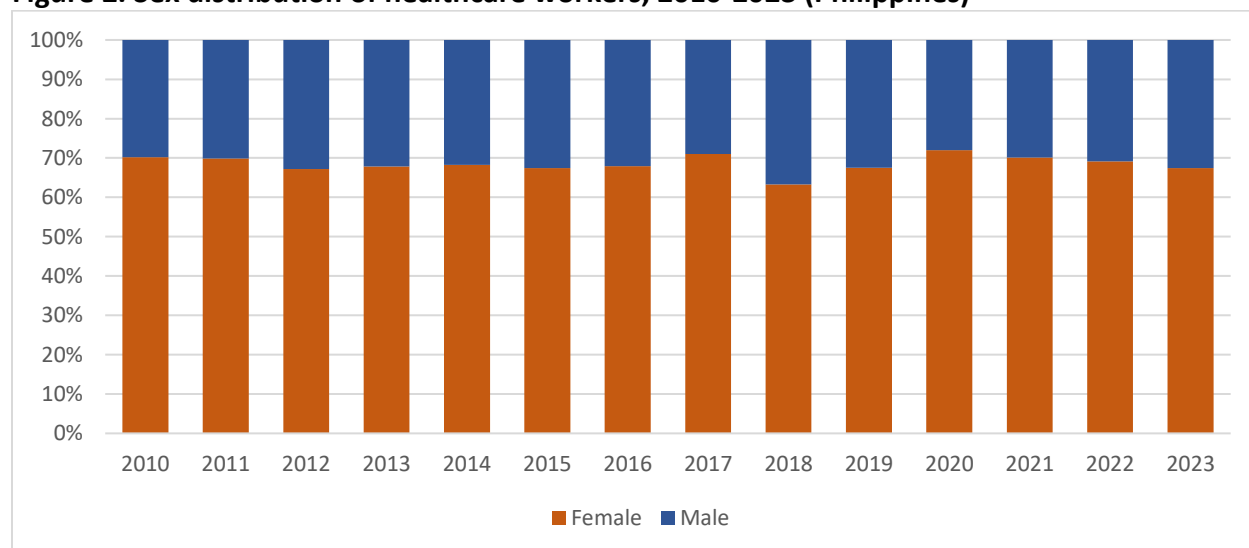
3.1. Health human resources and the economy

HRH plays a critical role in the economy and society.⁴ In 2022, 2.69% or 1.4 million out of 45.63 million total jobs in the country were in the health sector (PSA 2023e). The number of employees in the health sector has lagged compared to other sectors. Between 2010 and 2023, the average annual growth rate in the health sector was approximately 5%. This trend is expected to continue due to the increasing demand for healthcare, driven by demographic and epidemiological transitions. Nurses account for the largest share of healthcare workers in the Philippines (48%). According to the latest PSA data, about half of the health sector workers are registered nurses.

⁴ The definition of a healthcare worker varies by country. However, according to the World Health Organization (WHO), healthcare workers encompass all individuals who aim to improve health. This definition includes clinical professionals and non-clinical staff, covering front-end providers and back-end and support workers.

Most healthcare workers are women. According to the latest data from the Philippine Statistical Authority (PSA), about 67.4% of healthcare workers are women. **Figure 2** shows women's labor participation in health over time compared to other sectors. The predominance of women in the healthcare workforce significantly contributes to the Philippine economy by promoting labor participation and improving the sector's overall productivity.

Figure 2. Sex distribution of healthcare workers, 2010-2023 (Philippines)



Source: Authors' analysis of Labor Force Survey (various rounds)

About 53% of healthcare workers are in the private sector. The Philippines operates a mixed healthcare system where the public and private sectors deliver services and employ healthcare workers. However, in some cases, physicians could be classified as public and private because dual practice is allowed. The share of healthcare workers in the health sector varies across regions. The public sector employs fewer workers in economically disadvantaged areas than the private sector. In NCR, the richest region in the country, nearly 73% of healthcare workers are employed in the private sector.

3.2. *Labor market governance*

The compensation system for healthcare workers differs by sector, with the Philippine health system divided into public and private sectors. The Philippines has a decentralized health system. The Local Government Code (LGC) of 1991 mandates the devolution of health services to LGUs (RP 1991a). This divides the public health sector into the national level and the local government level. At the national level, albeit decentralized, the DOH still manages its national and regional health offices, regional hospitals, sanatoria, treatment and rehabilitation centers, and specialty hospitals (n=80). The GAA funds the expenditure on health facilities owned and operated by the DOH or national government (i.e., mostly end-referral regional hospitals). The Department of Budget and Management (DBM) develops a budget proposal that the legislature must enact as part of the General Appropriations Act (GAA). Public funds are disbursed to the appropriate government agencies by the DBM and allotted as each department's annual budget. The provincial

government manages the provincial health system at the local level (n=82), comprising the provincial health office and provincial and district hospitals. Within provinces, municipal governments manage the municipal health system (n=1,473), comprising the Municipal Health Office, Rural Health Units (RHUs), and Barangay Health Stations (BHS). These facilities provide primary healthcare services. The city government manages city hospitals, health centers, and BHSs. Each LGU provides its own PS budget based on its income. For a long time, LGUs must adhere to the PS limitation, which sets the maximum amount spent on personal services in a fiscal year, varying by income classification (RP 1991a).⁵ Lower-income LGUs and DOH-owned hospitals offer lower salary rates for their HRHs than higher-income LGUs. The remuneration of public HRH, both at the national and local governments, can be supplemented through entitled benefits such as the Magna Carta of Public Health Workers and professional fees from pooled funds of PhilHealth-accredited hospitals.

The private health sector only follows the minimum wage rates established in their region.

The private healthcare sector comprises for-profit and non-profit market-oriented health providers and facilities. The private sector only follows regional minimum wage packages. The remuneration of private HRH is funded primarily by the revenue of their respective healthcare facilities. The remuneration of private HRH in the Philippines is regulated by the National Wages Productivity Commission (NWPC) through the Regional Tripartite Wages and Productivity Boards (RTWPB) (RP 1989). Both government agencies ensure that all private organizations and employers comply with the regional minimum wages for their employees. Compared to public health workers, private HRHs are not entitled to the Magna Carta benefits and are mainly entitled to the minimum benefits and incentives stipulated in the Labor Code.

The Professional Regulation Commission (PRC) regulates the professional practice of healthcare workers. The PRC is the Philippine government's licensing and regulatory agency for the practice of skilled professionals in the country (PMA 2019). The PRC is mandated to regulate the practice of doctors, nurses, midwives, dentists, medical technologists, pharmacists, and other allied health professionals. Under the PRC, professional regulatory boards administer qualifying licensure examinations and serve executive, quasi-legislative, and quasi-judicial functions over each profession.

Self-governance of the professional practice of healthcare workers through professional organizations is limited to standard-setting and representation functions. Private and non-government organizations (NGOs) are likewise involved in the governance of the professional practice of healthcare workers. There are various professional organizations for the different HRH cadres, such as the Philippine Medical Association, the Philippine Nurses Association, and the Integrated Midwives Association of the Philippines. The PRC accredits these professional organizations and groups that serve standard settings and representation functions for their respective professions. In medicine, the PRC recognizes specialty societies and specialty boards as private, professional entities governing medical specialists. Societies such as the Philippine College of Physicians, the Philippine College of Surgeons, and the Philippine Pediatrics Society manage the accreditation of training institutions, qualifying examinations, and certification of the different medical specializations. The respective professional organizations and specialty societies

⁵ Section 325(a) General Limitations on Personnel Services.

do not set a standardized fee schedule for their members and instead rely only on a Code of Ethics that stipulates, for example, that “professional compensation should be reasonable and shall be guided by the patient’s capacity to pay, the standard fees in the community and such other factors as physician’s expertise, the difficulty of the case, and the patient’s co-morbid conditions” (PMA 2019).

In the Philippines, multiple approaches are employed to compensate healthcare providers across public and private sectors and by type of cadre. We created a matrix to describe the compensation approaches by cadre. Public physicians in government hospitals are salaried but may earn additional income through user fees, especially when practicing simultaneously in private wards within public hospitals. Public physicians earn additional income through PhilHealth professional fees. Private hospital physicians rely on user fees (i.e., out-of-pocket payments), private insurance, and PhilHealth reimbursements. Non-physicians, such as nurses or midwives, receive salaries in government facilities, though some also benefit from allowances. In certain cases, like community health workers/BHWs in LGUs, compensation is limited to allowances without a formal salary. Similarly, public physicians in RHUs are usually salaried under the payroll of LGUs. They may receive allowances and compensation through PhilHealth’s capitation for primary health care, though only a small proportion of RHUs are accredited by PhilHealth. In private clinics, physicians and non-physicians rely on direct user fees, usually paid by service. These multiple payment mechanisms across settings introduce potential effects. Public sector physicians may have incentives to engage in dual practice to supplement their income. The varying compensation models thus reflect differences in income sources and shape behaviors and service delivery patterns across healthcare settings (Dayrit et al. 2018).

Table 3. Summary of evidence on the impact of compensation and non-cash benefits on health outcomes

	Salaried	Case rate (PhilHealth)	FFS (user fees/OOP)	FFS (pooled – private insurance)	Capitation (PhilHealth)	Allowance
Public physician (in a public hospital) *						
Private physician (in a private hospital) **						
Public non-physician (in a public hospital)						
Private non-physician (in a private hospital)						

Public physician (in a public clinic) ***						
Public non-physician (in a public clinic) ****						
Private physician (in a private clinic) *****						

*In private wards of public hospitals, public MDs can practice and earn through user fees

***Residents are salaried

***But only a small percentage of RHUs are accredited by PhilHealth

****Community workers in most LGUs only receive an allowance, not a salary.

*****PhilHealth accredits a small number of private clinics

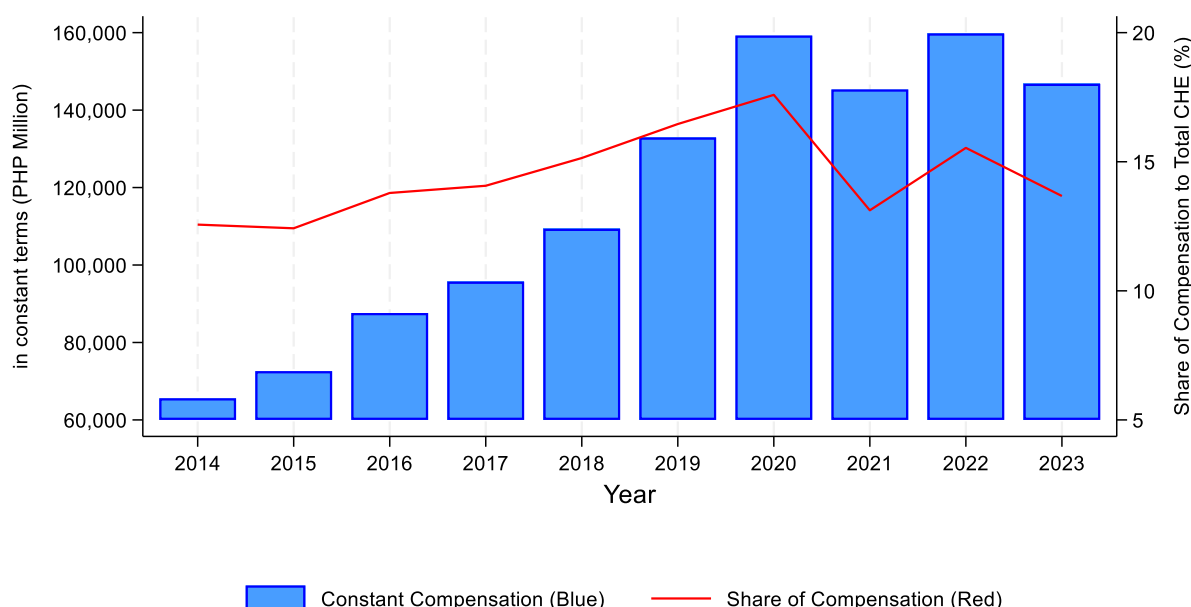
Sources: Authors' illustration on the effects of compensation on health outcomes

3.3. *Financing*

The country's spending on wages and salaries for HRH has steadily increased over time (even adjusting for inflation), and its share of overall health spending has remained relatively stable in recent years. Figure 3 illustrates the trends in healthcare worker compensation in the Philippines from 2014 to 2023. The blue bars represent compensation in constant terms, while the red line shows the share of compensation as a percentage of current health expenditure. Compensation has a consistent upward trend, peaking in 2020, followed by a slight decline in subsequent years. The share of compensation to total health expenditure fluctuates over the period, reaching its highest level in 2020 before gradually decreasing to approximately 15% in 2023.

The remuneration of health workers as a share of health spending in the Philippines is low when benchmarked with other countries. A study found that the average remuneration of HRH as a share of total health expenditure in countries ranged from 28% to 38% in the highest and lowest country income groups, respectively. The WHO estimated in 2017 that the global health workforce accounts for an average of 2.3% of GDP and 34% of total health expenditure. Based on the Philippine National Health Accounts, we estimated that the share of total compensation for human resources for health (HRH) constitutes between 12% and 18% of the country's current health expenditure. This figure is comparatively low when benchmarked against global standards reported in the literature. A more recent analysis in 2023 of 33 low- and middle-income African countries found that HRH remuneration is around 30% of the health expenditure of each country. (Toure et al. 2023).

Figure 3. Wages and salaries in billion PhP and as a share of total CHE, 2014-2022

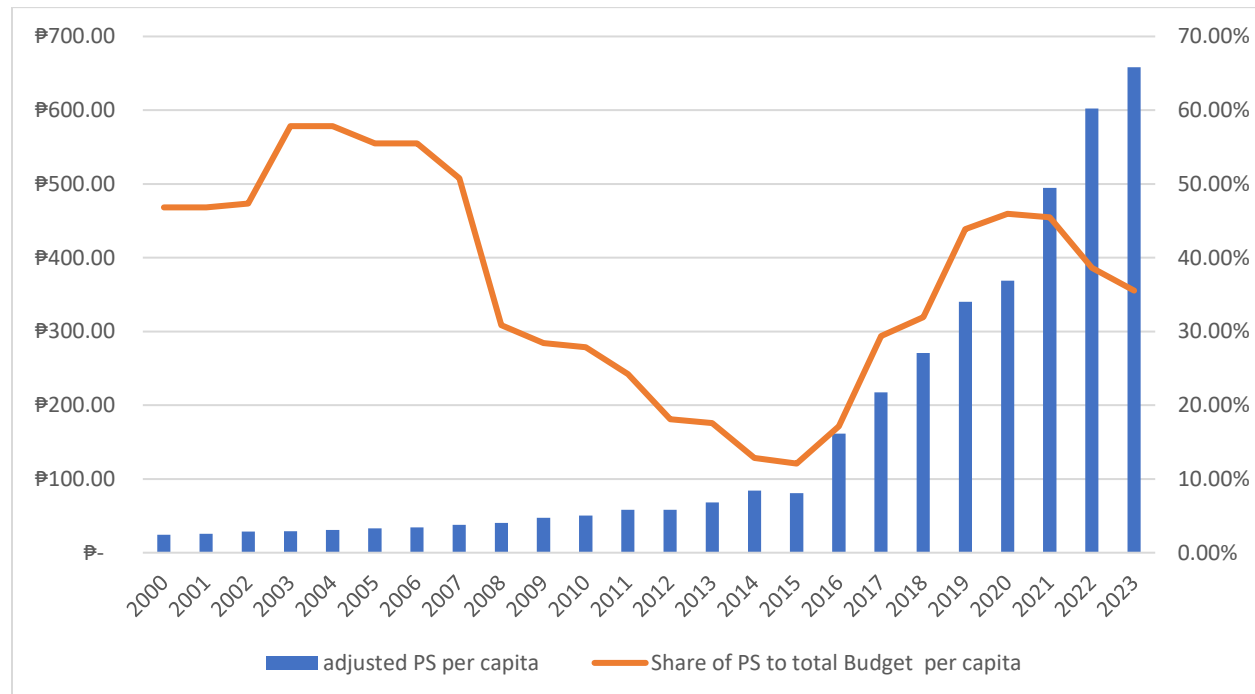


Source: Authors' analysis of the Philippine National Health Accounts (various rounds)

Over the past two decades, the national government's spending on PS for the health sector has increased rapidly in real per capita terms. However, its share of total health expenditures has fluctuated, likely reflecting changing policy priorities. In 2023, the national government's PS expenditure on health per capita reached PhP 660, about thirty times higher than two decades ago. This growth mirrors the general increase in public spending on health in the past decade (starting in 2016), with rapid government prioritization towards health.⁶ In the early 2000s, wage bills comprised around 50% of national health spending. However, this share significantly decreased as non-wage expenditures—particularly capital investments—rose. This trend was particularly evident when the national government accelerated capital investment programs such as the Health Facilities Enhancement Program (HFEP) in 2008 to address supply-side challenges. In recent years, the share of wage bills has increased again due to subsequent policies, including the SSL and health sector-specific wage increases to improve compensation for government workers. During the COVID-19 years, the share of wage bills fell again, perhaps because of the need to increase health and emergency response to address the pandemic.

⁶ In the recent decade, public spending on health per capita (constant terms) has increased from PhP 481 in 2014 to PhP 1,502 in 2023.

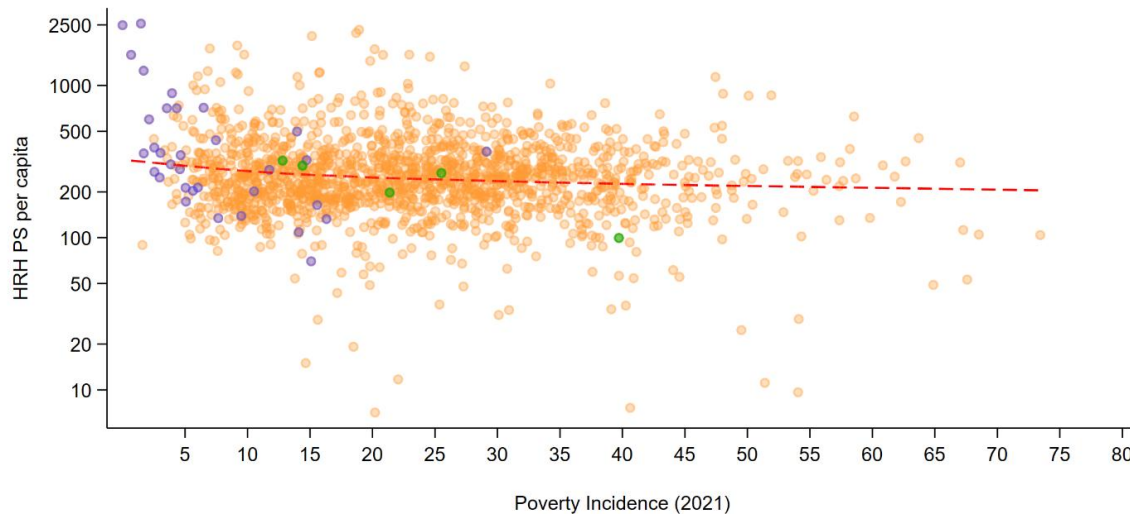
Figure 4. Wage bill per capita (2023 prices) and share of PS to total DOH budget per capita, 2000-2023



Source: General Appropriations, various years (Philippines)

LGU spending accounts for only 42% of the total PS expenditure for the public health sector in 2023 (54.3 billion), making the national government the primary source of wage funding. Despite the full devolution of health services, the responsibility of providing health services falls to the LGUs. On average, LGUs spend just PhP 291 per capita, with considerable variation, reflecting significant socio-economic disparities. This disparity highlights the varying capacity of local governments to support wage expenditures for health workers within their jurisdictions. Figure 5 illustrates the relationship between PS spending for HRH per capita and poverty incidence (2021) across municipalities and cities in the Philippines, including highly urbanized cities (HUCs) and independent component cities (ICCs).

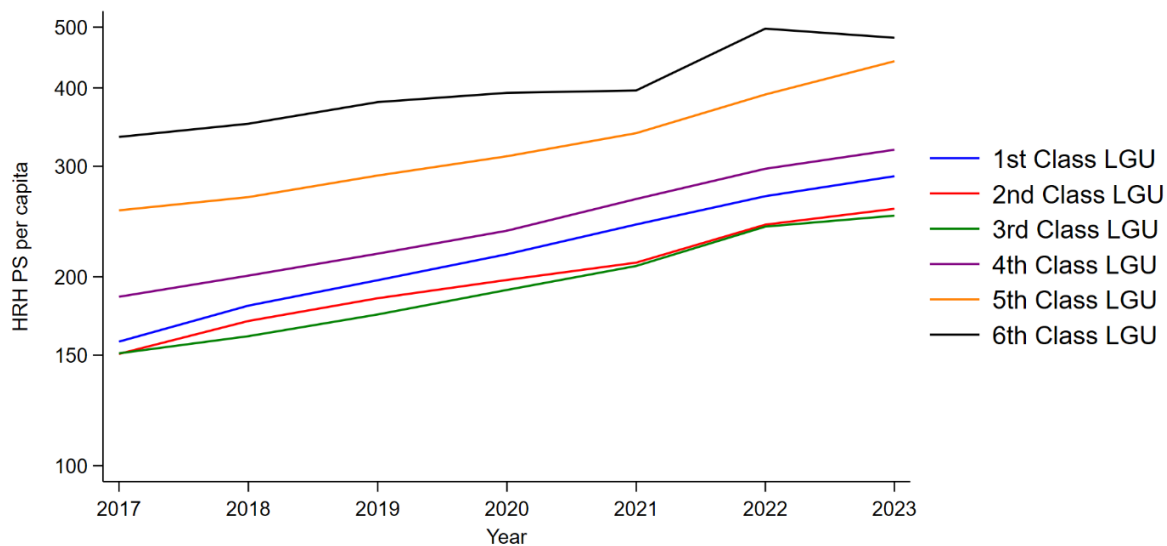
Figure 5. Personnel services for HRH per capita of LGUs (2022), by poverty incidence (2021)



Source: HNPC Expenditure: Bureau of Local Government Finance; Poverty Incidence 2021: Philippine Statistics Authority.

Note: y-axis: orange dots are municipalities and component cities, blue dots are highly urbanized cities (HUCs), and green dots are independent component cities (ICCs)

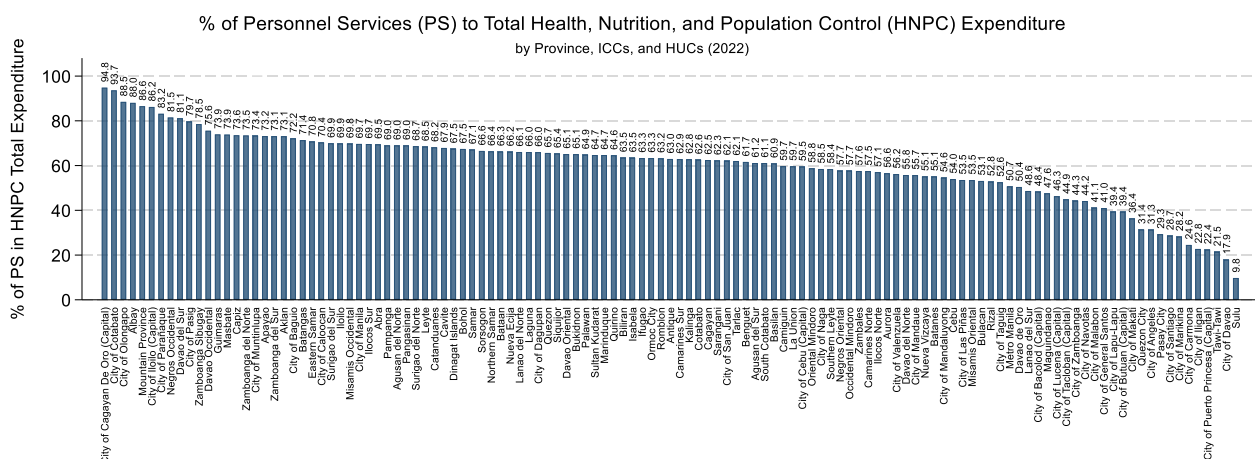
Figure 6. Personnel services for HRH per capita of LGU, by Income Class of Municipalities and Cities



Source: HNPC Expenditure: Bureau of Local Government Finance

The best available data suggests that, on average, local governments allocate 63% of their total health expenditures to PS, mirroring the proportion of PS spending nationally. However, the share of PS in local health spending varies across provinces, ranging from 6% to 95%. Variable shares of PS in local health spending indicate differences in fiscal capacity and policy priorities among local governments. A lower PS share may reflect limited resources or a focus on non-personnel investments, potentially leading to staffing shortages and inequitable

access to health services. A higher PS share suggests prioritizing health workers' compensation. Still, it may limit funding for other areas, such as capital expenditures and operation and maintenance expenses, impacting overall service delivery and fiscal sustainability (Toure et al. 2023). This may suggest that LGUs with higher PS shares rely on the national government grants and subsidies to provide MOOE expenses, such as pharmaceuticals and information system maintenance, and capital outlay through the HFEP. LGUs that rely heavily on national-level support may face sustainability issues considering the full devolution of health services and are subject to the shifting priorities of the national government. Our analysis of disaggregated PS per capita for HRH spending by LGU income classification reveals an interesting trend: lower-income LGUs pay more HRH PS per capita than their higher-income counterparts. This is likely due to lower population averages in lower-income class municipalities. Furthermore, this is compounded by stipulations in the LGC that allow 4th to 6th-class municipalities a higher PS limitation.



Some LGUs prioritize the salaries and wages of health workers more than others. In some LGUs, particularly highly urbanized cities (HUCs), almost 50% of PS spending is allocated to the health sector. This reflects that health workers comprise a significant portion of local government employees, given that health services are a devolved function. While education and health are typically the largest recipients of government wage bills, education remains under national government jurisdiction in the Philippines, leaving health as the primary focus for local governments. Figure 7 illustrates the proportion of HRH PS expenditure relative to total PS expenditure across LGUs in 2022. LGUs, with a high HRH PS share, demonstrate a stronger prioritization of health worker salaries over other personnel categories. However, this might limit resources for non-health personnel, potentially disrupting the balance of services these LGUs provide. Considering the full devolution of basic services to LGUs, these compromises may negatively impact the delivery of key services such as social welfare, agriculture, and the environment. Conversely, a low HRH PS share suggests that LGUs may be directing funds toward other personnel sectors, which could result in insufficient health staffing and difficulties in retaining HRH, particularly in areas with competing personnel demands.

Entity	% HRH PS to LGU PS	% Total LGU PS
City of Mandaluyog	47.3	47.3
City of San Juan	46.7	46.7
City of Marikina	46.0	46.0
City of Valenzuela	35.5	35.5
City of Marikina	28.0	28.0
City of Marikina	25.3	25.3
City of Marikina	23.6	23.6
City of Marikina	22.8	22.8
City of Marikina	21.7	21.7
City of Marikina	18.4	18.4
City of Marikina	17.9	17.9
City of Marikina	17.2	17.2
City of Marikina	16.6	16.6
City of Marikina	15.4	15.4
City of Marikina	14.4	14.4
City of Marikina	13.4	13.4
City of Marikina	12.9	12.9
City of Marikina	12.5	12.5
City of Marikina	12.3	12.3
City of Marikina	12.2	12.2
City of Marikina	12.1	12.1
City of Marikina	12.0	12.0
City of Marikina	11.9	11.9
City of Marikina	11.8	11.8
City of Marikina	11.7	11.7
City of Marikina	11.6	11.6
City of Marikina	11.5	11.5
City of Marikina	11.4	11.4
City of Marikina	11.3	11.3
City of Marikina	11.2	11.2
City of Marikina	11.1	11.1
City of Marikina	11.0	11.0
City of Marikina	10.9	10.9
City of Marikina	10.8	10.8
City of Marikina	10.7	10.7
City of Marikina	10.6	10.6
City of Marikina	10.5	10.5
City of Marikina	10.4	10.4
City of Marikina	10.3	10.3
City of Marikina	10.2	10.2
City of Marikina	10.1	10.1
City of Marikina	10.0	10.0
City of Marikina	9.9	9.9
City of Marikina	9.8	9.8
City of Marikina	9.7	9.7
City of Marikina	9.6	9.6
City of Marikina	9.5	9.5
City of Marikina	9.4	9.4
City of Marikina	9.3	9.3
City of Marikina	9.2	9.2
City of Marikina	9.1	9.1
City of Marikina	9.0	9.0
City of Marikina	8.9	8.9
City of Marikina	8.8	8.8
City of Marikina	8.7	8.7
City of Marikina	8.6	8.6
City of Marikina	8.5	8.5
City of Marikina	8.4	8.4
City of Marikina	8.3	8.3
City of Marikina	8.2	8.2
City of Marikina	8.1	8.1
City of Marikina	8.0	8.0
City of Marikina	7.9	7.9
City of Marikina	7.8	7.8
City of Marikina	7.7	7.7
City of Marikina	7.6	7.6
City of Marikina	7.5	7.5
City of Marikina	7.4	7.4
City of Marikina	7.3	7.3
City of Marikina	7.2	7.2
City of Marikina	7.1	7.1
City of Marikina	7.0	7.0
City of Marikina	6.9	6.9
City of Marikina	6.8	6.8
City of Marikina	6.7	6.7
City of Marikina	6.6	6.6
City of Marikina	6.5	6.5
City of Marikina	6.4	6.4
City of Marikina	6.3	6.3
City of Marikina	6.2	6.2
City of Marikina	6.1	6.1
City of Marikina	6.0	6.0
City of Marikina	5.9	5.9
City of Marikina	5.8	5.8
City of Marikina	5.7	5.7
City of Marikina	5.6	5.6
City of Marikina	5.5	5.5
City of Marikina	5.4	5.4
City of Marikina	5.3	5.3
City of Marikina	5.2	5.2
City of Marikina	5.1	5.1
City of Marikina	5.0	5.0
City of Marikina	4.9	4.9
City of Marikina	4.8	4.8
City of Marikina	4.7	4.7
City of Marikina	4.6	4.6
City of Marikina	4.5	4.5
City of Marikina	4.4	4.4
City of Marikina	4.3	4.3
City of Marikina	4.2	4.2
City of Marikina	4.1	4.1
City of Marikina	4.0	4.0
City of Marikina	3.9	3.9
City of Marikina	3.8	3.8
City of Marikina	3.7	3.7
City of Marikina	3.6	3.6
City of Marikina	3.5	3.5
City of Marikina	3.4	3.4
City of Marikina	3.3	3.3
City of Marikina	3.2	3.2
City of Marikina	3.1	3.1
City of Marikina	3.0	3.0
City of Marikina	2.9	2.9
City of Marikina	2.8	2.8
City of Marikina	2.7	2.7
City of Marikina	2.6	2.6
City of Marikina	2.5	2.5
City of Marikina	2.4	2.4
City of Marikina	2.3	2.3
City of Marikina	2.2	2.2
City of Marikina	2.1	2.1
City of Marikina	2.0	2.0
City of Marikina	1.9	1.9
City of Marikina	1.8	1.8
City of Marikina	1.7	1.7
City of Marikina	1.6	1.6
City of Marikina	1.5	1.5
City of Marikina	1.4	1

Beyond the finite fiscal resources available to each local government, budgetary rules force LGUs to make difficult decisions on financing trade-offs in providing basic services. LGU operations and budgets are governed by the Local Government Code, which outlines the extent of local autonomy to provinces, municipalities, and cities (RP 1991a). One limitation is that the LGC introduces the “PS limitation,” which sets a restriction on LGU appropriations for personnel services, computed as a share of the previous year's total annual income from regular sources of an LGU. This cap is set at 45% for first- to third-income class LGUs and 55% for fourth- or lower-income class LGUs. While the DBM regularly releases issuances that outline exemptions or waived items to the computation of the PS limitation for the fiscal years of 2022 to 2025, these are typically for special cases such as for emergencies, special benefits, or to improve compliance to certain laws, such as the provision of Magna Carta Benefits for HRH (DBM 2022a, 2024a, 2025; RP 2023). All local government Plantilla items and their corresponding salaries and benefits are generally charged to the PS of their respective LGUs. Since the PS limitation sets a maximum allowable allocation for the PS of an LGU in a budget cycle, this forces LGUs to decide on the appropriate split of their workforce. In this way, different sectors in LGU compete over the limited PS allocation.

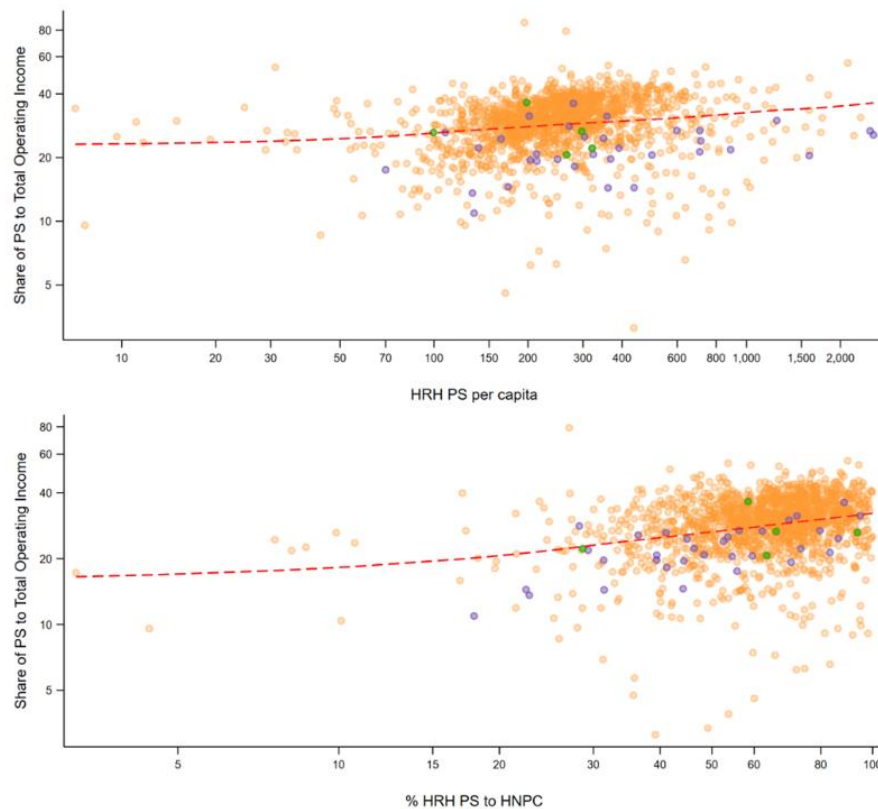
16

“Well, the very first thing that we do during budget preparation is we really allocate funds first to Personnel Services (PS). But we have to see to it that we will not exceed with the PS cap of 55%. [We do this] before applying other expenses like Maintenance and Other Operating Expenses (MOOE), and for other PPAs (Programs, Projects, and Activities) of the LGU.” – A2

“When an HRH applies to us for a position in our [organization chart], we elevate the application to our HR, then to the budget department. The question falls to if there is enough budget. If none, the person does not get hired, or does not get the position they applied for” – A3

“We have difficulties in regularizing [and promoting] our staff due to the ceiling of DBM. Only 45% can be promoted [to Plantilla positions] and for this year we are at the ceiling already. Of course, this ceiling is for the entire LGU not just health, so many are in limbo.” – A3

Figure 9. Personnel services as a share of total income vs. PS for HRH, 2022



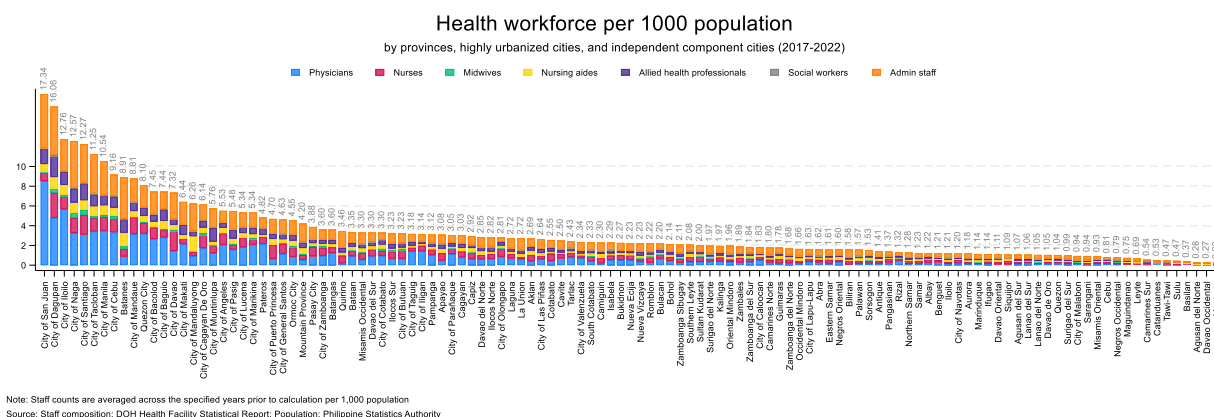
Source: HNPC Expenditure & Statement of Receipts: Bureau of Local Government Finance

Note: y-axis: orange dots are municipalities and component cities, blue dots are HUCs, and green dots are ICCs

3.4. Supply of healthcare workers in the Philippines

The maldistribution of hospital HRH is stark. We examined the density of health workers in hospitals across provinces and highly urbanized cities. Figure 10 illustrates the health workforce distribution per 1,000 population across various cities and provinces, highlighting significant disparities in healthcare personnel availability. The stacked bar chart displays different categories of healthcare professionals, including physicians, nurses, midwives, and other health workers. There is a noticeable gap in health workforce density, with major cities showing a substantially higher number of health workers per capita than other areas. For example, cities like Quezon City, Makati, and Manila have workforce ratios exceeding six (6) health workers per 1,000, while many provinces have ratios well below 1.0 per 1,000 population. This uneven distribution suggests that access to healthcare services is markedly better in urban centers, where health workers are more concentrated.

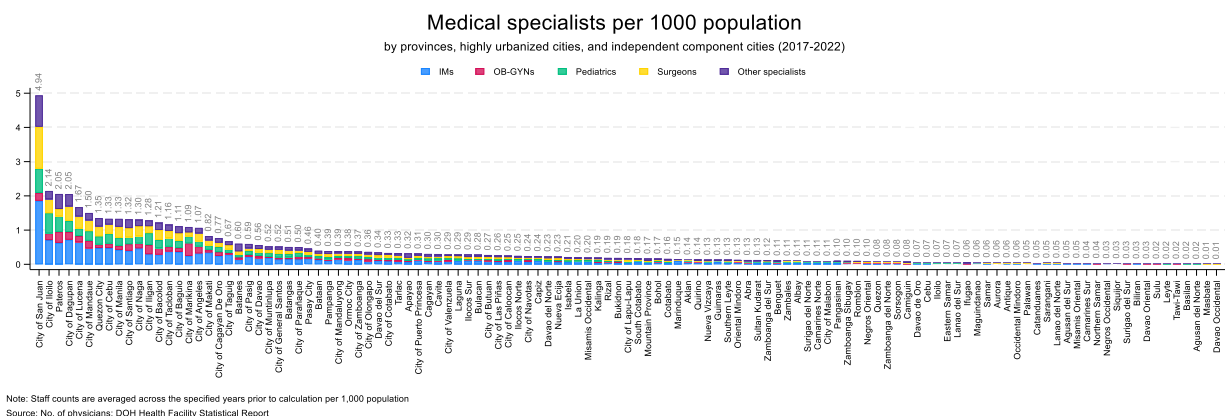
Figure 10. Number of health workforce per 1,000 Population



Source: Authors' analysis of the DOH Health Facility Statistical Report

The maldistribution of HRH is even more pronounced when focusing on specific cadres, such as medical specialists. Given the limited data availability, this study presents the first estimate of the density of medical specialists. Figure 11 shows the distribution of medical specialists per 1,000 population across various cities and provinces in the Philippines. The stacked bar chart categorizes medical specialists into different groups, including physicians, surgeons, anesthesiologists, pediatricians, and OB/GYN specialists. A few highly urbanized cities concentrate on most medical specialists, while most provinces exhibit much lower densities. Cities such as Quezon City, Manila, and Makati record the highest densities, reaching up to 3.34 specialists per 1,000 population, demonstrating a strong capacity to provide specialized care. In contrast, many provinces fall below 0.5 specialists per 1,000 population, revealing limited access to specialized medical services in these areas.

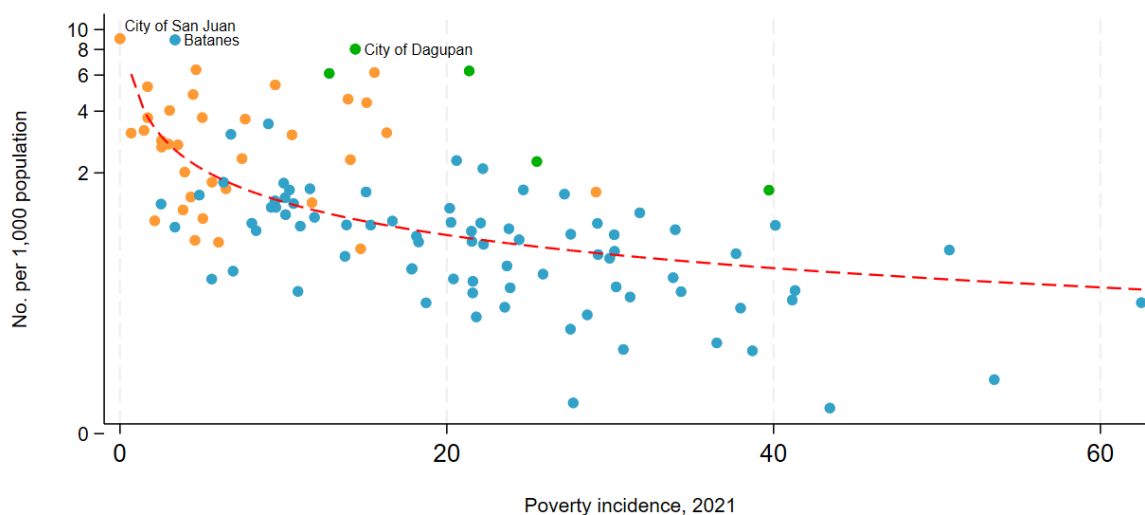
Figure 11. Number of specialists per 1,000 Population



Source: Authors' analysis of the DOH Health Facility Statistical Report

Socio-economic gradient in the distribution of hospital HRH relative to poverty incidence across LGU persists. Figure 12 shows the relationship between health workforce density per 1,000 population and poverty incidence, revealing significant disparities in the availability of healthcare personnel based on economic status. The trendline illustrates an inverse relationship, where areas with higher poverty levels tend to have lower health workforce densities. For example, regions such as the City of San Juan and Batanes, which have low poverty incidence, show higher health workforce densities. In contrast, many provinces with higher poverty levels fall below two (2) health workers per 1,000 population. This pattern suggests that economically disadvantaged areas struggle to attract and retain healthcare workers, leading to healthcare access and service provision inequities.

Figure 12. Health workforce density vs. poverty incidences



Note: y axis: blue plots are provinces; orange plots are highly urbanized cities; and green plots are independent component cities

Source: Authors' analysis of the DOH Health Facility Statistical Report and PSA Poverty Statistics

Figure 13. Number of Hospital Physicians per 1,000 Population by Province and Ownership

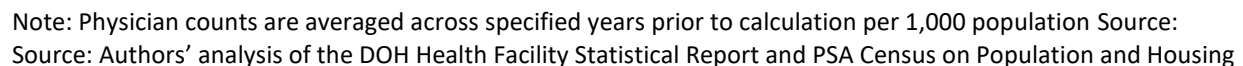
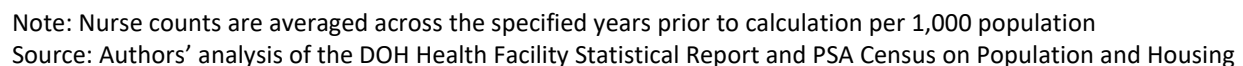


Figure 14. Number of hospital nurses per 1,000 population by province and ownership



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by region in the country. FTE measures the standardized workload of healthcare workers by converting part-time and full-time hours into a single metric. Our analysis shows that public sector physicians have a higher workload than their private sector counterparts, as reflected in lower FTE values for admissions and patient days in most regions. In the NCR, public physicians handle more admissions and patient days per FTE than private facilities, suggesting that public physicians face greater patient volumes. The number of nurses per FTE physician is lower in the public sector in several regions, indicating less nursing support per physician compared to the private sector. These findings highlight potential strains on public sector health workers and the need to improve staffing levels. **Table 4** shows the FTE workload indicators for physicians by public and private healthcare facilities and by level.

Table 4. Efficiency-related HRH indicators by type of facility, 2018-2020

	FTE Doctors per Annual Admission (x 1000)		FTE Doctors per Annual Patient Days		FTE Doctors per Bed		Nurses (FTE) per FTE Doctors		Nurses (all types) per FTE Doctors	
	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private
BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO (BARMM)	1.62	9.69	1.88	9.90	0.19	0.37	1.82	4.00	1.82	4.00
CORDILLERA ADMINISTRATIVE REGION (CAR)	1.74	3.17	6.47	2.98	0.24	0.24	1.64	6.90	1.65	4.42
NATIONAL CAPITAL REGION (NCR)	8.67	23.62	11.15	29.70	0.37	0.64	1.79	3.34	1.70	3.08
REGION I (ILOCOS REGION)	1.52	10.25	2.05	5.97	0.10	0.36	4.04	4.11	3.78	4.22
REGION II (CAGAYAN VALLEY)	3.10	8.14	1.45	5.84	0.14	0.50	2.28	4.65	2.67	4.59
REGION III (CENTRAL LUZON)	3.57	11.11	3.86	11.20	0.17	0.54	2.09	3.75	2.46	4.32
REGION IV-A (CALABARZON)	5.40	14.32	2.97	17.46	0.31	0.64	2.01	3.17	1.77	3.11
REGION IV-B (MIMAROPA)	2.84	3.57	2.73	1.50	0.27	0.25	1.16	3.04	1.16	3.38
REGION IX (ZAMBOANGA PENINSULA)	1.98	4.13	7.19	1.99	0.23	0.30	1.91	3.43	1.91	3.69
REGION V (BICOL REGION)	3.95	7.53	2.86	6.44	0.28	0.29	2.09	6.46	2.09	6.12
REGION VI (WESTERN VISAYAS)	2.43	8.63	2.27	8.98	0.23	0.38	1.69	5.83	1.65	5.92
REGION VII (CENTRAL VISAYAS)	3.88	9.33	2.96	12.39	0.18	0.45	2.26	2.58	2.26	4.32
REGION VIII (EASTERN VISAYAS)	1.97	4.87	1.64	3.43	0.20	0.31	2.70	5.71	2.70	4.21
REGION X (NORTHERN MINDANAO)	1.64	6.45	4.64	4.98	0.14	0.25	1.92	2.89	1.93	2.82
REGION XI (DAVAO REGION)	4.14	4.85	4.37	3.97	0.33	0.20	3.53	2.92	3.43	2.62
REGION XII (SOCCSKSARGEN)	2.02	3.74	3.11	3.37	0.19	0.23	1.71	4.31	1.80	4.16
REGION XIII (CARAGA)	1.90	15.89	4.04	8.84	0.12	0.61	2.30	1.40	2.30	1.40

Source: Authors' analysis of the DOH Health Facility Statistics Report

Table 5. Efficiency-related HRH indicators by type of facility, 2018-2020

	FTE Doctors per Annual Admission (x 1000)	FTE Doctors per Annual Patient Days	FTE Doctors per Bed	Nurses (FTE) per FTE Doctors	Nurses (all types) per FTE Doctors
Infirmary Government	3.01	1.12	0.19	2.61	2.61
Infirmary Private	4.58	1.8	0.23	3.2	3.2
Level 1 Government	1.79	2.23	0.17	2.67	2.68
Level 1 Private	4.85	2.81	0.27	3.73	3.58
Level 2 Government	2.74	4.13	0.22	2.37	2.09
Level 2 Private	11.59	9.74	0.44	4.05	3.99
Level 3 Government	6.01	13.09	0.23	1.12	1.03
Level 3 Private	10.99	26.24	0.46	3.43	3.33

Source: Authors' analysis of the DOH Health Facility Statistics Report

Despite the higher workload in public facilities, a significant portion of government Plantilla positions still need to be filled, which could have alleviated the workload pressure in the public sector. Due to limitations on available data, we can only analyze Plantilla items in DOH-retained and specialty hospitals, which constitute nearly 82 thousand health workers in 16% of all public hospitals across the Philippines. Based on the best available DOH data, 17% of all Plantilla items in DOH hospitals are unfilled; this amounts to almost 17 thousand positions. Across regions, the percentage of positions that remain unfilled varies, from 5.86% in CAR to 32.68% in CARAGA. Considering our findings above, the prevalence of unfilled positions may contribute to the higher workload of nurses and physicians in public facilities. The pervasiveness of unfilled positions in the government is not limited to the health sector. Based on the DBM National Government Staffing Summary for 2024, nearly 170 thousand unfilled positions are across all national government agencies. (DBM 2024c). This issue persists despite the public sector's reliance on Job Order and Contracts of Service workers, with the DBM and CSC identifying the difficulty in regularizing contractual government workers due to needing more qualifications and lack of Civil Service Eligibility (CSE). Policy developments by the CSC that began implementation in 2024 will allow JO and COS government workers to receive a CSE - Preference Rating subject to meeting specific requirements. (CSC 2023). This policy should circumvent a key bottleneck in hiring Plantilla items, although further analysis is required on the effectiveness of this intervention. Data limitations restrict our analysis to only DOH hospitals and prevent it from disaggregating to specific health cadres. However, our KIIs with LGU health offices provide additional insight into local government difficulties in meeting their HRH staffing needs. As discussed above, the key issues identified by our respondents are the limitations brought about by budget constraints and the PS limitations that prevent LGUs from absorbing these HRH.

Table 6. Plantilla items in DOH-retained and Specialty Hospitals, as of April 2024

Region	TOTAL	Filled	Unfilled	% Unfilled
BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO (BARMM)	3,227	2,843	384	11.90
CORDILLERA ADMINISTRATIVE REGION (CAR)	3,939	3,708	231	5.86
MIMAROPA REGION	984	806	178	18.09
NATIONAL CAPITAL REGION (NCR)	34,282	27,441	6,841	19.96
REGION I (ILOCOS REGION)	5,759	4,463	1,296	22.50
REGION II (CAGAYAN VALLEY)	5,430	4,835	595	10.96
REGION III (CENTRAL LUZON)	6,119	5,608	511	8.35
REGION IV-A (CALABARZON)	2,269	2,095	174	7.67
REGION IX (ZAMBOANGA PENINSULA)	4,392	3,677	715	16.28
REGION V (BICOL REGION)	4,851	3,979	872	17.98
REGION VI (WESTERN VISAYAS)	4,703	4,226	477	10.14
REGION VII (CENTRAL VISAYAS)	8,224	6,576	1,648	20.04
REGION VIII (EASTERN VISAYAS)	2,514	1,981	533	21.20
REGION X (NORTHERN MINDANAO)	4,039	3,226	813	20.13
REGION XI (DAVAO REGION)	5,935	4,925	1,010	17.02
REGION XII (SOCCSKSARGEN)	165	143	22	13.33
REGION XIII (CARAGA)	2,044	1,376	668	32.68

Source: Authors' analysis of the DOH Health Facility Statistics Report

4. HRH Remuneration: Implementation Challenges and Policy Gaps (SO2)

This section examines the policies in the Philippines regarding HRH compensation and welfare. It starts with a summary of policies mandating monetary and non-monetary benefits and policies enacted to ensure their welfare. A detailed discussion of policies related to salaries, non-cash benefits, and other intrinsic factors follows.

Over the last four decades, the government has implemented several HRH remuneration policies, which led to increased cash and non-cash benefits among public sector health workers. These significant general remuneration policies for all government workers (e.g., Salary Standardization) and specific policies for healthcare workers (e.g., Magna Carta of Public Health Workers (MCPHW) have resulted in improvements in the remuneration package of public health workers in the Philippines. **Table 7** summarizes the policies that affect the welfare of public healthcare providers in the country.

Table 7. Public HRH welfare policies, 1987-2024

Policy	Year	Coverage	Information
EO No. 292 (Administrative Code of 1987)	1987	- Cash income - Noncash benefits	Provided entitled benefits to government employees
RA 6758 / SSL I (Compensation and Position Classification Act/ SSL I)	1989	- Cash income	Provided a standardized salary structure for government employees
RA 7160 (Local Government Code of 1991)	1991	- Cash income	Devolved the provision of health, and hiring and managing of local public HRH to LGUs
RA 7305 (Magna Carta of Public Health Workers)	1992	- Cash income - Noncash benefits - Status or intrinsic motivation	Entitled public health workers to monetary and non-monetary benefits
SSL II	1994-1997	- Cash income	Provided an updated standardized salary package for government employees
RA 8291 (Government Service Insurance System Act)	1997	- Cash income	Provided retirement benefit packages for government employees
EO No. 219 (Grant of Salary Adjustment to All Government Personnel)	2000	- Cash income	Provided a 10% increase to the monthly basic pay of all government employees
AO No. 144 (Granting Additional Compensation in the Amount of Php1,000 per Month to All Employees in the National Government)	2006	- Cash income	Provided an increase of Php1,000 to the basic monthly salary of government workers in the national government
EO No. 719 (Compensation Adjustments for Government Personnel)	2008	- Cash income	Provided a 10% increase to the monthly basic pay of all government employees
SSL III	2009-2012	- Cash income	Provided an updated standardized salary package for government employees
SSL IV	2016-2019	- Cash income	Provided an updated standardized salary package for government employees
RA 11223 (Universal Healthcare Act)	2019	- Policy initiative	Established clauses for policy strategies in addressing HRH

			retention, regulation, training, and assessment
SSL V	2020-2023	- Cash income	Provided an updated standardized salary package for government employees
RA 11469 (Bayanihan Heal As One Act)	2020	- Cash income - Noncash benefits - Policy initiative (for cash income)	Provided a COVID-19 Special Risk Allowance; directed PhilHealth to shoulder any medical expense of public and private HRH to any COVID-19 or work-related expenses; monetary benefits for contracting COVID-19; provided housing and quarantine centers for health workers; allowed the hiring of temporary HRH staff to supplement the personnel of medical facilities
RA 11494 (Bayanihan Recover As One Act)	2020	- Cash income - Noncash benefits - Policy initiative (for cash income)	Provided a COVID-19 Special Risk allowance and Actual Hazard Duty Pay allowance for all health workers in both sectors that were on the frontlines, along with COVID-19 monetary risk benefits if a health worker contracted COVID-19 in the line of duty; provided housing and quarantine centers for health workers; expanded the PS limitation for LGUs; allowed the hiring of temporary HRH staff to supplement the personnel of medical facilities
Local Budget Circular No. 132	2021	- Policy initiative (for cash income)	Established that LGUs can provide the salary rates of 1 st class LGUs to their public health workers if they have adequate resources
Local Budget Circular No. 145 (Determination of Waived PS Items)	2022	- Policy initiative (for cash income)	Waived the PS limitation for LGUs to ensure the payment of salaries and benefits to their local public HRH
RA 11712 (Public Health Emergency Benefits and Allowances for Health Care Workers Act)	2022	- Cash income - Noncash benefits	Provided health emergency allowance for medical and non-medical staff; compensation package for COVID-19 contraction in the line of duty; full PhilHealth coverage for medical expenses during COVID-19

General Provisions Fiscal Year 2023 (GAA 2023)	2023	- Policy initiative (for cash income)	Waived the PS limitation for LGUs to ensure the payment of salaries and benefits to their local public HRH
Local Budget Circular No. 156 (Determination of Waived PS Items)	2024	- Policy initiative (for cash income)	Waived the PS limitation for LGUs to ensure the payment of salaries and benefits to their local public HRH
Local Budget Circular 163-2025 (Determination of Waived PS Items)	2025	- Policy initiative (for cash income)	Waived the PS limitation for LGUs to ensure the payment of salaries and benefits to their local public HRH

Source: Authors' illustration of the policy trends for public HRH remuneration and welfare 1987-2025

Unlike the public system, the salaries and benefits of private health workers primarily follow general labor standards with other professions and follow the regional minimum wage rates. For private HRH, the governance structure in place for salaries, benefits, and to protect their overall welfare are prescribed in the Labor Code, the Occupational Health and Safety Standards (OHS), and the general guidelines by the Department of Employment (DOLE) (D.O. 2017-182) for private HRH employment. Private health facilities are not mandated to provide the MCPHW benefits nor adjust the salaries of their personnel with each iteration of the SSL, as they are only required to comply with the minimum wage rates and general benefits in the Labor Code. **Table 8** provides a summary of policies implemented for private HRH welfare.

Table 8. Private HRH welfare policies, 1954-2022

Policy	Year	Coverage	Information
RA 1161 (Social Security Law)	1954	- Cash income (for pension)	Provided retirement benefit packages for workers in the private sector; amendments to the rates in 1994, 1997, and 2018
PD No. 442 (Labor Code of the Philippines)	1974	- Cash income - Noncash benefits - Status or intrinsic motivation	Provided the general labor standards for workers' right
RA 6727 (Wage Realization Act)	1989	- Cash income	Established mechanism of determining the regional minimum wage rates for employers to follow; institutionalized the National Wages and Productivity Commission and the Regional Tripartite Wages and Productivity Commission to conduct labor and productivity studies, offer technical assistance, and

			determine the minimum wage rates
D.O. 182-2017 (Guidelines Governing the Employment and Working Conditions of Health Personnel in the Private Healthcare Industry)	2017	<ul style="list-style-type: none"> - Cash income - Noncash benefits - Status or intrinsic motivation 	Established the guidelines of employment for private HRH in private medical facilities
RA 11058 (An Act Strengthening Compliance with Occupational Safety and Health Standards and Providing Penalties for Violations Thereof)	2018	<ul style="list-style-type: none"> - Noncash benefits 	Provided guidelines to ensure the safety of employees and to prevent work-related casualties
RA 11223 (Universal Healthcare Act)	2019	<ul style="list-style-type: none"> - Policy initiative 	Established clauses for policy strategies in addressing HRH retention, regulation, training, and assessment
RA 11469 (Bayanihan Heal As One Act)	2020	<ul style="list-style-type: none"> - Cash income - Noncash benefits - Policy initiative (for cash income) 	Provided a COVID-19 Special Risk Allowance; directed PhilHealth to shoulder any medical expense of public and private HRH to any COVID-19 or work-related expenses; monetary benefits for contracting COVID-19; provided housing and quarantine centers for health workers; allowed the hiring of temporary HRH staff to supplement the personnel of medical facilities
RA 11494 (Bayanihan Recover As One Act)	2020	<ul style="list-style-type: none"> - Cash income - Noncash benefits - Policy initiative (for cash income) 	Provided a COVID-19 Special Risk allowance and Actual Hazard Duty Pay allowance for all health workers in both sectors that were on the frontlines, along with COVID-19 monetary risk benefits if a health worker contracted COVID-19 in the line of duty; provided housing and quarantine centers for health workers; allowed the hiring of temporary HRH staff to supplement the personnel of medical facilities

RA 11712 (Public Health Emergency Benefits and Allowances for Health Care Workers Act)	2022	- Cash income - Noncash benefits	Provided health emergency allowance for medical and non-medical staff; compensation package for COVID-19 contraction in the line of duty; full PhilHealth coverage for medical expenses during COVID-19
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Source: Authors' illustration on the policy trends for private HRH remuneration and welfare 1954-2022

Since the passage of the Universal Healthcare Act of 2019 and the effects of the COVID-19 pandemic, policy initiatives have been implemented to expand HRH recruiting and retention. Aside from the increase in basic monthly salary rates of public health workers brought by the SSL V, efforts have shifted to ensure LGUs, and medical facilities can retain their HRH. For LGUs, the PS limitation was expanded to 5-10%, depending on the LGU income classification. Ultimately, the PS limitation was waived for the fiscal years from 2022 to 2025 to ensure that LGUs can provide their public HRH salaries and MCPHW benefits. For private health facilities, the Bayanihan Heal as One Act and the Bayanihan Recover as One Act enabled medical facilities to contract temporary HRH staff to augment their total health workforce. Aside from expanding the capacity of LGUs and healthcare facilities, the UHC Act also stipulated the National Human Resource for Health Masterplan (NHRHMP) for HRH development by DOH. The NHRHMP serves as the blueprint for the regulation, recruitment, training, and assessment of HRH in the Philippines as it provides better policy options to regulate the country's health worker labor force. Lastly, due to the dangers imposed by COVID-19, allowances, compensation packages, and other benefits were also enacted to compensate for the efforts of all healthcare workers during the pandemic. Even though all HRH in both the private and public sectors were entitled to the same benefits during the COVID-19 pandemic, the monthly basic salaries and other financial benefits continued to supplement the earning potential of public HRH caused by the SSL V and the entitled benefits from the MCPHW. In contrast, private HRH continued to be prescribed under the general labor standards.

The following subsection examines the compensation package of HRH in the country, including salaries, cash benefits, non-cash benefits, and other entitlements mandated for health workers in both the public and private sectors.

4.1. Scope and coverage of welfare services for HRH (SO-2a)

4.1.1. Salary

In the public sector, the policies that govern the salaries of healthcare workers have a progressive history. Following the ratification of the 1987 constitution of the Philippines, a new Administrative Code (RP 1987) was enacted to restructure the bureaucracy following the new constitution and government. The Department of Budget and Management (DBM) has been mandated to manage the budget. Part and parcel of this is the classification and compensation of all civil servants or public sector workers. Shortly after, the Compensation and Position

Classification Act (RP 1989) was implemented in 1989.⁷ The remuneration packages were determined by the Salary Schedule, a table that assigns a position to a salary grade corresponding to a specific monthly salary. The Salary Schedule contains step increments in all salary grade levels, starting from steps one to eight. These step increments are used to determine salary pay adjustments and are granted to government employees for either their length of service or due to meritorious performance. According to Civil Service Commission (CSC) guidelines, a government employee can be granted one or two-step increments for meritorious service if their performance ratings meet the required criteria under the Performance Management System (PMS). In contrast, step increments for length of service are granted to employees for rendering three continuous years of service and maintaining a satisfactory service assessment. These step increments can be granted simultaneously if a government employee qualifies for both criteria. However, these step increments can only be provided to five percent (5%) of the total workforce within a government agency or LGU in each fiscal year. The funding for the step increments is sourced from an employee's respective agency or LGU. Therefore, government entities must first assess their capacity if they can absorb the step increments of their employees (CSC 2012, 2016). The step increments, however, only apply to government employees with Plantilla positions, excluding employees hired under contractual and job order employment status. For public health workers, aside from the salary step increment from CSC regulations, the Magna Carta of Public Health Workers entitles them to a longevity pay that increases their salary to five percent (5%) of their total monthly basic pay for every five years of continued service. Like the CSC regulations, they must maintain a satisfactory performance rating to be eligible for this salary increase. Public health workers are entitled to receive a salary grade increase if they are still in service three months before the compulsory retirement age and a two percent (2%) increase equivalent to their monthly basic pay for finishing post-graduate studies (DOH 1999; RP 1992b). Although the law stipulates that all public health workers, regardless of employment status, are entitled to the benefits of the Magna Carta, the 2012 implementing rules and regulations (IRR) established that public health workers must hold a Plantilla position in their respective public health facility to be eligible for these pay increases (DBM and DOH 2012).

The SSL was created to provide a comprehensive approach to civil servants' remuneration to ensure that all government workers are compensated fairly for the responsibilities their profession demands. The policy further cited that a periodic review of the salary packages offered will be conducted due to inflation and factors affecting purchasing power, yet to ensure that all government workers are being compensated fairly for the policy does not identify the review mechanism. It does, however, state that increases in salary grade can be permitted through additional policies. The SSL provides salary adjustments for local government employees depending on their income class.

⁷ The policies related to Human Resources for Health (HRH) in the Philippines are the following. **EO 292 (1987)** established general provisions for the Department of Budget and Management (DBM) functions. **RA 6758: Compensation and Position Classification Act (1989)** formulated a standardized Compensation Plan to set the monthly salary rates of all government employees. **RA 6727: Wage Rationalization Act (1989)** aimed to monitor employer compliance with regionally established minimum wages. **RA 7160: Local Government Code (1991)** outlined devolved functions to Local Government Units (LGUs) and introduced the Personnel Services (PS) limitation, which impacts HRH funding. **RA 11466: Salary Standardization Law (2019)** implemented a four-tranche salary increase for government employees, including healthcare workers, enhancing compensation to improve recruitment and retention.

Table 9. Position and salary grades of public HRH (MO, MS, Nurse, and MT) as of 2023

Position	Salary Grade	Monthly Base Salary
Medical Officer I	16	P39,672 – P42,694
Medical Officer II	18	P46,725 – P50,382
Medical Officer III	21	P63,997 – P70,933
Medical Officer IV	23	P80,003 – P89,281
Medical Officer V	25	P102,690 – P115,012
Rural Health Physician	24	P90,078 – P100,888
Medical Specialist I	22	P71,511 – P79,349
Medical Specialist II	23	P80,003 – P89,281
Medical Specialist III	24	P90,078 – P100,888
Medical Specialist IV	25	P102,690 – P115,012
Medical Specialist V	26	P116,040 – P129,964
Medical Specialist VI	28	P148,171 – P165,951
Medical Specialist VII	30	P189,199 – P211,902
Nurse I	11	P27,000 – P29,075
Nurse II	15	P36,619 – P39,367
Nurse III	17	P43,030 – P46,355
Nurse IV	19	P51,357 – P56,790
Nurse V	20	P57,347 – P63,485
Nurse VI	22	P71,511 – P79,349
Nurse VII	24	P90,078 – P100,888
Medical Technologist I	11	P27,000 – P29,075
Medical Technologist II	15	P36,619 – P39,367
Medical Technologist III	18	P46,725 – P50,382
Medical Technologist IV	20	P57,347 – P63,485
Medical Technologist V	22	P71,511 – P79,349

Source: Department of Budget and Management Staffing Summary (2023) and Index of Occupational Services (2018)

Table 10. Salary grade provision for each LGU Class, as of 2024

LGU Classification	Province	SG 15 Example	Municipalities	SG 15 Example
1 st Class	100%	36,619.00	90%	32,957.10
2 nd Class	95%	34,788.05	85%	31,126.15
3 rd Class	90%	32,957.10	80%	29,295.20
4 th Class	85%	31,126.15	75%	27,464.25
5 th Class	80%	29,295.20	70%	25,633.30
6 th Class	75%	27,464.25	65%	23,787.35

Source: SSL V; LGC 1991

Note: The percentages here are base salaries per SG relative to the LGU income classification. These changes for provinces and Municipalities. For example, a third-class province will pay only 90% of the base salary for the same SG, while a third-class municipality will pay 80%, and a first-class city or province will pay 100%.

The salaries of public health workers have increased through the evolution of SSL and policy interventions that increase the salaries of specific cadres. The Compensation and Position Classification Act of 1989, known as the Salary Standardization Law (SSL), provided a comprehensive and standardized salary process for government employees (RP 1989). It has developed over the years since its inception to provide updated salary rates adjusted for inflation. SSL II succeeded SSL I in 1994, which mandated DBM to implement the new salary schedules for four years incrementally. SSL II increased the basic salary of civilian employees, ranging from P700-P800, depending on the salary grade⁸, to be added annually over four years (P 1994). Before SSL III, two additional policies were enacted to increase the salaries of government employees. The first one in 2007 provided an additional P1,000 to all employees, while the latter added a 10% increase to their basic salary in 2008 (RP 2006, 2008). SSL III was enacted shortly after in 2009, and its full implementation was in 2012. SSL IV was followed by SSL from 2016 to 2019, and SSL V from 2020 to 2023 (RP 2009, 2016, 2020c). **Table 11** depicts the trends in the entry-level salary grade for the cadres of medical specialists, medical officers, nurses, and midwives in each evolution of SSL. The last tranche presents the salary grade per cadre for SSL II, SSL III, SSL IV, and SSL V. The salary grade assignments for each cadre follow the Index of Occupational Services (IOS)⁹ from DBM, which determines the salary grade assignment of all government professions. However, due to the limited available data, the IOS from 2006 will be used from SSL I to SSL III, while the IOS 2018 will be used for SSL IV, and the IOS 2022 will be applied to SSL V. The salary grades that are applied for each iteration of the SSL will be sourced from the actual salary grade as depicted in each evolution. **Table 11** shows that SSL has consistently increased the salaries of public health workers. Policy interventions such as the SSL have provided a standardized salary increase for public health workers, which can be enacted through administrative or executive orders or ratifying pay hikes for specific professions.

Figure 15 shows the salary of selected cadres in constant terms (adjusting for inflation), which shows an increasing trend over time, and these increases happened mostly in the last ten years.

Our respondents point to the strong nursing lobby in the country as a reason why nurses are “in the best position” among HCWs due to the Philippine Nursing Act of 2022 (C1 2024). The Nursing Act resulted from strong advocacy and lobbying by nursing professionals and groups (C1 2024). Other health cadres do not have a cadre-specific law that outlines minimum salary grade, career progression, and additional incentive and benefit systems. Attempts to pass legislation for other health cadres, such as an act for midwives, have yet to progress past the committee level. Nurses working in the public sector have a comparatively higher salary grade (SG 15) compared to other public workers such as teachers, medical technologists, and pharmacists.

⁸ SG 1 – SG 10 are granted PHP800 increase while SG 11 and higher salary grades are granted a PHP700 (E.O. 164 1994)

⁹ The IOS is used to publish the latest adjustments or reclassification of government positions and salary grades (DBM 2018)

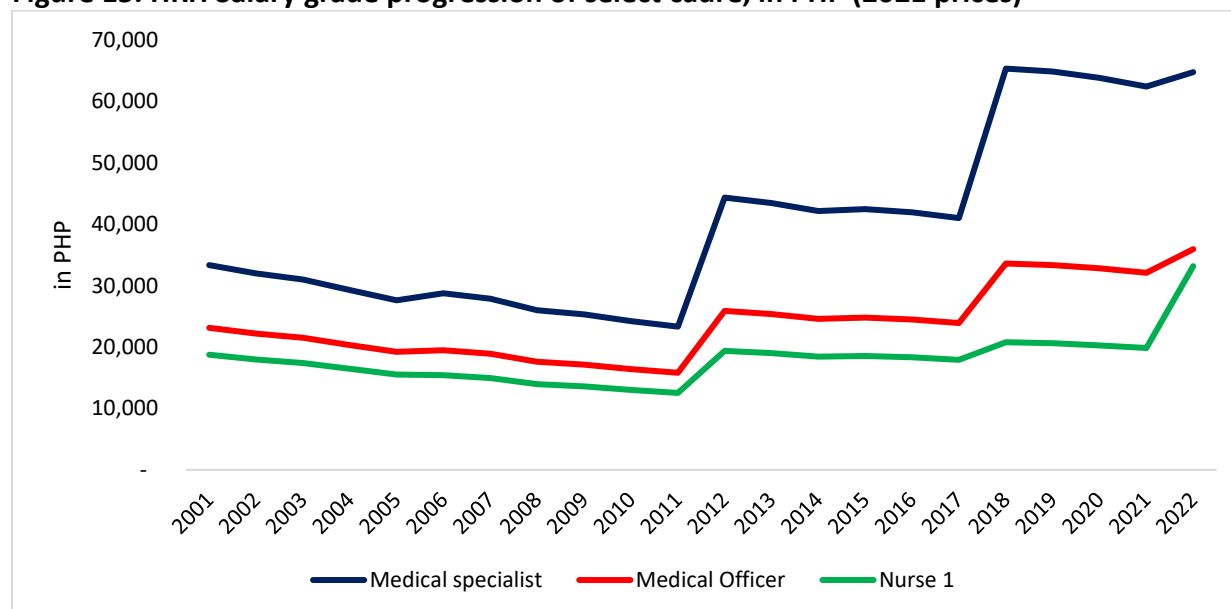
Table 11. HRH Salary grade progression of the SSL 1989-2023, in PHP

HRH Cadre	SSL I (1989)	SSL II 4 th Tranche (1994- 1997)	E.O. 219 (2000)	A.O. 144 (2006)	E.O. 719 (2008)	SSL III 4 th Tranche (2009- 2012)	SSL IV 4 th Tranche (2016- 2019)	SSL V 4 th Tranche (2020- 2023)
	IOS 2006						IOS 2018	IOS 2022
Medical Specialist I	7,478	16,026	17,628	18,628	20,361	39,493	65,319	71,511
Medical Specialist II	8,250	16,667	18,333	19,333	21,176	42,652	73,811	80,003
Medical Specialist III	9,131	17,334	19,067	20,067	22,022	46,064	83,406	90,078
Medical Officer I	4,091	10,853	11,938	12,938	13,801	23,044	33,584	39,672
Medical Officer II	4,786	12,206	13,426	14,426	15,508	26,878	40,637	46,725
Medical Officer III	5,670	13,715	15,086	16,086	17,425	31,351	57,805	63,997
Nurse I	3,102	8,605	9,465	10,465	10,933	17,255	20,754	36,619
Nurse II	4,091	10,853	11,938	12,938	13,801	23,044	30,531	39,672
Nurse III	4,786	12,206	13,426	14,426	15,508	26,878	36,942	43,030
Midwife I	2,473	6,585	7,243	8,243	8,367	12,921	17,975	21,211
Midwife II	2,752	7,540	8,294	9,294	9,580	14,931	20,754	27,000
Midwife III	3,309	9,121	10,033	11,033	11,589	18,549	25,232	31,320

Note: E.O. 219 and A.O. 144 are estimated figures as both policies did not provide an updated salary grade table, while the IOS 2006 was used for the years 1989 to 2012.

Source: Author's illustration of the HRH salary grade adjustment for each policy evolution on the SSL.

Figure 15. HRH Salary grade progression of select cadre, in PHP (2021 prices)



Source: Author's illustration of the Labor Force Survey (LFS) on the trends of MS, MO, and Nurse 1 Salaries

The pay hike for the Nurse I position from 2020 to 2021 is due to the first tranche implementation of the SSL IV, which provided a 54% salary increase.¹⁰ Additionally, the salary grade of the Nurse II position was adjusted in the same year from SG 15 to SG16, highlighting the continuous increase in salaries by nurses in the public sector caused by constant lobbying and cadre-specific policies on salary increase.

In the private sector, a uniform framework provides remuneration packages and is primarily governed by the minimum wage rates. The Wage Realization Act mandates employers in the private sector to follow the minimum wage rates established in each region. This legislation created two (2) government offices attached to the Department of Labor and Employment (DOLE). The National Wages and Productivity Commission (NWPC) and the Regional Tripartite Wages and Productivity Boards (RTWPBs) (RP 1989). RTWPBs monitor and determine the minimum wage rates per region while NWPC develops guidelines and research labor productivity. RTWPBs have corresponding regional offices that adjust the minimum wage according to the ten (10) indicators for minimum wage setting.¹¹

In the private sector, the average base salary for health workers is below the national average wage. An HRH worker earns almost PHP 12,000 less than a worker in the Information and Communications sector, with the highest average base salary in the Philippines. Comparing the average base pay per HRH cadre, we find that only doctors, dentists, and nurses earn above the national average. In the public sector, the average monthly wage for an HRH worker is 1.67 times the national average wage. Nearly all public sector HRH cadres earn above the national average, with only midwives, nursing aides, and radiologic technicians earning less. Comparing public to private average wages, we find that public sector health workers earn more than their private counterparts. The gap is largest for Specialist Medical Practitioners or Medical Specialists. On the other hand, the differential is smallest for nursing aides, who earn the lowest average monthly salary in the public sector.

Table 12. Average base salary by cadre of health workers, 2020

	Private		Public	
	Average monthly base salary	Ratio to national average	Average monthly base salary	Ratio to national average
General Medical Practitioner	₱42,414.10	1.88	₱67,818.62	3.01
Specialist Medical Practitioner	₱36,191.24	1.61	₱83,033.24	3.68
Nursing Professional	₱25,715.25	1.14	₱36,310.98	1.61
Midwife	₱15,086.82	0.67	₱20,451.64	0.91
Nursing Aide	₱15,247.79	0.68	₱15,473.04	0.69
Dentist	₱29,715.00	1.32	₱50,364.59	2.23

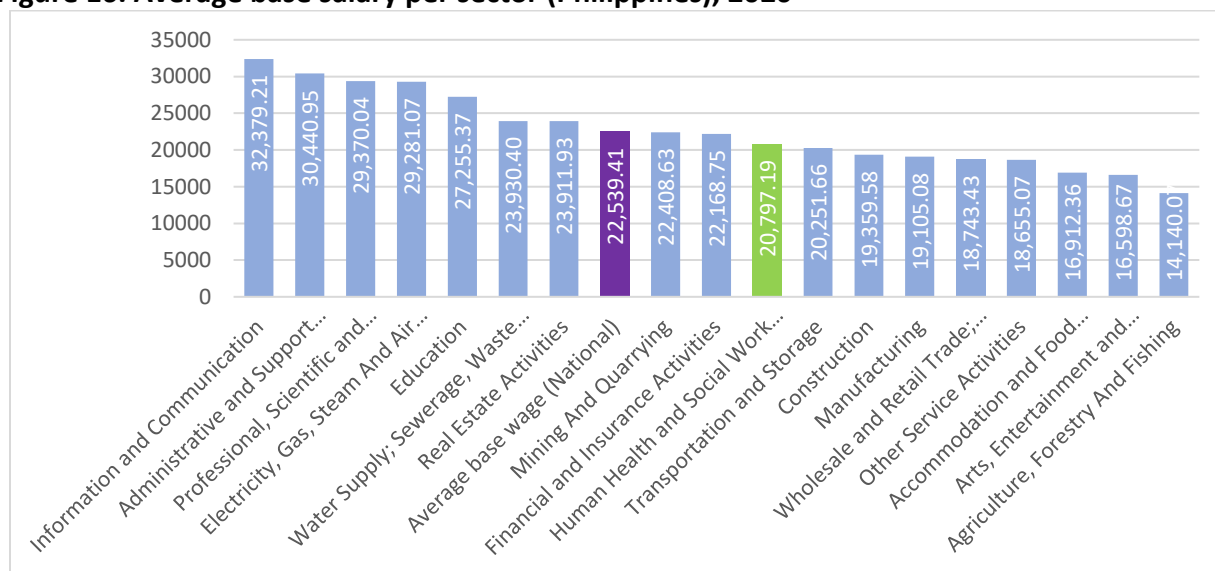
¹⁰ The salary grade assignment of Nurse I was revised from SG 11 (PHP 20,754) to SG 15 (PHP 32,054) (E.O. 201, 2016; SSL V, 2019)

¹¹ The Regional Tripartite Wages and Productivity Board (RTWPB) established ten indicators to guide the minimum wage setting in each region. These indicators include: the demand for living wages; wage adjustments in relation to the consumer price index; the cost of living and any changes therein; the needs of workers and their families; the need to encourage industries to invest in rural areas; improvements in standards of living; prevailing wage levels; fair return on invested capital and the employers' capacity to pay; the effects on employment generation and family income; and the equitable distribution of income.

Pharmacist	₱16,924.76	0.75	₱28,854.59	1.28
Physiotherapist	₱16,970.96	0.75	₱25,401.81	1.13
Dieticians and Nutritionists	₱21,676.69	0.96	₱34,600.84	1.54
Medical Imaging and Therapeutic Equipment Technicians	₱19,095.89	0.85	₱19,889.98	0.88
Medical and Pathology Laboratory Technicians (Medical Technologists)	₱21,720.94	0.96	₱29,910.45	1.33
Accounting and Bookkeeping Clerks	₱17,889.18	0.79	₱41,734.80	1.85
Average all cadres	₱23,220.72	1.03	₱37,820.38	1.68

Source: Private HF's - PSA Occupational Wages Survey (2020); Public HF's - Author's analysis of the Salary Standardization Law V First Tranche (2020) and DBM-DOH DBM Joint Circular No. 2, s. 2023

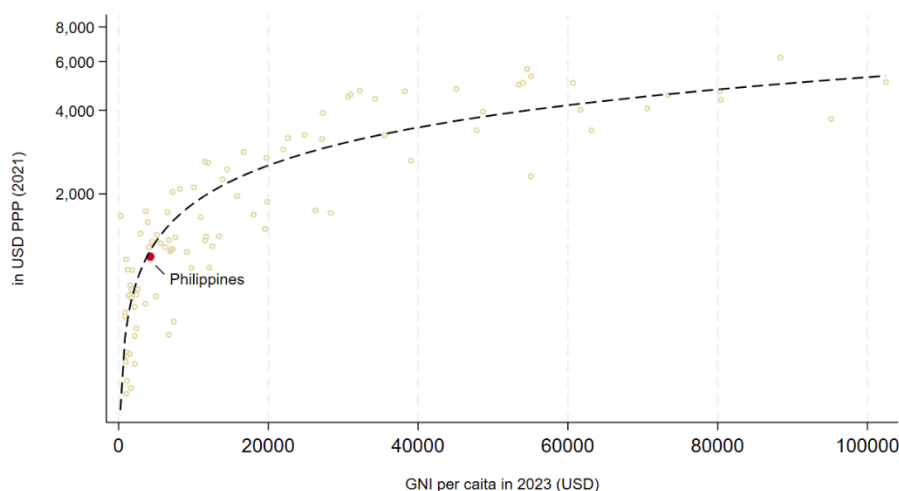
Figure 16. Average base salary per sector (Philippines), 2020



Source: Philippine Statistics Authority Occupational Wages Survey (2020)

The average monthly salary of health workers in the Philippines is relatively low and falls below the global average for its income level, even after adjusting for purchasing power parity (PPP). This suggests that the purchasing power of health worker salaries in the Philippines is still lower compared to other countries.

Figure 17. Average monthly salary of health workers in PPP (in 2021 prices)



Source: Analysis of data from the International Labor Organization

4.1.2. Cash allowance and benefits

Fixed or variable fringe benefits supplement basic salary and are added to an employee's compensation package. In the public sector, the DBM (2012) defined fixed compensation as remuneration granted to all employees, while variable compensation applies to employees based on specific qualifications or provision of special services. Fringe benefits for public sector employees would include the Personnel Economic Relief Allowance (PERA), Additional Compensation (ADCOM), Uniform/Clothing Allowance (UCA), and thirteenth month (13th) pay, among others.¹² For public and private sector employees, the government required employers to provide their employees with a thirteenth (13rd) pay month. These bonuses, however, are not always applicable to Contract of Service (COS) or Job Order (JO) workers with no employer-employee relationship.

Variable fringe benefits allow for additional compensation for most HCWs, given their work circumstances and conditions. Legislation-mandated benefits include allowances and additional pay from The Magna Carta of Public Health Workers (RA No.7305), honoraria, overtime pay, night differentials, and PhilHealth claims in government hospitals (RP 1992b). The Magna Carta of Public Health Workers was one of the first policies that enabled HCWs to receive additional compensation, including hazard allowance, subsistence, laundry, remote assignment, and longevity pay. During the COVID-19 pandemic, several policies were published providing risk allowances and hazard pay to health facilities and public health workers, which included the One COVID-19 Allowance and the Health Emergency Allowance (Leyva et al. 2024). Although non-specific to health workers, government employees are eligible for honoraria, overtime pay, and

¹² The guidelines for PERA were issued by the DBM through Budget Circular (BC) No. 2009-3 and 2011-2, implemented to alleviate employees from the rising costs of living at Php 2,000.00 per month. ADCOM is provided as a supplement to basic pay at the rate of Php 1,500 per month as initially authorized by Administrative Order No. 53 in 1993 with its subsequent increase by Administrative Order No. 144 in 2006. Recent guidelines for the grant of the UCA were detailed in DBM's BC No. 2024-1, which authorized a maximum annual expenditure of Php 7,000.00 for uniforms.

night differentials as part of benefits for special working conditions, with its guidelines provided by DBM Budget Circulars (Saguil et al. 2023).

The Magna Carta provides a hazard allowance, subsistence allowance, laundry allowance, remote assignment allowance, and housing allowance to public health workers. These allowances supplement the salary packages offered to public health workers as the nature of their jobs will put them at risk of exposure to infection or require them to provide healthcare services in geographically isolated and disadvantaged areas (GIDA). The rates of these allowances are stipulated in the IRR of the Magna Carta and incentivize public health workers for job retention in the government. Aside from cash allowances, when no Medico-Legal Officer is present within a locality, a rural physician can be assigned to render this service and is entitled to additional incentives.

Table 13. Cash allowances for public HRH in the Magna Carta of Public Health Workers

Cash Allowances	Formula
Hazard Pay	At least twenty-five percent (25%) of their basic salary for salary grades nineteen (19) and below and five percent (5%) for salary grades twenty (20) and above
Subsistence allowance	Not less than fifty pesos (P50) or one thousand pesos (P1,000) per month
Laundry allowance	One hundred fifty pesos (P150) per month
Remote assignment allowance	One-time relocation allowance of twenty-thousand pesos (P20,000)
	Equivalent to fifty percent (50%) of their basic pay for the first twenty-four (24) months and reduced to twenty-five (25%) for the next twenty-four (24) months
Housing allowance	A housing allowance rate at the prevailing rental rate in the locality
Medico legal honorarium	Conduct of medical examination on: Slight physical injury – P500 Less serious physical injury – P500 Serious physical injury – P1,000 Rape victim – P2,000 Child sexual and/or physical abuse victim – P2,000 Conduct of necropsy or autopsy – P2,500 Each court appearance to testify on findings – P1,500

Source: Author's illustration of the cash allowances provided in the Magna Carta (DBM-DOH Joint Circular 1 2012)

Health workers in the private sector have limited benefits as they comply with General Labor Standards (GLS) and Occupational Safety and Health Standards (OSHS). For private healthcare workers, the bonuses, entitled minimum wage rates, social welfare benefits, and the right to work in a safe and humane working environment are all established in the Labor Code, the OSHS manual, and the D.O. 182-2017. The monetary benefits pertain to base salary rates that comply with regional rates, holiday pay, premium pay for special days, overtime pay, night-shift differential, paid leaves, etc. Even though D.O. 182-2017 served as the guidelines for employing HRH in private health facilities, it mainly followed, as mentioned earlier, stipulations in the GLS,

so the monetary benefits private HRH receive are like the entitled benefits and pay for other professions. For OSHS, it safeguards the well-being of private HRH by establishing work environment standards within different employers. OSHS mandates employers from small to large-scale enterprises to provide essential medications for staff, designate or hire first-aiders, provide medical treatment to injured or ill employees, etc. In contrast with public health facilities, they ensure that the conditions of public health facilities cater to the needs of public HRH as a prerequisite for DOH accreditation.

Following the framework provided in this report to examine the welfare of HRH in both the public and private sectors in terms of compensation, **Table 14** provides a brief checklist of the entitlements for HRH per sector. It is evident that due to the formulation of the MCPHW, public HRHs are entitled to more benefits than their private counterparts.

Table 14. Checklist of entitled additional compensation

No.	Allowance/Benefits for HRH	Public	Private	Observation
1	Salary Structure	✓		No cadre-specific structure for private HRH
2	Night-Shift Differential Pay	✓	✓	Both sectors provide a 10% increase to base salary
3	Overtime Pay	✓	✓	25% and 30% increase respectively
4	Hazard Pay	✓		5%-25% increase to base salary
5	Retirement Pay	✓	✓	Public HRH receive a salary increase upon retirement
6	Longevity Pay	✓		Only SIL is provided for private HRH
7	On-Call Pay	✓	✓	No indicated rates for private HRH
8	Subsistence Allowance	✓		P25-P50 for public HRH
9	Laundry Allowance	✓		P150 per month for public HRH
10	Transportation Allowance	✓		RHPs receive P2,200 per month
11	Remote Assignment Allowance	✓		+50% of their base salary for public HRH
12	Pay for working on special days/holidays	✓	✓	200% given to private HRH on special days (public HRH receive an additional 50%)
13	Thirteenth (13 th) Month Pay	✓	✓	Mandated by law to provide
14	Mid-year bonus	✓		Equivalent to a one (1) month basic salary
15	Housing Allowance	✓		Housing allowance or housing facilities are provided for public health workers

16	Special Risk Allowance (COVID-19)	✓	✓	Public receive more due to additional COVID-19 bonuses
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Source: Author's illustration of the entitled additional benefits and allowances for HRH (DBM-DOH Joint Circular No. 1, 2012)

Public facilities rely heavily on guaranteed funding for salaries and wages. Meanwhile, private facilities with lower compensation-to-income ratios must balance wage costs with revenue generation, which may constrain their ability to adjust salaries or benefits.

Table 15 presents indicators that show the level of resources allocated, salaries, and other compensation relative to total income and income generated from hospital fees. Some public hospitals do have private wings that generate income from patient fees. For public facilities, the high ratio of wages and compensation relative to hospital fees suggests that they rely heavily on guaranteed funding through line items or budgets from local governments to support their workforce, as their revenue from patient fees is low as expected as some public facilities collect patient fees as part of their revenue-generating activities. Public hospitals have more stable resources to maintain staffing levels but may have less flexibility in adjusting salaries or benefits based on hospital performance or additional revenue. In contrast, private facilities need to generate sufficient income from patient fees to cover wages and compensation, resulting in a lower ratio of compensation to income. This indicates that private hospitals may face more financial constraints when increasing staff salaries or benefits, as their revenue is directly tied to service provision and patient volume.

Table 15. Salary-to-net-patient-revenue ratio

	Salary to hospital fees income	Total compensation to hospital fees income	Salary to total income	Total compensation to total income
Infirmarium Government	2.85	5.51	1.34	2.69
Infirmarium Private	0.19	0.26	0.28	0.34
Level 1 Government	1.71	2.96	0.69	1.2
Level 1 Private	0.62	1.06	0.22	0.35
Level 2 Government	1.25	2.6	0.78	1.6
Level 2 Private	0.25	0.56	0.18	0.28
Level 3 Government	8.19	16.22	0.35	0.69
Level 3 Private	0.36	0.54	0.19	0.27
Total	1.8	3.1	0.34	0.56

Source: Authors' analysis of hospital financial statements data and the DOH Health Facility Statistics Report

4.1.3. User fees and PhilHealth payments

User fees are sourced from patient charges. In the Philippines, it remains an important incentive that influences the behaviors of healthcare providers in the public and private sectors. User fees, usually in the form of household out-of-pocket (OOP), constitute a major funding source, accounting for 40% of health spending in the country.

User fees are largely unregulated in the Philippines and often unmonitored in public and private facilities. While public facilities are, in principle, free from the patient's perspective, they may have private wards where public physicians can receive additional payment as part of their private practice, allowing them to charge user fees on top of their salaries. This system incentivizes specialists to practice in public facilities while enabling them to engage in private practice. However, some specialists are affiliated with public facilities without regular salaries, especially in teaching hospitals. There are policies in place to reduce user fees in public facilities. PhilHealth's No Balance Billing (NBB) policy stipulates that patients in basic or ward accommodation cannot be charged any user fees, including professional fees paid to HRH. Patients who choose "pay" accommodations or non-basic, non-ward accommodations in public facilities are subject to hospital fees, professional fees, and other user fees. Such a system incentivizes specialists to practice in the public system, improving the facility's capacity, but potential effects must be balanced with equity goals. This creates a two-tiered system that may disadvantage lower-income patients who cannot afford to pay extra for better accommodations (Dayrit et al. 2018). User fees and government mandates for free services can also create confusion for patients, who may not understand when they are being charged for services and how much they should expect to pay.

PhilHealth is the country's national health insurance that purchases health services for all Filipinos. As mandated by the Universal Healthcare Act, every Filipino is automatically a member of PhilHealth, which contracts with both public and private healthcare providers for inpatient and outpatient services. While PhilHealth aims to be the primary purchaser of healthcare services, it currently only accounts for 16% of total health spending. In 2023, PhilHealth reimbursed health facilities PHP 122 billion to public and private providers. Since 2011, PhilHealth has implemented a case rate system in paying providers for inpatient care services, which bundles all costs, including professional fees, into a single payment for each case to improve efficiency and streamline reimbursements. For the current primary care benefit, PhilHealth has implemented a capitation payment system where providers are paid a fixed amount per patient per year. However, primary care benefits services remain limited. In 2023, it only accounts for less than 1%¹³ of total claims reimbursed (PhilHealth 2023).

Case rates are designed to cover total care costs, including professional fees. PhilHealth's professional fees serve as additional compensation for the regular line-item budget salary for public facilities. Based on PhilHealth policy, 30% of the case rate amount is allocated as professional fees for medical cases. For surgical cases, the professional fees are either determined by the Relative Value Unit (RVU) factor or set at 40% of the case rate, depending on the specific procedures involved.^{14,15} Government hospitals pool all PhilHealth professional fees distributed among PhilHealth-accredited doctors. However, non-PhilHealth-accredited doctors and other healthcare professionals, such as nurses or medical technologists involved in the care team, are not eligible to receive a share of these professional fees. In general, the distribution of PhilHealth professional fees is at the discretion of the facility management. Some facilities share the pool of

¹³ Considering only Konsulta benefit expense. Based on 2023 PhilHealth Stats and Charts.

¹⁴ PC 35 s2013 https://www.philhealth.gov.ph/circulars/2013/circ35_2013.pdf

¹⁵ The list of medical and procedural case rates, as well as the corresponding splits to facility or professional fees, is published by PhilHealth. The latest was updated in 2024 in PhilHealth Circular No. 0012 s. 2024

PFs across all cadres, sometimes including non-health professionals. Based on existing PhilHealth policies, the health professional fees are paid directly to facilities. In 2016, the DOH expanded the scope of sharing professional fees by including non-physician health workers from government hospitals in the shared pool. This extends the entitlement of the shared pool to health workers regardless of their employment status and, thus, to part-time health workers. The composition of the pooled funds was pegged at fifty percent (50%) for doctors and the other fifty percent (50%) for non-physician health workers, with part-time health workers receiving half of the amount full-time workers would receive. Healthcare institutions are likewise instructed not to apply the withholding tax under BIR guidelines for payments of health workers. In private health facilities, no policies regulate or mandate professional fees and, therefore, vary per facility or institution.

Box 1. Computation of distribution of Pooled Funds from PhilHealth

The distribution of the pooled funds will be provided as follows:

$$\text{POOLED FUNDS} = a(c) + b(c) \cdot (1/2)$$

A = Full-time doctors and other non-physician health workers

B = Part-time doctors and other non-physician health workers who shall receive 50% of (c)

C = 100% of cash that 'a' or the number of full-time doctors who will receive the full amount

Note: 50% of the pooled funds will be allocated to doctors while the other half will be allocated for non-physician health workers.

Source: Author's illustration on the Pooled Funds calculation according to DOH A.O. 2016-0033

4.1.4. Pension

The retirement benefits for government employees incentivize health workers to practice in the public sector rather than private health facilities. Public and private health workers are governed by different pension systems, with the Government Service Insurance System (GSIS) covering the former while the Social Security System (SSS) covers the latter (RP 1954, 1997). Membership is mandatory for all employees in their respective sectors. Still, workers with no employer-employee relationship are excluded from GSIS. While members of GSIS contribute more to their monthly salaries than employees under SSS, GSIS offers more flexibility with multiple pension packages and the option to retire at 55 if one can render 20 years of service in the government. These multiple pension packages under GSIS enable government employees to choose a comprehensive pension plan. For employees under the SSS, the retirement benefits are based on the monthly contributions they could provide once they reach the age of 60-65 years old (Reluao et al. 2023; RP 2019a). Without a retirement or pension plan, the Labor Code established provisions to ensure pension benefits for employees in the private sector. **Table 16** depicts the pension plans available for health workers in the Philippines, with GSIS providing more than one option to government employees.

Table 16. Pension plans available for HRH in the Philippines

Pension Plan	Coverage	Benefits and/or Eligibility
GSIS Act of 1997(RA 8291)	GSIS	<ul style="list-style-type: none"> • Provided two (2) options for retirement benefits • Option 1: Lump sum that is equivalent to 5 years of basic monthly pension • Option 2: Cash payment of a lump sum of 18 months of basic monthly pension and immediate provision of basic monthly pension for life
Pension or Cash Payment (PD 1146)	GSIS	<ul style="list-style-type: none"> • Provided two (2) options for retirement benefits • Option 1: Pension (5-year lump sum or immediate basic monthly pension) • Option 2: Cash separation benefit (at least 3 years of service)
Take All Benefit (RA 1616)	GSIS	<ul style="list-style-type: none"> • Provides two (2) retirement benefits • Benefit 1: Gratuity pay that is equivalent to the years of rendered service and multiplied by the highest salary received (Provided by last employer) • Benefit 2: Refund of retirement premiums (Provided by GSIS)
Magic 87 (RA 660)	GSIS	<ul style="list-style-type: none"> • This retirement package adds the age when one government worker retires and adds their total years of service (that should be equal or more than the value of 87) • Criteria 1: 63 and above receive a 5-year lump sum • Criteria 2: Below 63 but at least 60 receive an initial 3-year lump sum and a 2-year balance payable at 63 • Criteria 3: Below 60 receive a monthly pension paid annually
Portability Law (RA 7699)	GSIS	<ul style="list-style-type: none"> • Combines and credits both the years of service and contributions made under GSIS and SSS • Amount is dependent on the contributions and services rendered by the employee
SSS Act of 1997 (RA 11199)	SSS	<ul style="list-style-type: none"> • Must have provided 120 monthly contributions • Entitled to a monthly pension for life and an option to receive the first 18 monthly pension in lump sum • The computation of the monthly pension is dependent on the years of service and monthly salary credits made by an employee

Note: The eligibility criteria per pension plan of GSIS differs

Source: Retirement Benefits (GSIS n.d.); GSIS Act of 1997; SSS Act of 1997

4.1.5. Non-cash benefits

Healthcare workers often provide additional hours of service or overtime to ensure uninterrupted care in healthcare facilities. To support this, the Magna Carta of Public Health Workers mandates that public health workers required to stay within the premises of their assigned facilities are entitled to free living quarters. A housing allowance is provided if accommodation is unavailable until suitable quarters are accessible. The DOH can initiate housing projects on government land to support its workforce, particularly in rural areas and GIDAs. In contrast, private health workers do not have similar housing benefits, as there are no

specific stipulations in the Labor Code or Department Order No. 182 (2017) for housing allowances. Private employers are only broadly required to provide transportation for night workers (DOLE 2017).

Only public health workers are entitled to transportation benefits. The Magna Carta provides municipal health officers (MHOs) and rural health physicians with a representation and transportation allowance (RATA). At the same time, reimbursement for their cost of transportation is given to public health work in remote areas and difficult-to-reach (or GIDA) regions. RATA is generally given to government employees and officials, and DBM provides guidelines for the computation of transportation. However, the RATA given to LGUs is subject to PS limitations. Local chief executives (LCEs) have autonomy in providing RATA on a reimbursement basis to their healthcare workers.

The government offers non-cash benefits such as housing, logistical support, and training opportunities to participants in the Doctors to the Barrios (DTTB) program, a national initiative established in 1993 to deploy physicians to municipalities without doctors. The DTTB program aims to attract community-oriented medical professionals to serve in GIDA nationwide. Physicians in the program commit to a two-year assignment and receive competitive compensation, currently around PhP 120,000 per month, with hazard pay. Additional benefits include scholarships, subsistence and laundry allowances, housing, and insurance (Flores et al. 2021). On average, each year, 600 doctors join the DTTB program.

Table 17. Benefits for DTTB as stated in the memorandum of agreement (MOA)

Benefit	Agency Responsible	Details
Housing (Board and Lodging)	LGU	LGUs offer LGU-owned housing facilities as housing options
Training	DOH CHD, LGU	DOH (through the CHDs) to provide training to DTTBs; LGUs allow DTTBs to take time off for trainings
Technical Assistance to DTTB through Training	PHO	PHOs provide training to MHO/CHO staff, including DTTBs
Benefits in the Magna Carta of Public Health Workers, Representation and Travel Allowance (RATA), hazard pay, other incentives as deemed fit	LGU, DOH CHD	Magna carta benefits were covered by the CHD; LGUs provide honorarium of differing amounts; LGUs provide RATA if the DTTB is an MHO or CHO position
Logistical Support	PHO, LGU	PHOs provide logistical support for health activities such as COVID vaccination drives; CHOs coordinate with LGUs and barangays for health activities at the community level
Safety and Security	LGU, PHO, DOH CHD	The LGU provides day-to-day safety and security in the conduct of their duties; The PHO and DOH CHD likewise provide safety and security if there are incidents that need to be elevated above the LGU level

Source: Authors' illustration on entitled benefits of the DTTB

Box 2. Non-cash Benefits of DTTB

Housing benefits varied per LGU as these were typically accommodations in LGU-owned housing facilities such as tourist inns, hostels, or even a non-functional Drug and Rehabilitation Center. However, during the COVID-19 pandemic, some of these facilities doubled as COVID isolation units, which limited their accessibility to DTTBs. Magna Carta Benefits, RATA, and honorarium were routinely provided, although the honoraria differed per LGU. Monthly honorariums were provided monthly but LGUs typically did not specify or stipulate what these were to be used for.

The experiences of DTTBs in receiving training and technical assistance support from both the DOH CHD and PHOs of their LGUs varied. During COVID-19, many DOH CHDs were unable to provide training. DTTBs, as part of the program, are enrolled in MPH courses from the UP College of Public Health. PHOs likewise provided training to MHO and CHO staff, and DTTBs could attend these as part of their duties. Due to the time lost to training and courses, this may cause some friction in LGUs as other Plantilla or organic staff shoulder the workload

Despite not being a tangible benefit, safety and security are crucial components that DTTBs rely upon during their stay in the program. This is particularly important to DTTBs deployed in crisis or conflict areas. For the most part, the LGU, in coordination with local police or military, safeguards the DTTBs and other health workers in the conduct of health activities. Aside from this, safety is also a concern during the routine consultations of DTTBs in RHUs. An unfortunate occurrence that DTTBs have experienced harassment from patients and local government officials. The response of LGUs, PHOs, and the DOH CHD varies in these circumstances.

Source: Author's analysis of the non-cash benefits provided under the DTTB program

These mechanisms to finance the welfare of HRH in the Philippines have developed over the years. However, despite the trends and policy developments formulated to address the issues concerning HRH welfare, especially compensation, significant issues that influence the retention of health workers in the country remain.

4.1.6. Other factors

The more tangible monetary incentives in HRH compensation often overshadow intrinsic rewards. Although health workers in the Philippines consider the intrinsic component of their profession in their employment, it is often sidelined for opportunities that provide a better financial earning potential. However, studies such as one by Moller et al. (2019) found that physicians' autonomous motivation was positively associated with better overall health, lower risk for depression and burnout, improved work satisfaction, and, most importantly, a lower intent to leave their current practice. The motivations of health professionals affect their ability to deliver high-quality health services and their decision to stay with their current employment (Karaferis, Aletras, and Niakas 2022).

Investing in the professional growth opportunities of HCWs through training or learning initiatives can significantly enhance the competency of healthcare workers while contributing to their overall increased motivation and job satisfaction (Karaferis et al. 2022). The above policies on Barangay Health Workers, the Reproductive Health Act, and the Plan of Action against Tuberculosis include sections on capacity development of the healthcare workforce.

Further contextualizing capacity development within the health sector, the 2020-2040 HRH Masterplan of the Department of Health sets forth the strategies that emphasize developing HRH competencies under Strategic Objective 2 (SO 2). The HRH Masterplan outlines short-term and long-term strategies to achieve SO 2 by fostering continuous professional development and learning among local healthcare professionals (DOH 2020).

Beyond national strategies and policies aimed at providing intrinsic motivators, job satisfaction has been associated with more personal factors such as relationships at work, workload, and transformational leadership (Hellín Gil et al. 2022; Kitsios and Kamariotou 2021; Othman and Khrais 2022; Wang et al. 2020). The study by Lu et al. (2017) described that the doctor-patient relationship positively impacted job satisfaction. Consistent with findings from West Ethiopia, management recognition and patient appreciation positively influenced job satisfaction among health workers (Deriba et al. 2017). A study among Filipino nurses was able to establish a correlation between increased workload and a decrease in job satisfaction (Bautista et al. 2020). Similarly, a study conducted in Jordan revealed overall better job satisfaction and employee retention were related to having a manager with the ability to create a workplace that is oriented towards learning while also being aligned with its organization's objectives (Abdelhafiz, Alloubani, and Almatari 2016; Othman and Khrais 2022).

Studies on intrinsic rewards can lead to strategies to ensure healthcare worker retention and improve the quality of patient care (Karaferis et al. 2022; Kitsios and Kamariotou 2021). Examining organizational factors in health facilities, particularly those affecting intrinsic motivation, is essential to sustaining a robust healthcare workforce. Intrinsic compensation is comparatively undervalued in literature and national strategies. However, a comprehensive approach to employee satisfaction is essential, given the relationship between intrinsic and extrinsic rewards.

Several laws have been enacted to ensure proper work environments and provide opportunities for the growth of the Filipino workforce. The figure below illustrates the timeline of publication of major Philippine policies or issuances affecting working conditions of HRH, and the table will focus on grouping major policies that focus on the (1) quality of work-life and (2) capacity development of healthcare workers.

Table 18. List of factors affecting intrinsic motivation and corresponding major Philippine policies or issuances

Factors affecting intrinsic motivation	Major Philippine policies or issuances	Relevance to human resources for health
Quality of work-life	Presidential Decree No. 442 of 1974	Policies codifying labor protection promote employment and human resource development and ensure industrial peace.
	Republic Act No 7305	Policy that emphasizes improving well-being, as well as skills development of health workers
	Republic Act No. 9710	A policy that aims to protect against violence to women in society

	Department of Health Administrative Order No. 2012-0020	Issuance strengthens the government policy of ensuring occupational safety and service provisions for health workers.
	Executive Order No. 51 of 2018	Issuance protects worker rights by preventing illegal contracting or subcontracting.
	Republic Act No. 11058	A policy that emphasizes the importance of hazards in the workplace
	Department of Health Administrative Order No. 2022-0016	Issuance that provides guidelines for health workers in response to the COVID-19 pandemic
	Department of Health Administrative Order No. 2020-0038	Issuance that formulates a procedural work-out for human resources for health deployment under the NHWSS
	Department of Health, Department of Labor and Employment and Civil Service Commission Joint Administrative Order No. 2023-001	Issuance that creates a framework for the creation of healthy workplaces under the UHC Law
Capacity development	Republic Act No. 7883	Policy that grants barangay health workers opportunities for skills training and career enrichment
	Republic Act No. 10354	Policy that empowers local government units in the promulgation of responsible parenthood and reproductive health
	Republic Act No. 10767	Policy that provides a comprehensive strategy for elimination of Tuberculosis via a multi-sectoral approach
	Department of Health: Human Resource for Health Philippine Masterplan 2020-2040	Issuance that provides a long-term strategic plan for the creation and maintenance of human resources for health

Source: Author's illustration on relevant policies, quality of work-life, and capacity development

4.2. ASEAN remuneration comparison

We conducted a reconnaissance of remuneration policies of ASEAN countries. Table 19 illustrates the common financial incentives, the ASEAN countries that provide their public HRH with these monetary benefits, and the countries in which these apply. Across ASEAN, health worker remuneration in the public sector is anchored in civil service pay structures, with standardized base salaries often supplemented by various allowances and incentives. **Please refer to the appendix for the details.**

The most common financial incentives for public HRH in ASEAN countries are the remote area assignment allowance and the service or function allowance. Many, if not all, ASEAN countries included in this policy scoping have experienced recruitment and retention issues of public health workers in remote areas. These remote allowances supplement the basic monthly salary of public RH, some ranging from adding 50% of their salaries to providing an overall higher remuneration package. Also, the service or function allowance is a general incentive for all civil servants in most ASEAN countries, or professions considered ‘critical’ or vital in public service. For the details of the other financial incentives unique to each ASEAN country, **Box 3** briefly analyzes these benefits and how other factors, such as dual practice, influence public HRH retention.

Table 19. List of common financial incentives among ASEAN countries for public HRH

Financial Incentives	Philippines	Cambodia	Indonesia	Laos	Malaysia	Myanmar	Thailand	Vietnam
Monthly salary	✓	✓	✓	✓	✓	✓	✓	✓
Remote area allowance			✓	✓	✓	✓	✓	✓
Hazard pay	**✓			✓	✓	✓		
Position allowance					**✓		**✓	**✓
Shift allowance	**✓			✓		✓	✓	
Overtime pay	**✓			✓				
Service/ function allowance			✓	✓	✓	✓		✓
Cost-of-living allowance / Relocation allowance	**✓				**✓		**✓	✓
Housing allowance					**✓			
Transportation allowance	**✓		✓	✓				
Capitation share/user fee share	✓	✓	✓					✓
Tax allowance / exemption			✓			**✓		
Additional allowances	✓	✓	✓	✓	✓	✓	✓	✓

Notes: The checks with asterisks are benefits that are not provided to all due to job classification, their type of employment or other additional requirements they need to qualify to be provided with their incentives or allowances; the transportation allowance in some countries is only for official travel or only applicable to certain positions; the cost-of-living allowance is a form of economic relief allowance while the relocation allowance is for civil servants or public HRH that have to relocate to another area for their profession.

Source: Authors' illustration on the available or utilized financial incentives for public HRH across ASEAN countries

Box 3. Analysis of ASEAN Remuneration Policies

Some ASEAN countries provide unique financial incentives or have implemented drastic salary reforms to improve HRH retention and recruitment. These incentives are provided to public HRH or applicable civil servants in their respective countries. Unique allowances, such as a non-private practice allowance, are provided to medical doctors in Thailand to prevent them from engaging in dual practice with the private sector. For civil servant benefits that apply to public HRH, a concurrent allowance is provided to officials who hold multiple positions and responsibilities in Vietnam. In Myanmar, awards and remuneration incentives are provided for civil servants who go beyond their scope of work. For the salary reforms, Vietnam's Decree 33/2023 ND-CP mandated provincial authorities and government agencies to allocate a portion of their unutilized funds (not including budget for personnel salaries and benefits) and additional revenue, including public health facilities (at least 35% of their generated revenue), to be set aside and augment the salaries of their employees in line with the new policy. In Thailand, the provision of their monthly remuneration is split by the Ministry of Public Health (MOPH) and their respective health facility. The MOPH provides the position allowance and living maintenance allowance, while their respective health facility finances the non-private practice allowance, remote area allowance, and overtime pay. The provision of the base salary, however, is dependent on the job classification (i.e., temporary employee, civil servant, government employee, etc.) of the public HRH, as the MOPH covers the civil servants, government employees, and permanent employees, while the health facilities provide the basic salaries of temporary employees.

Dual practice is permitted among public HRH across ASEAN. All countries examined in this policy scoping have been reported to permit the practice of dual practice by their public health workers. This is mainly caused by the low salaries in the public sector despite the numerous financial incentives to which they are entitled. Public HRH in ASEAN can dual practice during their off hours at their public health facility. Aside from dual practice, health workers also indulge in informal practices and even illegal practices, as reported in Laos. Some reported practices of these are health workers who are selling the medicines to patients directly, providing care to patients at their clients' residences, and even falsifying forms and documents without conducting a proper diagnosis.

Source: Authors' analysis upon reviewing ASEAN public HRH remuneration policies

4.3. *Assessment of accessibility of HRH welfare services and policy and implementation limitations (SO2b and SO2c)*

4.3.1. Challenges in HRH salaries

Empirical evidence indicates a statistically substantial wage differential between public and private health workers. The results from our pooled Ordinary Least Squares (OLS) regression analysis of the 2021-2023 Labor Force Survey show that the wage differential between public and private health workers is statistically significant. On average, wages in the public sector are 17.6% higher compared to the private sector, holding other variables constant. This public-private differential in wages is more conspicuous among female health workers. The positive and sufficient correlation suggests that public health workers are better compensated than their private counterparts. This model also controls for time to account for any temporal wage variations. This wage premium in the public sector could reflect better job security, benefits, or other institutional

factors typical in public sector employment, which will be discussed in the previous and succeeding sub-sections.

Table 20. Regression Results on Public-Private Wage Differential

VARIABLES	log(wage)		
	(1) All	(2) Male	(3) Female
Ownership	0.176*** (0.0149)	0.145*** (0.0250)	0.190*** (0.0186)
Age	0.0236*** (0.00526)	0.0238*** (0.00895)	0.0234*** (0.00643)
Age squared	-0.000188*** (6.48e-05)	-0.000164 (0.000110)	-0.000199** (7.91e-05)
Sex	0.0360** (0.0154)		
<i>Region</i>			
Region II (Cagayan Valley)	-0.0173 (0.0519)	0.123 (0.0947)	-0.0783 (0.0620)
Region III (Central Luzon)	0.0521 (0.0405)	0.131* (0.0745)	0.0126 (0.0487)
Region IV-A (CALABARZON)	0.0453 (0.0424)	0.0985 (0.0835)	0.0276 (0.0494)
Region V (Bicol Region)	-0.153*** (0.0466)	-0.0828 (0.0890)	-0.182*** (0.0545)
Region VI (Western Visayas)	-0.0637 (0.0440)	-0.0346 (0.0819)	-0.0724 (0.0522)
Region VII (Central Visayas)	-0.0312 (0.0450)	-0.00618 (0.0804)	-0.0418 (0.0542)
Region VIII (Eastern Visayas)	-0.161*** (0.0485)	-0.183* (0.0936)	-0.134** (0.0548)
Region IX (Zamboanga Peninsula)	-0.177*** (0.0512)	-0.233** (0.0946)	-0.148** (0.0607)
Region X (Northern Mindanao)	-0.0222 (0.0446)	-0.0636 (0.0818)	-0.00725 (0.0528)
Region XI (Davao Region)	0.0176 (0.0469)	0.102 (0.0900)	-0.0251 (0.0531)
Region XII (SOCCSKSARGEN)	-0.184*** (0.0489)	-0.203** (0.0884)	-0.173*** (0.0592)
National Capital Region (NCR)	0.277*** (0.0378)	0.318*** (0.0713)	0.262*** (0.0448)
Cordillera Administrative Region (CAR)	0.0848** (0.0424)	0.0784 (0.0795)	0.0803 (0.0500)
Autonomous Region in Muslim Mindanao (ARMM)	-0.287*** (0.0880)	-0.478*** (0.145)	-0.262*** (0.100)
Region XIII (Caraga)	-0.161***	-0.0925	-0.188***

	(0.0498)	(0.0919)	(0.0592)
MIMAROPA Region	-0.212***	-0.191**	-0.221***
	(0.0512)	(0.0936)	(0.0610)
<i>Civil status</i>			
Married	-0.0804***	-0.141***	-0.0505**
	(0.0178)	(0.0302)	(0.0220)
Widowed	-0.342***	-0.321***	-0.322***
	(0.0597)	(0.0948)	(0.0688)
Divorced/Separated	-0.280***	-0.433***	-0.233***
	(0.0340)	(0.0710)	(0.0385)
Annulled	0.409***		0.454***
	(0.149)		(0.148)
Unknown	-0.0663	0.361***	-0.408***
	(0.255)	(0.0592)	(0.0582)
Constant	5.815***	5.814***	5.903***
	(0.108)	(0.176)	(0.126)
Observations	14,292	4,404	9,888
R-squared	0.106	0.125	0.104

Robust standard errors in parentheses

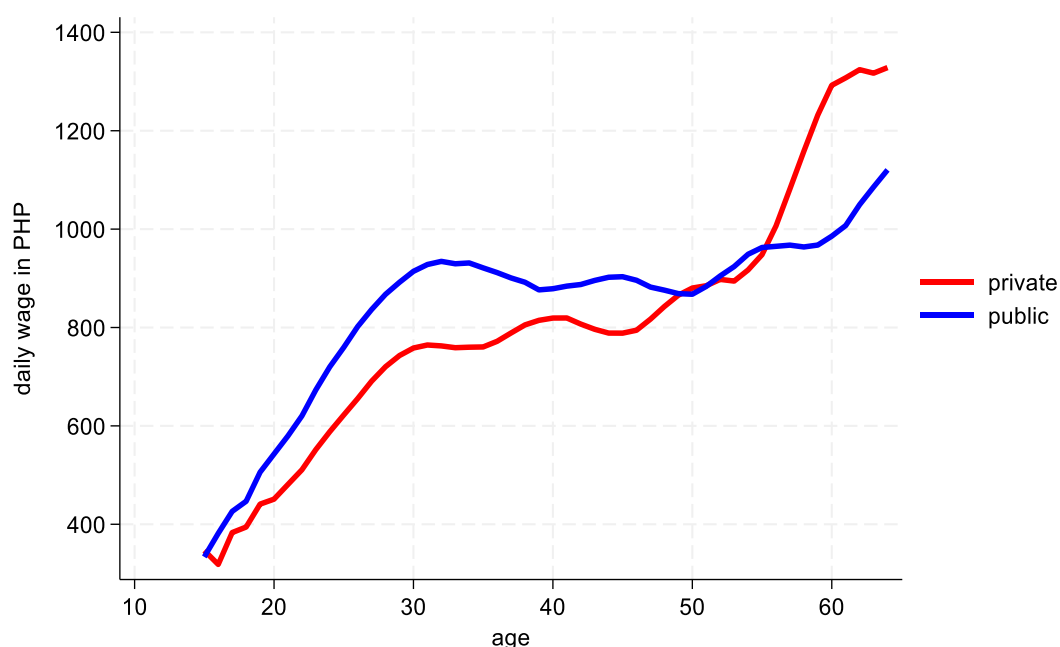
*** p<0.01, ** p<0.05, * p<0.

Source: Authors' analysis of pooled 2021-2023 Labor Force Survey (LFS)

The wage differential between the public and private sectors shows notable variations across age groups. While the average wage in the public sector tends to be higher, this pattern changes depending on the age group. In the public sector, wages increase rapidly but hit a plateau in the 30s, whereas, in the private sector, wages continue to rise steadily and surpass public sector wages toward the age of 60. However, this generalized wage differential may not fully capture the complexities across healthcare cadres. The available wage data is not by cadre. Among physicians, dual practice can significantly influence overall earnings, particularly for specialists in the public sector, who may supplement their income by providing services in private hospitals or clinics. Since this might not be fully captured in the survey, there is a gap in understanding the true wage differential between the sectors. The lack of transparency and comprehensive data, particularly for high-earning cadres like physicians, complicates efforts to assess wage differentials accurately. Without clear data on the extent of dual practice, including the income it generates for healthcare workers, it becomes difficult to paint a complete picture of compensation across the public and private sectors. This gap in data is particularly pertinent for policies aimed at improving healthcare workforce distribution and retention, as it leaves a significant portion of healthcare worker earnings unaccounted for in wage analyses.

The wage structures for other cadres, such as nurses, midwives, and allied health professionals, may show different patterns from those of physicians. Public sector nurses, for example, often benefit from structured salary increases through government-mandated systems like the Salary Standardization Law, while private sector nurses may experience less predictable wage growth. This cadre-specific variation in wage progression underscores the need for a more nuanced analysis of wage differentials that consider the employment sector and the specific roles within the healthcare workforce.

Figure 18. Estimated daily wage of public and private healthcare workers PhP, by age



Source: Authors' analysis of pooled 2021-2023 Labor Force Survey (LFS).

Note: We used restricted cubic spline regression (i.e., 10 knots for the age 18-70 years old) to predict the daily wage of private and public sector by yearly age.

The salary differentials between the public and private HRH entice health workers in the country to either practice in the public sector or look for other high-paying opportunities. Our data and the input from our respondents have made the wage disparity among sectors very clear. When discussed with a representative from an HRH association in the Philippines, despite the ‘calling’ of the profession, our health workers in the country need to have good wages to take care of themselves as well.

“Even if a nurse is called to serve, they too have [financial] needs. As a profession for that matter, they should receive the amount of salary that they deserve to earn given the difficulty of their profession. Nurses are not dignified with the salaries they receive. It’s sad but it’s true. The salaries and benefits they receive in other countries are far greater compared to here.” – D1

“The situation wherein our healthcare workers in the country work their hardest but only receive the minimum salary rates is really saddening. Although their employers don’t violate the labor code because they provide the prescribed wage rates it’s just sad to see that the monetary investments put in their education does not reflect back in their demanding line of work” – C4

From labor unions to medical associations, LGUs, public health facilities, and even NGAs, all respondents agree that HRH workers in the Philippines should be paid more, especially with private HRH, as the pay disparity is significant compared to the public HRH. Respondents from medical labor unions have even postulated that the salary increases for private HRH should be ratified through legislation like the SSL. This is caused by the dismay of the medical labor groups,

who described the wage increase through the Wage Boards as too minimal and did not consider other miscellaneous expenses of employees aside from the expenses they spend on their daily subsistence.

“One of the calls that our group has constantly asked from the government is to make the salary increases across all labor sectors, private health workers included, materialize it through legislation and not through the Wage Boards.” – D3

Underpayment of minimum wages in the private healthcare industry has been considered one of the top violations of general labor standards in recent years. In a KII with a representative from another attached agency of DOLE, the Bureau of Working Conditions (BWCs), the respondent cited that private hospitals and/or clinics provide wage rates below the regional minimum wage rates. The bureau’s labor inspectors inspect these healthcare facilities; they examine the private establishments per region and determine if private HRH employers comply with the General Labor Standards (GLS) and the Occupational Safety and Health Standards (OSHS).

Table 21. Violation of minimum wage provision in the private healthcare sector

Underpayment of Minimum Wage Rates in the Private Healthcare Industry					
	2018	2019	2020	2022	2023
Compliance Rate (%)	83.5%	87.53%	91.52%	94.74%	91.17%

Note: Fiscal year 2021 did not have underpayment of minimum wage as part of the top five violations

Source: Labor Inspection Data: Healthcare Industry: Bureau of Working Conditions

Although compliance with the underpayment minimum wage rate has primarily increased over the years, it was still counted as one of the top five GLS violations in five out of the last six years. Its compliance starting from the fiscal year 2018 was at 83.5%, which ultimately ended past ninety (90) percent with 91.2% in 2023 but experienced a slight decrease in compliance in comparison with 2022 and 2022’s compliance rates, which were at 91.5% and 94.7% respectively. It is important to note that the compliance rates are relative to the total number of establishments the BWC inspected in each region per fiscal year.

Private healthcare compliance with GLS remains an issue, while the compliance rate with OSHS standards is even more alarming. Like the observation on the compliance to the regional minimum wage rates, although the private healthcare industry’s compliance with the labor standards in the country continued to rise over the years, the data from BWC suggests that there is yet to be full compliance with the labor standards in the private healthcare industry within the Philippines. GLS, which are legally mandated benefits entitled to employees within a private institution, which includes the provision of minimum wage rates, only maintained an average of 70.8% compliance rate across the last six years. At its lowest, it recorded a staggering 52.7% in the fiscal year 2018. For OSHS, which ensures that all employers must provide a safe working environment to minimize potential risks in all professions, the compliance rate is way lower than the GLS. OSHS compliance rate only maintained a 50.9% compliance rate from 2018 to 2023 and

recorded its lowest compliance record in 2019, where only 29.8% of inspected private health facilities complied with OSHS guidelines.

Table 22. Compliance with GLS and OSHS in the private healthcare industry, 2018-2023

Region	Compliance Rate											
	2023 (as of June 2023)		2022		2021		2020		2019		2018	
	GLS (%)	OSHS (%)	GLS (%)	OSHS (%)	GLS (%)	OSHS (%)	GLS (%)	OSHS (%)	GLS (%)	OSHS (%)	GLS (%)	OSHS (%)
NCR	76.79	41.96	80.65	41.94	84.68	51.91	76.32	53.95	60.51	27.9	49.14	44.57
CAR	100	100	81.25	56.25	77.78	55.56	50	50	91.67	50	56.25	100
Region I	63.64	63.64	60	6.67	71.43	42.86	33.33	33.33	44.83	6.9	75	100
Region II	85.19	44.44	47.27	40	0	50	83.33	58.33	28.57	0	28.13	37.5
Region III	78.57	64.29	81.69	61.97	63.04	56.52	70.59	35.29	46.9	11.5	49.18	52.46
Region IV-A	76.27	54.24	88.1	80.95	83.78	86.49	77.78	72.22	71.17	41.44	52	70
MIMAROPA Region	100	100	100	66.67	60	40	100	0	100	50	100	0
Region V	80	46.67	76.92	48.72	75	75	50	50	83.33	75	100	100
Region VI	90.48	80.95	87.3	71.43	66.67	66.67	100	100	78.13	31.25	66.67	100
Region VII	73.53	41.18	87.8	70.73	33.33	33.33	83.33	33.33	64.58	29.17	43.48	65.22
Region VIII	88.89	44.44	57.69	53.85	33.33	33.33	100	100	46.15	15.38	50	50
Region IX	0	0	83.33	50	66.67	33.33	-	-	34.62	15.38	40	40
Region X	96.55	75.86	82.46	73.68	84.62	92.31	50	50	67.74	35.48	63.64	54.55
Region XI	56.25	62.5	84.78	47.83	72.73	54.55	100	62.5	71.43	38.78	65.85	78.05
Region XII	66.67	66.67	73.17	63.41	95.45	50	40	20	61.9	47.62	61.11	86.11
CARAGA Region	50	25	63.64	45.45	100	0	-	-	55.56	5.56	66.67	53.33
Total	77.04	52.54	79.81	53.93	79.15%	55.92%	74.55	53.33	61.44	29.79	52.72	59.76

Source: Labor Inspection Data: Healthcare Industry: Bureau of Working Conditions

Private HRH personnel must utilize collective bargaining agreements (CBAs) to negotiate for higher salaries. Since the regional minimum wage rates govern the salaries, private HRH need to be proactive and negotiate with their employers if they wish to get higher pay. This was corroborated by our KII with NWPC (attached agency of DOLE) when we inquired about the wage setting per region.

“The minimum wage is the floor wage. Nobody should be paid below the floor wage. As it is, the purpose is to protect vulnerable workers from undue work pay. These are mostly unskilled workers and those who are not organized. Specifically, we believe that the skilled professionals similar to those in the health sectors, they are skilled, organized, and have the capacity to bargain for higher wages because of the skills they possess.” – C3

“The main policy of the state and the law governing us is that the primary mode of setting wages is negotiation. Not necessarily an organization or through labor unions. As much as possible, the state doesn’t want to intervene in these things because we want the market to drive it. – C3

NWPC described that there is a misconception as some perceive the minimum wage rates as a ‘ceiling’ for private institutions in providing salaries when it is only the floor wage employers must comply with in each region. The purpose of the regional minimum wage rates is focused on

unskilled laborers, highlighting the crucial role of collective bargaining within the private health sector for private HRH to achieve higher salaries.

In the public sector, pay disparity persists amongst public HRH because their salary rates depend on the income class of their LGU. The 1999 IRR of the Magna Carta established that public HRH are entitled to the salary rates at the national level.¹⁶ However, the RA 6758 (Compensation and Position Classification Act of 1989) shall apply to the salary scale of public HRH. This contradicts the equality in pay scale clause in the IRR because RA 6758 reinforces that payments to the employees of LGUs are dependent on their income classification (DOH 1999). With each iteration of the SSL emphasizing the salary rate's dependency on an LGU's income classification, the salary progression of public HRH varies. This pay disparity is corroborated by the respondents, expressing concern about the retention of public HRH in lower-income LGUs (A2 2024; D2 2024) .

“The challenge is on standardizing the salary. How come the national employees receive higher salaries than us and is there any difference on the provision of service when you're providing it in a 5th class LGU and a 1st class LGU? Does it mean that the quality of service is different in a 5th class LGU because they have a lower salary? It should be standardized.” – D2

“We do our work the same as they [higher-income LGUs] do with the limited means we have. We have the same job so why is there a gap in our salaries when all professional health workers do the same work?” – A2

Many public HRH are not entitled to benefits, have no job security, and most likely do not receive their entitled Magna Carta benefits due to their employment status. The respondents highlighted budget constraints when probing why many of their HRH are JO, COS, and contractual employees. This is a bottleneck for the regularization of HRH, especially in LGUs, since the creation of Plantilla positions would have to be charged under their total PS budget, which is already limited by the PS limitation. Additionally, HRH are not the only employees in their respective localities, so they must forecast the granting of Plantilla positions to ensure that their LGU can absorb the additional cost in their PS budget, as Plantilla positions also have additional monetary benefits that must also be provided.

JO and COS employees are easier to hire because they have no entitled monetary benefits, and the budget for their salaries is sourced from the MOOE. Because of the PS limitation for regularizing their HRH personnel, LGUs and public health facilities hire JO, COS, and contractual HRH to augment their staff. Sourcing the salaries from the MOOE bypasses the PS limitation. It is more financially feasible for LGUs to absorb as they would only have to pay for the basic salary of these personnel. This dynamic has been described with the KII with DOH-BLHSD and corroborated from the interviews with LGUs (B1 2024; C1 2024).

“If you really want to increase the number of your HRH, you will need to hire through job orders. You will be able to utilize your MOOE for salaries and not your PS budget.” – C1

¹⁶ Rule XV, Section 4: Equality in Salary Scale (IRR of Magna Carta of Public Health Workers 1999)

“We can’t just provide the Plantilla positions instantly since the requests will first be sent and assessed by DBM which can take a long time. We hire COS workers because it more likely to be permitted since COS don’t receive any benefits” – B1

LGUs must strategize how they convert their JO, COS, and/or contractual employees to Plantilla positions. After LGUs forecast their financial capacity for absorbing new Plantilla positions, converting these employees to Plantilla is mostly done gradually despite the demand for HRH regularization. They must also consider employees from LGUs that work in other sectors that are also lobbying for regularization (A2 2024; A5 2024).

“For example, when we need 10 nurses in our LGU but with the budget we have can only regularize two of them, we first convert these two into Plantilla employees and hopefully after a year or two if our budget increases from the allocation from the national government, we can then regularize maybe two or three nurses to Plantilla positions. We do it incrementally until we reach the required number of Plantilla HRH.” – A5

“Most of the office in our LGU are one-man office so I don’t want to be selfish and always lobby Plantilla positions for our HRH because I know other departments are also struggling and understaffed. As much as I want to demand for Plantilla positions, I don’t always do it because I fully understand the limitations of our LGU, no matter how much our office or our LCE is willing to hire. We just make the most of what we have” – A2

The lack of Plantilla items and the waiting time to be granted regular status greatly influences HRH retention, making JO, COS, and contractual personnel apply to other offices or facilities with available Plantilla items. With the limited available Plantilla items for public HRH to apply to, they opt to find other offices or opportunities where they can be hired as regular employees. LGU representatives cited their experience as their HRH applied to another office to attain a Plantilla position, and DOH-HHRDB corroborated this phenomenon (A1 2024; C2 2024).

“There was an instance in our LGU where our HRH were looking for jobs at the Department of Education as a School Nurse because we couldn’t provide the security of tenure.” – A1

“We also experience an internal migration from rural to urban. From local public health facilities to national offices. This trend is happening because of the issue on salary.” – C2

“Actually, I have staff who tell me ‘Doc, I’ll take SG 12 or SG 10 as long as it’s permanent.’ But our Finance Committee said this wasn’t allowed... You’re not allowed to take a lower salary grade but this is too demoralizing to our healthcare workers.” – A2

The Philippine government has had issues with the number of JO, COS, and contractual employees ever since, with total JO and COS reaching past 832,000 in 2024.¹⁷ Employees can wait up to years, even decades¹⁸, before receiving a Plantilla position.

¹⁷ 580,323 or 69.68% of all COS and JO workers in the government work in LGUs (Panti 2024)

¹⁸ A3 cited that a health worker in their facility waited 20 years to obtain a Plantilla position.

Health workers who aspire to get a Plantilla position in their respective LGU or public health facility face the challenge of job security since only a limited number of Plantilla positions are available. As a result, LGUs and public health facilities hire through JOs or COS to supplement the number of their staff. Per policy, JOs and COS workers are only hired during emergencies when a job arises, and technical expertise is needed to complete a project. COS and JO employees should neither be hired to perform the regular functions of regular employees in their respective agencies nor be hired to perform any supervisory roles toward Plantilla personnel. CSC regulations on benefits do not cover them, so they are not entitled to any benefits or security of tenure. Their services cannot be credited as government services. They can only be hired for a maximum of one year and are subject to renewal by the head of their concerned office (DBM and COA 2020; RP 1987). Despite the limitations this can put on the earning potential of public health workers, they still opt to be hired through this employment status because the pay is higher compared to the entry-level rates in private health facilities or they want to gain more work experience (DOH 2021b). **Table 23** depicts the reasons for considering the disadvantages of working as a COS/JO HRH in the Philippines.

Table 23. Advantages and disadvantages of JO/COS workers

Considerations	Disadvantages
Acquire necessary work experience No CSC eligibility No available Plantilla position Lacking work experience Higher entry-level pay compared to private health facilities	No monetary and statutory benefits Not creditable as government service Fewer work-related training opportunities Constant fear because of no job security Subject to CSC guidelines but have a no employer-employee relationship

Source: Authors' illustration of the considerations and disadvantages for getting hired under COS/JO according to the NHRHMP 2020-2040

This lack of job security for JO/COS HRH can be a problem for public health workers, especially those working at local health facilities undergoing an administrative transition. The jobs of JO/COS HRH can be removed if the local chief executive views that there is no longer any need for supplemental staff for their local health facility or when health is not considered as an agenda. Findings from the KIIs highlight the disadvantages of being hired under JO/COS (A1 2024; A3 2024).

“We have to consider the political aspect. I hope they [COS/JO public HRH] don’t become victims of politics because health workers have a very crucial role, and we continue doing our job regardless of if we support a politician or not. Nurses we’re even transferred to waste management positions so they can clean instead.” – A1

“There are trainings that exclude our JO HRH. When we try to approve their budget requirements to our budget officer, they remove the JO personnel. That’s one of the problems that we experience so what we do instead is we assign them as the secretariat for documentation; we find a way for them to also go to trainings.” – A1

“Benefits such as hazard pay, laundry allowance, subsistence allowance, transportation allowance – RATA, midyear bonus, and 13th month bonus, yes – we have all those. But those are for regular employees only.” –A3

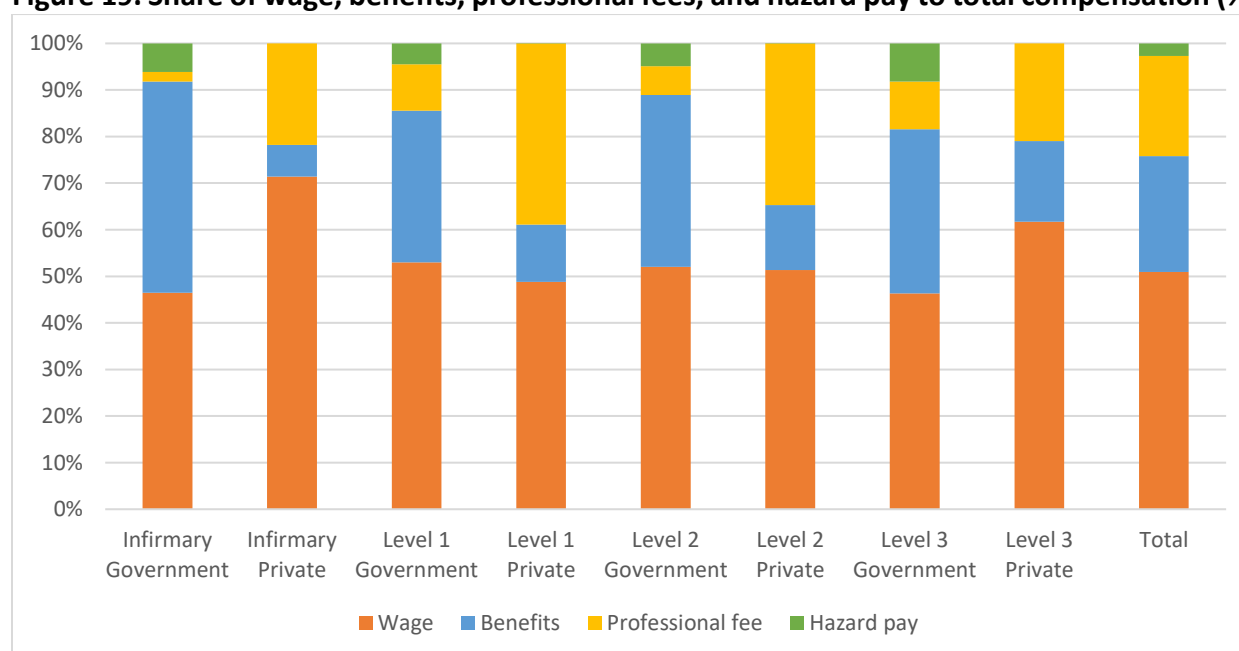
This lack of job security and enforcement issues on the Magna Carta can heavily influence the retention of public health workers. As a result of these disadvantages and the realization of the importance of JO/COS HRH during the COVID-19 pandemic, one public health facility created a healthcare benefit for the retention of their contractual health workers. Although this is a good practice that public health facilities and LGUs can explore, this initiative was made possible with support from their local chief executive (LCE) in providing benefits to their JO/COS personnel. The lack of available Plantilla positions for public HRH influences health worker retention, causing internal migration as health workers try to find vacant positions to apply elsewhere. The incentive to move to another government office or facility that provides higher salary rates is made a bigger problem for LGUs that provide lower salary rates due to their income classification and the pay differential by the SSL (B1 2024).

“I presented my health care proposal to the mayor, and they were already considering this idea since plantilla employees had hazard pay while contractual employees don’t receive it. We have to make it equal so our COS employees can stay. We increased their salaries and gave them health cards. This move, however, also enticed HRH from nearby hospitals to move to our facility.” – B1

4.3.2. Challenges in the implementation of other cash and non-cash benefits

Across all levels, public health facilities allocate a higher percentage of total compensation to benefits than private facilities. The difference is most pronounced at the infirmary level, where public infirmaries spend almost half of total compensation on benefits, while private infirmaries allocate only less than 10%. This trend continues but narrows as facility levels increase. Level 3 government hospitals spend 35% of compensation on benefits, compared to 17% in private Level 3 hospitals. While public hospitals spend more on benefits and hazard pay, private facilities allocate more compensation to professional fees, especially in the Level 2 and Level 3 categories, where private facilities spend more on professional fees than public facilities. This spending pattern suggests private facilities may attract health workers through higher professional fees. In contrast, public facilities rely more on comprehensive benefits packages and hazard pay to support their workforce.

Figure 19. Share of wage, benefits, professional fees, and hazard pay to total compensation (%)



Source: Authors' analysis of hospital financial statements data and the DOH Health Facility Statistics Report

Table 24. Average compensation and benefits per FTE Staff, in PHP

	Total compensation per FTE staff	Wage per FTE staff	Benefits per FTE staff	Hazard pay per FTE staff	Professional fees per FTE Physician
Infirmary Government	295,709.47	165,531.46	118,047.35	22,088.43	562,949.54
Infirmary Private	105,502.78	78,094.64	9,433.64	0	1,108,752.72
Level 1 Government	428,729.42	207,432.80	194,165.15	25,680.31	1,625,295.61
Level 1 Private	215,635.00	120,617.12	36,610.12	3,185.99	1,621,937.34
Level 2 Government	486,770.01	247,447.39	185,307.80	35,132.13	618,408.02
Level 2 Private	312,485.97	186,671.50	71,938.79	14,623.33	2,129,073.48
Level 3 Government	926,204.37	443,653.62	342,819.77	85,186.01	669,852.71
Level 3 Private	510,570.91	333,363.41	132,095.22	0	907,841.10
Total	375,231.95	204,379.85	141,171.49	34,667.62	1,517,861.46

Note: Full-time equivalent (FTE) represents the total number of full-time permanent and contractual workers.

Source: Authors' analysis of hospital financial statements data and the DOH Health Facility Statistics Report

The lower compensation in the private healthcare sector is likely a significant factor contributing to high turnover rates, particularly among certain cadres. As shown in Table 25, turnover rates are especially high for nurses and general physicians, with private-sector nurses experiencing the highest attrition. Public hospitals offer more stable employment packages, including higher base salaries, allowances, and additional benefits, which private facilities often struggle to match. Francisco and Macaranas (2014) explored the public-private wage gap for nurses in the Philippines, highlighting that multiple factors shape an individual's earning capacity.

These include human capital, such as job experience, professional background, and education; social capital, in the form of personal or professional networks; and the sector of employment, which influences wages, working conditions, and career advancement opportunities. They found nurses in the public sector receive higher salaries and better opportunities than their counterparts in private facilities, leading to higher turnover rates in the latter. Alibudbud (2023) further illustrated this disparity, noting that entry-level nurses in public hospitals earn between PHP 20,000 to PHP33,575. In contrast, private hospital nurses could earn half the public sector salary. This significant wage differential has driven many nurses to leave the healthcare sector for alternative employment, such as in Business Process Outsourcing (BPO) companies, where salaries and benefits are more competitive. BPOs actively recruit healthcare professionals, especially nurses, due to their health-related expertise. These companies also offer attractive perks, such as assistance processing U.S. Nursing Board licensure, further incentivizing nurses to leave local healthcare facilities.

Table 25. Health workforce indicators (Philippines)

Variable	All Hospitals (n=344)	National (n=29)	LGU-owned (n=97)	Private (n=218)
General Physicians				
<i>Staff to-bed ratio</i>	0.1 (0.1-0.2)	0.2 (0.1-0.4)	0.1 (0.1-0.2)	0.1 (0.0-0.2)
<i>% Staff contractual</i>	0 (0-50)	0 (0-20)	36 (10-58)	0 (0-42)
<i>% Filled positions (Permanent)</i>	100 (80-100)	84 (66-96)	76 (100-100)	100 (100-100)
<i>% Filled positions (Contractual)</i>	100 (80-100)	100 (58-100)	100 (100-100)	100 (56-100)
<i>% Turnover (Permanent)</i>	0 (0-10)	5 (0-16)	0 (0-6)	0 (0-14)
<i>% Turnover (Contractual)</i>	0 (0-28)	13 (0-44)	0 (0-34)	0 (0-0)
Registered Nurses				
<i>Met the staffing standards*</i>	142 (41)	14 (48)	62 (64)	
<i>Staff to bed ratio</i>	0.7 (0.5-1.0)	0.9 (0.6-1.1)	0.6 (0.4-0.8)	0.8 (0.5-1.1)
<i>% Staff contractual</i>	0 (0-44)	2 (0-24)	63 (33-76)	0 (0-0)
<i>% Filled positions (Permanent)</i>	92 (68-100)	92 (84-96)	94 (80-100)	90 (63-100)
<i>% Filled positions (Contractual)</i>	100 (92-100)	100 (100-100)	100 (96-100)	100 (48-100)
<i>% Turnover (Permanent)</i>	10 (0-30)	2 (2-4)	0 (0-3)	21 (10-38)
<i>% Turnover (Contractual)</i>	6 (1-26)	15 (6-18)	24 (0-12)	26 (0-100)

Source: Authors' analysis of hospital survey of PIDS

The Magna Carta benefits that LGUs are only required to provide are hazard pay, subsistence allowance, and laundry allowance. A KII with the Bureau of Local Health System Development (DOH-BLHSD) revealed that the only mandated benefits that LGUs must provide

are hazard pay, laundry allowance, and subsistence allowance, with the hazard pay not needing to be paid directly at full rates as per the KII (C1 2024). These are the only benefits being monitored in the LGU Health Scorecard because they are the benefits that LGUs most likely can provide to their HRH after consulting with DOH-BLHSD. Box 1 analyzes the KII with the DOH-BLHSD regarding the provision of Magna Carta benefits.

The provision of the Magna Carta benefits is subject to the availability of funds. Even if the LCEs prioritize the health field as one of their priorities or want to increase the salaries of their local HRH, they will not have the capacity to do so if they have an inadequate budget to provide the funds and the full national rates. As a result, pay discrepancies exist as LGUs provide different rates of Magna Carta benefits and salaries according to their income classification (C1 2024; C2 2024).

“We had a KII with one LCE and he/she wanted to provide the Magna Carta benefits but since their LGU only had a limited budget, they must strategize the use of their funds. Health isn’t the only sector that he/she is concerned with, they have public works, education, safety and security, etc. So, they should really budget their funds carefully.” – DOH-HHRDB

“The Magna Carta of Public Health Workers has a provision that says these benefits should be provided based on the availability of funds. Local HRH can file cases against LCE when they don’t provide the benefits but the easiest way out for the LCE is to show the books of the municipality showing the funds and the available amount they can only provide. They can easily withhold the benefits by showing them the only available funds their LGU has.” – DOH BLHSD

The DBM waived the PS limitation in 2022 to 2025 to allow LGUs more flexibility in using their budgets to provide the Magna Carta benefits to their public HRH (DBM 2022a, 2024a, 2025; RP 2023). However, as stipulated in the KIIs with DOH and LGUs, even if they are given more liberty to use their resources for the Magna Carta, it would still be difficult to implement with only limited resources.

Only 70% of LGUs provide Magna Carta benefits to their health workers. The poorer the LGU, the lower the compliance. Table 26 corroborates the stipulation of DOH-BLHSD, where the number of LGUs complying with the Magna Carta provision has increased yearly. This trend can be attributed to limiting the benefits to only hazard pay, laundry allowance, and subsistence allowance, which makes it more feasible for LGUs to comply.

Table 26. Number of LGUs providing the Magna Carta benefits by income classification per year, 2014-2022

LGU Income Class	Magna Carta compliance, n (%)								
	2014	2015	2016	2017	2018	2019	2020	2021	2022
1	202 (58.4%)	205 (56.6%)	213 (58.8%)	231 (60.6%)	248 (65.8%)	263 (68.8%)	289 (75.9%)	308 (80.2%)	305 (79.4%)
2	91 (49.5%)	91 (51.4%)	96 (53.0%)	110 (56.4%)	117 (60.0%)	130 (66.0%)	146 (74.1%)	153 (76.9%)	162 (81.0%)

3	125 (46.1%)	123 (44.6%)	128 (45.7%)	144 (48.8%)	154 (52.0%)	174 (58.6%)	187 (63.6%)	216 (72.5%)	229 (76.3%)
4	157 (42.2%)	150 (40.7%)	161 (42.9%)	170 (42.1%)	189 (46.6%)	214 (51.8%)	259 (63.2%)	292 (69.9%)	304 (72.6%)
5	76 (29.1%)	73 (29.0%)	72 (28.3%)	92 (33.6%)	97 (35.3%)	116 (42.0%)	144 (52.0%)	176 (62.2%)	183 (64.7%)
6	11 (44.0%)	9 (47.4%)	8 (38.1%)	11 (44.0%)	13 (50.0%)	18 (66.7%)	13 (52.0%)	16 (59.3%)	17 (63.0%)

Source: Analysis of the DOH – LGU Health Scorecard (2022)

The PS limitation was waived to enable LGUs to provide the MCPHW benefits, but the effects of increasing MCPHW compliance may be inconclusive. The DBM waived the PS limitation from 2022 to 2025 to allow LGUs more flexibility in using their budgets to provide the MCPHW benefits to their public HRH (DBM 2022a, 2024a, 2025; RP 2023).

In 2021, DBM also allowed LGUs to provide national or 1st class provinces/special city rates to pay their public HRH if they have adequate funds to finance this initiative in 2021 in line of the new tranche implementation from the SSL(RP 2020b). However, as stipulated in the KIIs with DOH and LGUs, it would still be difficult to implement with only limited resources, even if they are given more liberty to use their resources for the said benefits. Aside from this, respondents even cited collaboration issues with their local finance committee to implement this initiative, while others were unaware that the MCPHW benefits were waived.

“...the local finance committee, including the HR office in the localities in the LGUs, they don’t understand that the PS limitation is waived for HRH. They are not aware that health is exempted from the PS cap, which they always emphasize with us.” – D2

“You definitely need to coordinate this with the local finance committee, but we ended up not doing that because once the committee said that our LGU can’t finance these benefits because of the PS limitation, then we can’t have the said benefits. Even though DBM and DOH released a circular on the waiving of the PS limitation for health, our local finance team told us that we still have no additional funds to implement the MCPHW benefits.” – A5

“In our locality, the only items that were waived from the PS limitation are our terminal leave benefits and monetization of leave credits” – A5

The results from the KIIs indicate that removing the MCPHW benefits from the PS limitation may not have greatly influenced the increase in compliance from 2019 to 2022. LGUs were given more autonomy to utilize their resources for PS, but due to the lack of available budget and the consideration of budgeting the salaries of their other local personnel outside of HRH, the issue of budget remains despite being given more autonomy to finance the MCPHW benefits. Ultimately, limiting the entitled benefits with the hazard pay, subsistence, and laundry allowances for LGU compliance may have more effects to the increase of compliance over the years as per our KII with DOH-BLHSD.

Box 4. Experiences in the Implementation of the MCPHW

Providing the hazard pay with the laundry allowance and subsistence allowance were the chosen benefits to enable LGUs to provide the Magna Carta benefits. The DOH-BLHSD cited that after consulting with the local governments, the LGUs requested that the required Magna Carta benefits be the ones that will be more economically feasible for LGUs to comply. This is due to the provision of the hazard pay which already amounts to 25% of the basic pay of public health workers.

“When we consulted with the local governments, when we’re establishing the indicators [Magna Carta of PHWs compliance] in the LGU Scorecard and the Seal of Good Local Governance (SLGL), the LGUs requested to include parameters that are much easier for them to provide and comply with. The hazard pay is quite expensive, which is 25% of the basic pay of public health workers. The laundry allowance is quite affordable and can be given by the LGU but it’s still a good benefit included in the Magna Carta of PHWs, along with the subsistence allowance.” – C1

Limiting the provision of Magna Carta benefits has increased the number of compliant LGUs over the years. They stated that there has been an increase in compliance over the years when the Magna Carta benefits were limited to the hazard pay, laundry allowance, and subsistence allowance, over the years.

“The LGU Health Scorecard, we are measuring the implementation of Magna Carta benefits on three parameters so far only. So, this is just 3 parameters, this is the: (1) provision of the hazard pay, (2) provision of the laundry allowance, (3) and provision of the subsistence allowance. Only these three parameters. So, if you look at this implementation for the hazard pay, the national average is already at 75% as of 2022. The compliance rate is higher for laundry allowances. As of 2022, 93% of LGUs provide the laundry allowance while 94% provide the subsistence allowance. That’s a lot of difference considering that the implementation of the Magna Carta benefits for 2019 is as low as 56% in 2019.” – C1

The provision of the hazard pay can be provided in tranches to reach the full 25% over the years. DOH-BLHSD cited that lower-income LGUs from 4th to 6th class municipalities have difficulty complying with the hazard pay if they require them to provide the full 25% pay immediately. As a result, they enable them to provide the benefits without amounting to 25% of the basic pay of their HRH and still be considered as compliant to the provision of the Magna Carta.

“The provision of the hazard pay that is monitored is not exactly the full provision. If even a portion of the hazard pay has already been provided – because there are a lot of LGUs especially the 4th, 5th, and 6th class municipalities, providing the full 25% in just a single tranche will be quite difficult. So, if there’s an agreement to provide the 5% first then the following year increase it to 10% and then 15%, 20%, and eventually 25%, we already consider it as compliance with the provision of the hazard pay.” – C1

Source: Author’s analysis on the KIIs with C1 on providing the Magna Carta of PHWs benefits.

Magna Carta of PHW benefits is only given to regular employees despite its stipulation of including all public health workers regardless of employment status. The Magna Carta identifies its beneficiaries as ‘health workers’ who conduct health-related work in public hospitals and local health facilities regardless of their employment status (DOH 1999). However, the revised IRR of the MC PHWs in 2012 cited that it only covers casual, contractual, and regular employees

(DBM and DOH 2012). Contractual and casual employees are already entitled to the same benefits regular employees receive as per CSC regulations; these stipulations deprive JO/COS of the Magna Carta benefits due to technicality since their employment status is not mentioned specifically in the IRR even if their scope of work in delivering health services is the same as that of their contractual, casual, and Plantilla colleagues. **Table 27** provides the differences between the contractual employees and JO/COS.

Table 27. Distinction between Casual, Contractual, JO and COS Employees

Employment Status	Guidelines for Hiring	Duration	Applicable Benefits
Casual	<ul style="list-style-type: none"> Contracted for essential services when there is inadequate staff to meet the necessary demand for service For emergency cases and intermittent period Should not conduct the duties and responsibilities of a vacant Plantilla position 	Maximum of one (1) year and subject to renewal	Benefits of regular employees MC PHWs
Contractual	<ul style="list-style-type: none"> Contracted for specific work that requires technical expertise not available in their respective office for a specified duration Should not conduct the duties and responsibilities of a vacant Plantilla position 	Maximum of one (1) year and subject to renewal	Benefits of regular employees MC PHWs
Contract-of-Service (COS)	<ul style="list-style-type: none"> COS hiring is limited to consultants, learning service providers, and/or technical experts for special projects for a specified duration. Should not conduct any task that is within the job description of regular employees of their respective office Should not be designated to have supervisory roles over regular employees 	Maximum of one (1) year and subject to renewal	Premium payment of up to 20% of their salary but subject to the availability of funds

Job Order (JO)	<ul style="list-style-type: none"> • Hiring of JO is limited to emergency or intermittent work (i.e. clearing debris on roads, canals, waterways after natural/man-made disasters; trades and crafts; carpentry, plumbing, painting, electrical, etc.) • Should not conduct any task that is within the job description of regular employees of their respective office • Should not be designated to have supervisory roles over regular employees 	No indicated duration but subject to renewal.	Premium payment of up to 20% of their salary but subject to the availability of funds
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Source: Author's illustration on the distinction of Casual, Contractual, COS, and JO employees according to the 2017 Omnibus Rules on Appointments and Other Human Resource Actions (Revised July 2018) and the Updated Rules and Regulations Governing Contract of Service (COS) and Job Order (JO) Workers in the Government (2020).

Similarities can be identified in the guidelines for hiring each employment type, especially with the contractual and COS guidelines. The most common theme that these four employment types have is that they are only contracted to work for a specified period, and their work should not cover the job description of regular employees or the unfilled vacant Plantilla of their respective agency. Although contractual and casual employees are entitled to the Magna Carta benefits according to the IRR, the findings in our KIIs indicate that regular and casual employees only receive the benefits (A3 2024; B1 2024).

“Only casual and regular employees receive hazard pay while JOs don’t since there’s no employee-employer relationship.” – A3

“If we’re talking referring to Plantilla positions, yes, we provide hazard pay, laundry allowance, and subsistence allowance.” – B1

Apart from excluding contractual, JO, and COS public HRH from the Magna Carta, the sources for the payments under JO and COS are different. The Magna Carta benefits are budgeted under the PS of LGUs and public health facilities, while the salaries of JO and COS personnel are sourced from maintenance and other operating expenses (MOOE) (A1 2024; DBM and COA 2020).

“...the LGU is responsible for the salaries and other benefits of regular employees. It is mandatory for every budget preparation that the salary and other benefits, like the Magna Carta for Public Health Workers, are incorporated in the regular budget of the office. However, we also have our JO employees and contractual employees, they are also included in the budget, but they have a separate account. They are not directly included in our regular budget plan.” – A1

This limits the provision of Magna Carta benefits to Plantilla items. The budget allocation for JO/COS employees only consists of their salaries unless their employer provides additional compensation. Therefore, public HRH employed under Plantilla items mostly receive the benefits of the Magna Carta. Still, these benefits are limited due to the availability of funds and the three benefits that LGUs and public health facilities are most likely to provide, given their limited capacity to reinforce the Magna Carta benefits.

Most public HRH in LGUs and public health facilities are JO, COS, and/or contractual personnel. The findings in the KIIs indicate a common trend: most public HRHs are contracted through JO and COS. Regardless of income classification and type of public health facility, JO and COS workers are greater in number than regular or Plantilla HRH (A1 2024; A2 2024; A5 2024; B1 2024).

“Well, honestly speaking, if we are going to consider the total number, I think it is adequate. However, if we will also consider the employment of each employee, since only 6 out of 21 are regular employees of the LGU, and the rest are job order workers” - A2

“50%-60% of our HRH are contractual or JO” – A5

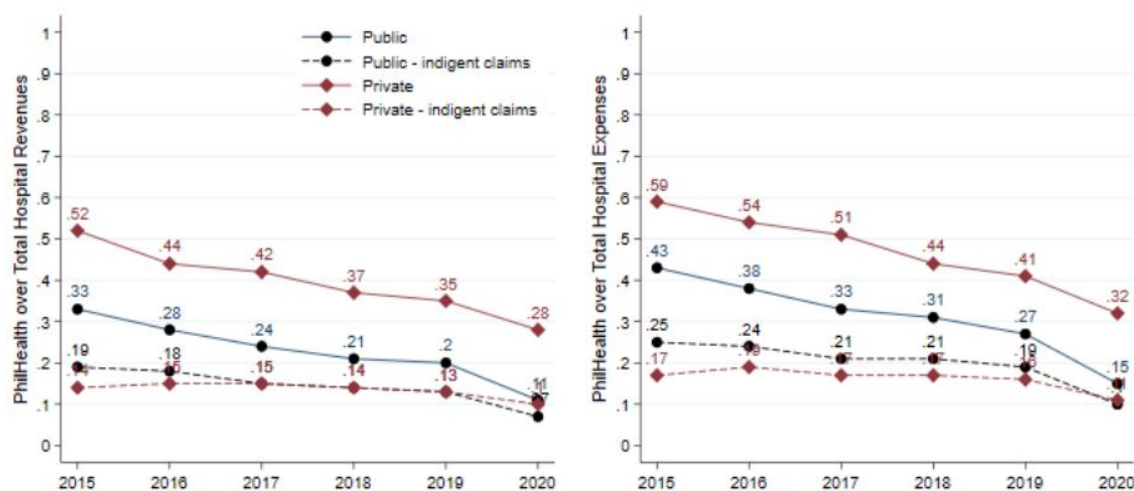
“The number of our regular employees are around 55-57 while the JO HRH amount to 83 personnel” – A1

“We have 846 employees. 356 are Plantilla positions while 490 are COS.” – B1

Many public HRH are not entitled to benefits, have no job security, and most likely do not receive their entitled Magna Carta benefits due to their employment status. The respondents highlighted budget constraints when probing why many of their HRH are JO, COS, and contractual employees. This is a bottleneck for the regularization of HRH, especially in LGUs, since the creation of Plantilla positions would have to be charged under their total PS budget, which is already limited by the PS limitation. Additionally, HRH are not the only employees in their respective localities, so they must forecast the granting of Plantilla positions to ensure that their LGU can absorb the additional cost in their PS budget, as Plantilla positions also have additional monetary benefits that must also be provided.

The best available data suggests that facilities may not optimize PhilHealth as a potential resource to augment personnel services and hospital operations. Estimating the contribution of PhilHealth professional fees and salaries from line-item budgets remains challenging due to limited financial data from hospitals. Understanding this contribution is essential to gauge the total amount of compensation, how much these fees supplement their income, and what incentives they provide. An analysis of hospital revenues related to PhilHealth reimbursements—where professional fees as part of the case rates are included—suggests a declining trend. However, triangulating PhilHealth and hospital financial statements from public and private hospitals reveals interesting patterns regarding the potential role of PhilHealth as a source of revenue and, in turn, an additional source of compensation. The ratio of PhilHealth reimbursements to overall hospital revenue is declining in public and private. However, the ratio is lower in public hospitals than in private hospitals. Private hospitals are more likely to utilize PhilHealth for their operations, including salaries and wages.

Figure 20. Revenue to PhilHealth reimbursement in public and private hospitals



Source: PIDS-DP No. 2021-36 (Uy et al. 2021)

While PhilHealth case rates are designed to cover total healthcare costs, user fees remain the primary source for funding operations, salaries, and wages in the private sector. The various challenges associated with PhilHealth reimbursements have led to an increased reliance on user fees. PhilHealth applies a non-differential rate across public and private facilities. To illustrate, the reimbursement for treating pneumonia is the same regardless of the provider type. Public facilities benefit from multiple revenue streams, including line-item budgets, salary subsidies, and capital investment operational expense grants from national and local governments. In contrast, private facilities rely on PhilHealth reimbursements and user fees to cover personnel services and operating costs. These non-differential payment rates, without any form of unbundling, create inefficiencies. The stagnation of PhilHealth’s case rates, which have not adjusted for inflation or rising healthcare costs since its implementation in 2013, exacerbates the situation. In an under-regulated environment, private providers often supplement their income by charging additional fees to offset “inadequate” PhilHealth reimbursements and cover market-driven, loosely regulated professional fees of private providers. In addition, issues stemming from untimely or unprocessed PhilHealth payments would affect the fiscal sustainability of the hospitals. Delays in benefit payouts have been documented in several studies, often noting an inefficiency in the claims processing done by PhilHealth (Cielo, Santillan, and de Claro 2024; Picazo et al. 2014). Impacting the financial management of these hospitals may lead to concerns related to delays in compensation or withholding of HCW benefits.

User fees charged at the point of service in private facilities and private beds in public hospitals are market driven. Professional fees charged to patients at the point of care are unregulated and lack a standard rate-setting process or procedure. Unlike their counterparts in government facilities, physicians in private facilities often do not receive any form of basic pay for providing care or earn significantly less. Sometimes, these physicians may receive compensation for administrative functions related to the hospital's operations. However, earnings from professional fees collected from outpatient consultations or hospital admissions largely impact their overall remuneration. We examined PhilHealth data to analyze user fees channeled to

both public (in basic and private wards) and private hospitals, as this provides insight into the extent of user fees on top of PhilHealth reimbursements. However, the hospital data may not fully reflect the total resources derived from user fees, as patients may pay private providers (both public and private) directly rather than through the facilities. This practice can vary by facility and may lead to underestimating the financial data we analyzed from PhilHealth and hospital financial statements (BIR 2014). Efforts by the BIR to monitor professional fee rates and the charging thereof have largely failed due largely to an initial restraining order from the Supreme Court, codified in a 2023 ruling¹⁹ that invalidated BIR requirements for submitting a fee schedule from professionals. No national government agencies monitor or regulate the professional fee schedule of HRH in the practice of medicine in the country.

Table 28. Median Value per PhilHealth Claim and Median Hospital Charges, 2018-2021

	DOH-retained		LGU Hospital		Private	
	Ward	Private room	Ward	Private room	Ward	Private room
Median value per claim	10,993	15,642	7,852	10,713	10,096	11,218
Median hospital charges	14,024	33,350	7,988	12,490	15,705	31,139
Support value	60%	45%	68%	61%	54%	40%
# of claims (%)	4.0 (92%)	0.3 (8%)	7.2 (93%)	0.5 (7%)	2.7 (26%)	7.8 (74%)

Source: Author's illustration on the Median Value of PhilHealth Claims in Hospital charges by ownership type (Uy et al. 2021)

To supplement our analysis of the challenges in implementing non-cash benefits in addition to salaries (i.e., salary supplements), we present findings from a provider survey conducted in public facilities across eight (8) provinces. The tables below present data on the annual monetary salary supplements received by medical doctors and allied health professionals (nurses and midwives) in public facilities across different provinces in the Philippines. The supplements include per diems for training, PhilHealth sharing, clothing allowances, duty allowances, cash gifts, and 13th-month pay, with notable variations across regions. PhilHealth sharing consistently provides the highest monetary benefit, while the 13th-month pay is widely received with relatively stable amounts. However, some supplements, such as duty allowances, are less commonly provided, with significant disparities between provinces. The data highlight disparities across LGUs.

¹⁹ Integrated Bar of the Philippines v. Philippine College of Physicians, et al., G.R. Nos. 211772 & 212178, April 18, 2023 [Per J. Leonen, En Banc]

Table 29. Annual monetary salary supplements of medical doctors by province (in PHP)

Monetary Salary Supplements	North & Central Luzon				South Luzon				Visayas				Mindanao				Overall N = 355 (100.0%)	
	La Union N = 127 (35.8%)		Benguet N = 21 (5.9%)		Batangas N = 50 (14.1%)		Laguna N = 30 (8.5%)		Iloilo N = 64 (18.0%)		Aklan N = 28 (7.9%)		Davao de Oro N = 22 (6.2%)		Sarangani N = 13 (3.7%)			
	n* (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)
Per Diem when attending training	45 (47.1%)	36,313 (39,614)	12 (3.8%)	11,120 (9,865)	15 (7.9%)	18,216 (22,752)	9 (2.5%)	9,652 (9,039)	36 (20.3%)	19,564 (19,960)	11 (8.3%)	26,072 (35,514)	3 (1.2%)	14,028 (13,899)	5 (9.0%)	62,160 (49,422)	136 (100.0%)	25,527 (31,496)
PhilHealth Sharing	103 (41.4%)	227,295 (181,596)	8 (3.9%)	274,770 (384,349)	21 (7.5%)	201,219 (257,422)	16 (8.3%)	294,188 (167,608)	38 (16.3%)	242,871 (132,685)	15 (10.8%)	406,479 (230,669)	17 (8.7%)	289,059 (126,556)	12 (3.0%)	142,832 (85,299)	230 (100.0%)	245,637 (193,168)
Clothing Allowance	93 (36.1%)	6,430 (5,765)	20 (6.9%)	5,725 (1,303)	41 (14.2%)	5,737 (2,058)	23 (8.2%)	5,896 (1,424)	50 (17.4%)	5,772 (1,262)	26 (9.3%)	5,942 (1,299)	13 (4.8%)	6,154 (801)	8 (2.9%)	6,000 (926)	274 (100.0%)	6,038 (3,561)
Duty Allowance	27 (51.2%)	56,444 (71,445)	3 (10.3%)	102,400 (84,728)	3 (7.5%)	74,000 (48,867)	5 (11.7%)	69,600 (51,194)	2 (4.4%)	64,800 (74,670)	1 (4.2%)	126,000 (.)	2 (7.0%)	104,500 (28,991)	1 (3.6%)	108,000 (.)	44 (100.0%)	67,586 (65,355)
Cash Gift	56 (38.4%)	15,194 (22,640)	10 (2.3%)	5,050 (2,242)	36 (9.3%)	5,736 (2,291)	21 (6.6%)	6,905 (5,585)	43 (16.9%)	8,686 (12,322)	17 (5.6%)	7,353 (5,037)	13 (6.5%)	11,000 (11,128)	7 (14.4%)	45,571 (48,156)	203 (100.0%)	10,903 (17,623)
13th Month Pay	100 (32.8%)	72,538 (17,204)	20 (7.5%)	82,644 (16,445)	40 (16.9%)	93,260 (128,886)	25 (9.1%)	80,438 (16,722)	50 (17.2%)	76,024 (17,150)	23 (8.1%)	77,768 (23,884)	13 (4.8%)	81,347 (12,964)	9 (3.6%)	87,618 (13,395)	280 (100.0%)	78,871 (51,266)

Note: *Number of providers who answered "yes" when asked if they received the following salary supplement

Source: Authors' illustration of the PIDS COBP-CATCH Healthcare Provider Survey (Conda et al. forthcoming)

Table 30. Annual monetary salary supplements of allied health professionals (nurses and midwives) by location (in PHP)

Monetary Salary Supplements	North & Central Luzon				South Luzon				Visayas				Mindanao				Overall N = 676 (100.0%)	
	La Union N = 162 (24.0%)		Benguet N = 35 (5.2%)		Batangas N = 159 (23.5%)		Laguna N = 121 (17.9%)		Iloilo N = 119 (17.6%)		Aklan N = 30 (4.4%)		Davao de Oro N = 31 (4.6%)		Sarangani N = 19 (2.8%)			
	n* (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)	n (%)	amount, mean (SD)
Per Diem when attending training	50 (37.7%)	34,019 (62,123)	21 (3.9%)	8,471 (9,920)	66 (20.6%)	14,102 (13,539)	34 (6.7%)	8,936 (9,836)	56 (15.1%)	12,166 (17,973)	15 (4.8%)	14,565 (21,341)	16 (3.9%)	10,922 (11,346)	14 (7.3%)	23,543 (22,460)	272 (100.0%)	16,609 (30,982)
PhilHealth Sharing	132 (42.8%)	77,204 (130,959)	15 (1.9%)	30,277 (20,721)	79 (10.7%)	32,246 (24,648)	89 (17.6%)	47,031 (36,198)	66 (13.4%)	48,437 (59,037)	15 (4.1%)	65,125 (51,941)	24 (6.6%)	65,516 (29,200)	19 (2.9%)	36,851 (27,297)	439 (100.0%)	54,270 (80,617)
Clothing Allowance	105 (19.9%)	6,095 (1,043)	34 (6.4%)	6,015 (1,395)	141 (25.9%)	5,914 (1,376)	92 (17.5%)	6,117 (4,157)	99 (18.4%)	5,983 (916)	29 (5.0%)	5,550 (1,526)	24 (4.6%)	6,167 (1,274)	13 (2.4%)	5,923 (494)	537 (100.0%)	5,995 (2,032)
Duty Allowance	40 (43.0%)	24,330 (16,979)	0 (0.0%)	. (.)	12 (27.4%)	51,752 (30,652)	9 (12.0%)	30,267 (14,889)	2 (6.2%)	69,600 (71,276)	2 (4.7%)	53,400 (43,275)	3 (6.6%)	50,000 (39,950)	0 (0.0%)	. (.)	68 (100.0%)	33,274 (25,963)
Cash Gift	86 (19.7%)	9,558 (10,572)	16 (3.5%)	9,129 (7,898)	133 (23.2%)	7,286 (5,920)	102 (20.2%)	8,295 (7,531)	91 (15.9%)	7,324 (6,872)	25 (4.7%)	7,820 (5,190)	27 (7.2%)	11,111 (10,562)	8 (5.7%)	29,625 (31,722)	488 (100.0%)	8,570 (9,043)
13th Month Pay	105 (19.0%)	33,219 (8,499)	34 (6.2%)	33,528 (7,700)	144 (27.9%)	35,570 (9,069)	98 (18.2%)	34,126 (8,686)	97 (16.7%)	31,519 (11,464)	29 (5.1%)	31,987 (9,543)	25 (4.5%)	32,794 (7,447)	14 (2.3%)	30,630 (10,257)	546 (100.0%)	33,568 (9,350)

Note: *Number of providers who answered "yes" when asked if they received the following salary supplement

Source: Authors' illustration of the PIDS COBP-CATCH Healthcare Provider Survey (Conda et al. forthcoming)

The coverage of non-monetary benefits, including intrinsic motivation, also varies across LGUs. In addition to salary supplements, we also examined the coverage of non-monetary benefits in selected provinces, including time-off, training opportunities, and awards/recognition, which are more consistently provided, though subsidized housing and food rations remain limited. Additionally, motivation scores indicate high intrinsic motivation and recognition levels among healthcare providers, though working conditions and employment security show room for improvement. These findings suggest that while certain incentives are widely accessible, coverage varies across local governments.

Table 31. Non-monetary compensation of medical doctors in the public sector

Non-monetary salary supplements	North & Central Luzon		South Luzon		Visayas		Mindanao		Overall N = 355 (100.0%)
	La Union N = 127 (35.8%)	Benguet N = 21 (5.9%)	Batangas N = 50 (14.1%)	Laguna N = 30 (8.5%)	Iloilo N = 64 (18.0%)	Aklan N = 28 (7.9%)	Davao de Oro N = 22 (6.2%)	Sarangani N = 13 (3.7%)	
Time-Off / Vacations, n* (%)	103 (81.1%)	20 (95.2%)	39 (78.0%)	26 (86.7%)	47 (73.4%)	21 (75.0%)	12 (54.5%)	9 (69.2%)	277 (78.0%)
Clothing, n* (%)	31 (24.4%)	4 (19.0%)	10 (20.0%)	9 (30.0%)	25 (39.1%)	12 (42.9%)	8 (36.4%)	2 (15.4%)	101 (28.5%)
Training, n* (%)	113 (89.0%)	15 (71.4%)	39 (78.0%)	21 (70.0%)	51 (79.7%)	19 (67.9%)	12 (54.5%)	9 (69.2%)	279 (78.6%)
Certificates / Awards/ Recognitions, n* (%)	103 (81.1%)	13 (61.9%)	40 (80.0%)	20 (66.7%)	47 (73.4%)	17 (60.7%)	10 (45.5%)	8 (61.5%)	258 (72.7%)
Food ration/meals, n* (%)	25 (19.7%)	3 (14.3%)	7 (14.0%)	6 (20.0%)	13 (20.3%)	12 (42.9%)	12 (54.5%)	10 (76.9%)	88 (24.8%)
Subsidized housing, n* (%)	0 (0.0%)	4 (19.0%)	1 (2.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (4.5%)	1 (7.7%)	7 (2.0%)

Note: *Number of providers who answered "yes" when asked if they receive the following salary supplement
Source: Authors' illustration of the PIDS COBP-CATCH Healthcare Provider Survey (Conda et al. forthcoming)

Table 32. Non-monetary compensation of allied health professionals in the public sector

Non-monetary salary supplements	North & Central Luzon		South Luzon		Visayas		Mindanao		Overall N = 676 (100.0%)
	La Union N = 162 (24.0%)	Benguet N = 35 (5.2%)	Batangas N = 159 (23.5%)	Laguna N = 121 (17.9%)	Iloilo N = 119 (17.6%)	Aklan N = 30 (4.4%)	Davao de Oro N = 31 (4.6%)	Sarangani N = 19 (2.8%)	
Time-Off / Vacations, n* (%)	118 (72.8%)	32 (91.4%)	137 (86.2%)	102 (84.3%)	85 (71.4%)	25 (83.3%)	24 (77.4%)	15 (78.9%)	538 (79.6%)
Clothing, n* (%)	61 (37.7%)	11 (31.4%)	49 (30.8%)	25 (20.7%)	40 (33.6%)	20 (66.7%)	22 (71.0%)	4 (21.1%)	232 (34.3%)
Training, n* (%)	145 (89.5%)	31 (88.6%)	131 (82.4%)	102 (84.3%)	100 (84.0%)	25 (83.3%)	26 (83.9%)	15 (78.9%)	575 (85.1%)
Certificates / Awards/ Recognitions, n* (%)	113 (69.8%)	30 (85.7%)	115 (72.3%)	82 (67.8%)	93 (78.2%)	27 (90.0%)	23 (74.2%)	10 (52.6%)	493 (72.9%)
Food ration/meals, n* (%)	16 (9.9%)	1 (2.9%)	12 (7.5%)	6 (5.0%)	2 (1.7%)	6 (20.0%)	0 (0.0%)	1 (5.3%)	44 (6.5%)
Subsidized housing, n* (%)	1 (0.6%)	1 (2.9%)	2 (1.3%)	0 (0.0%)	1 (0.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	5 (0.7%)

Note: *Number of providers who answered "yes" when asked if they receive the following salary supplement
Source: Authors' illustration of the PIDS COBP-CATCH Healthcare Provider Survey (Conda et al. forthcoming)

Table 33. Mean scores on the scales and domains of provider motivation

Provinces		Motivations as a healthcare provider						
		Income	Security of Employment and Opportunities	Intrinsic Motivation	Working Conditions	Quality and Style of Supervision	Recognition	Autonomy
North & Central Luzon	La Union N=289 (28.0%)	264 (91.3%)	256 (88.6%)	275 (95.2%)	199 (68.9%)	230 (79.6%)	270 (93.4%)	258 (89.3%)
	Benguet N=56 (5.4%)	54 (96.4%)	44 (78.6%)	56 (100.0%)	43 (76.8%)	45 (80.4%)	54 (96.4%)	46 (82.1%)
South Luzon	Batangas N=209 (20.3%)	197 (94.3%)	188 (90.0%)	208 (99.5%)	184 (88.0%)	183 (87.6%)	198 (94.7%)	194 (92.8%)
	Laguna N=151 (14.6%)	141 (93.4%)	138 (91.4%)	151 (100.0%)	131 (86.8%)	140 (93.3%)	144 (95.4%)	137 (91.3%)
Visayas	Iloilo N=183 (17.7%)	167 (91.3%)	157 (85.8%)	181 (98.9%)	141 (77.0%)	157 (85.8%)	163 (89.1%)	163 (89.1%)
	Aklan N=58 (5.6%)	55 (94.8%)	53 (91.4%)	58 (100.0%)	48 (82.8%)	52 (89.7%)	57 (98.3%)	54 (93.1%)
Mindanao	Davao de Oro N=53 (5.1%)	49 (92.5%)	45 (84.9%)	53 (100.0%)	44 (83.0%)	44 (83.0%)	51 (96.2%)	46 (86.8%)
	Sarangani N=32 (3.1%)	29 (90.6%)	28 (87.5%)	32 (100.0%)	27 (84.4%)	25 (78.1%)	32 (100.0%)	26 (81.2%)
Overall N=1031 (100%)		956 (92.7%)	909 (88.2%)	1,014 (98.4%)	817 (79.2%)	876 (85.0%)	969 (94.0%)	924 (89.7%)

Source: Authors' illustration of the PIDS COBP-CATCH Healthcare Provider Survey (Conda et al. forthcoming)

Note: Providers are asked to score statements using a 4-point Likert Scale (1 - strongly disagree, 2 - disagree, 3 - agree, 4 - strongly agree). Frequencies reflect the respondents who strongly agreed and agreed to the statements about the different domains of provider motivation.

5. Discussion and Recommendations

This report has two general objectives. The first objective is to examine the state of the HRH system in the Philippines, specifically its current stock and economic contribution. It also outlines HRH governance and financing in the Philippines. The second objective includes reviewing the scope and coverage of existing welfare and services for HRH, assessing the accessibility of welfare services, and identifying policy and implementation limitations in the delivery of HRH welfare services.

The following are the main findings under the first objectives.

- The health sector accounts for about 4% of total employment. Women dominate the healthcare workforce; about 70%% of all health workers in the country. The health sector operates through a mix of public and private health workers, with 53% in private institutions. The compensation system for healthcare workers in the Philippines varies between the public and private sectors. The public sector is divided into national and local levels. The DOH manages national hospitals (mostly end-referral regional hospitals), while LGUs manage provincial, city, and municipal health facilities. PS expenditure of LGU-owned facilities depends on LGU income levels, and remuneration can be supplemented

through the Magna Carta benefits and PhilHealth professional fees. The private sector follows regional minimum wage regulations, and compensation, and is primarily funded by healthcare facility revenues (mostly from user-fees), with no entitlement to Magna Carta benefits.

- Multiple compensation systems exist for health workers. Public physicians in government hospitals receive salaries but may earn additional income from user fees, PhilHealth reimbursements, and private practice. Non-physician healthcare workers are salaried in government facilities. In private facilities, healthcare workers depend on direct user fees, private insurance, and PhilHealth reimbursements. These different compensation models influence healthcare worker behavior and service delivery patterns across public and private healthcare settings.
- Regarding HRH financing, expenditure for HRH compensation has steadily increased in real terms, though its share of total health expenditure has fluctuated. While PS expenditure peaked in 2020, it remains low compared to international benchmarks. HRH remuneration only accounts for 12–18% of current health expenditure, far below the global average of 30–38%. The national government remains the primary source of PS. Analysis of LGU financial data suggests a large variation in HRH spending, both in per capita terms and in terms of a share of their total health expenditure. Also, LGUs have faced structural limitations for many years, restricting the expansion of PS relative to the share of income, which led to trade-offs between staffing and other health investments.
- The distribution of hospital healthcare workers in the Philippines is highly uneven, with urban centers having significantly higher densities than rural areas. Major cities have over six health workers per 1,000 population, while many provinces fall below one per 1,000, exacerbating disparities in healthcare access. This maldistribution is more pronounced for specialists (e.g., surgeons, medicine, OB-GYNE). Public and private sector segmentation is also apparent, with private physicians concentrated in urban markets while rural areas depend on the overstretched public sector.
- Public sector health workers experience higher workload, on average. Our estimates using administrative data from licensing data suggests the number of FTE health workers per admissions as high as two times in private facilities. This higher workload in government in facility is exacerbated by unfilled government positions.

The following are the main findings under the second objective.

- Several public policies shape the welfare services for HRH in the Philippines. The policies govern salary level, allowances, benefits, and working conditions. The Salary Standardization Law (SSL) ensures structured compensation in the public sector, with adjusted several times over the past decade. Public health workers are entitled to additional pay increments, such as longevity pay and step increments, based on performance and tenure. However, disparities persist across LGUs, where salary adjustments depend on the income classification of the LGU. In contrast, regional minimum wage laws largely dictate private sector HRH compensation as remuneration policies for the private sector workers.

is limited based on our policy analysis. On average, lower average salaries and fewer benefits than their public-sector counterparts.

- At least in policy, in addition to salaries, public HRH receives cash and non-cash benefits, including hazard pay, subsistence, laundry allowances, and representation and travel allowances. These benefits are largely mandated under the Magna Carta of Public Health Workers. Private sector HRH, however, receives fewer benefits, as their entitlements are primarily based on labor standards rather than sector-specific policies. Non-cash benefits, such as housing and logistical support, are available for selected public sector health workers. Pension systems further differentiate public and private healthcare workers. Multiple retirement benefit options cover public HRHs. In contrast, private HRHs have limited retirement benefits based on accumulated contributions.

In terms of coverage and implementation challenges of these HRH welfare services. We observed the following:

- Based on the results of our regression model, the wage disparity between public and private healthcare workers in the Philippines is statistically significant, with public sector workers earning an average of 17.6% more than their private sector counterparts.
- The private health sector struggles with labor violations and wage compliance. Data shows that over 10% of private health facilities fail to meet minimum wage standards. Compliance with Statutory and General Labor Standards (SGLS), which include minimum wage provisions, averaged 70% over the past six years. Compliance with Occupational Safety and Health Standards (OSHS) is even lower, averaging 50.9% from 2018 to 2023.
- In the public sector, salary disparities exist across LGUs, as pay scales depend on an LGU's income classification. Many public HRH work under Job Order or Contract of Service arrangements, lacking job security, statutory benefits, and career advancement opportunities. Due to budget constraints and PS limitation policy for many years, LGUs prioritize hiring contractual workers over permanent positions. Political considerations can affect job security and career progression, particularly for contractual workers facing employment instability with local administration change.
- Analysis of administrative data from DOH shows variations on how health facilities allocate compensation. Public institutions dedicate a higher share to benefits, with the gap most evident at the infirmary level. Public infirmaries allocate nearly 50%, while private ones spend under 10%. This difference narrows at higher facility levels but remains significant. For example, level 3 government hospitals allocate 35% to benefits, compared to 17% in private counterparts. Public hospitals prioritize benefits and hazard pay, while private facilities focus more on professional fees. This suggests private facilities attract workers with higher fees, whereas public institutions rely on benefits and hazard pay.

- LGUs are only required to provide hazard pay, subsistence allowance, and laundry allowance under the Magna Carta benefits, but compliance remains low based on our analysis of administrative data from DOH, with only 70% of LGUs providing these benefits; poorer LGUs have lower compliance rates despite the DBM's waiver of the PS limitation from 2022 to 2025, highlighting ongoing financial and administrative challenges.
- Hospitals may not fully optimize PhilHealth reimbursements to support personnel services and operations due to financial data limitations. The ratio of PhilHealth reimbursements to total hospital revenue has been declining in both public and private hospitals, with private hospitals relying more on these funds. Public hospitals receive multiple revenue streams, while private hospitals depend on PhilHealth and user fees to cover costs. Since 2013, PhilHealth case rates have remained stagnant despite inflation, leading private providers to charge additional fees.
- The provider survey conducted across eight provinces in the Philippines highlights disparities in monetary salary supplements for public sector healthcare workers. Among doctors, PhilHealth sharing provides the highest benefit, averaging PHP 245,637 annually, while 13th-month pay is widely received at an average of PHP 78,871. However, duty allowances are less common, with significant variations across provinces, ranging from PHP 56,444 to PHP 108,000. For nurses and midwives, PhilHealth sharing is the highest supplement, averaging PHP 54,270, though per diem allowances and other benefits remain inconsistent. These findings underscore regional disparities in salary supplements, reflecting LGU income classifications and funding availability.
- In terms of non-monetary benefits, time-off and training opportunities are widely available, with 78.6% of doctors and 85.1% of allied health professionals reporting access. However, food rations (24.8%) and subsidized housing (2.0%) remain limited, particularly in lower-income areas. Motivation scores reveal strong intrinsic motivation and recognition among healthcare workers but working conditions and employment security remain areas for improvement. Despite policies promoting standardized incentives, access to both monetary and non-monetary benefits remain highly uneven, potentially affecting retention and job satisfaction in underserved regions.

In our review of the current landscape of HRH compensation in the country, three main themes emerged that underpin our analysis. These are the following:

Fragmentation and lack of predictability and transparency on wages/salaries and benefits.

The salaries and benefits in the Philippines that govern HRH differ depending on the employment sector. For example, public HRHs are governed by the SSL and MCPHW, while private HRHs are mostly subject to facility-based policies and market forces. Compensation sources are likewise fragmented based on the cadre of HRH, facility type and ownership, and political jurisdiction. This

multi-tiered fragmentation makes monitoring and estimating the total compensation package of HRH in the country difficult. This makes it difficult for the HRH to know what benefits they are entitled to and when. This lack of transparency creates unpredictability for these workers, particularly in making informed career decisions and may negatively impact workforce retention (B1 2024). An additional layer of fragmentation exists for the non-permanent HRH in the country, which make up a significant percentage of DOH and LGU workers (DOH 2021). The prevalence of non-permanent HRH reflects trends in both the public and private sector as a whole.

Unlike in many other health systems where wages and benefits are derived from predictable sources, the Philippine system is characterized by considerable variability. While regulation exists to govern the public sector, implementation and coverage are unpredictable depending on the facility, location, and cadre. For example, PhilHealth professional fees, which could represent substantial additional income for HRH, are often unclear regarding calculation and distribution. These fees are subject to local government and cadre-specific practices (e.g., only physicians can receive them) and facility-specific policies, contributing to the variability in implementation. Furthermore, the existing payment mechanisms of PhilHealth reimbursements exacerbate these inconsistencies due to a lack of transparency and predictability.

Even across the public sector, there is variability in implementing laws such as the MCPHW, as this is left to the purview of the local government. Another example is community health workers' salaries, who receive salaries in some local governments but do not in others. These variations are not driven by workload or scope of work but rather by inconsistent policies, limited fiscal resources among local governments, and, in some cases, political economy factors (A1 2024; B1 2024). Implementation issues persist due to the devolution of health services, where HRH in LGUs are subject to shifting LCE priorities. These manifest not just in HRH working environments, such as increased workload due to understaffing, but in service delivery and health (Toure et al. 2023).

Significant wage differentials between the public and private healthcare sectors.

Using labor force data, we conducted a regression analysis to estimate the difference in wages, showing that health workers in the public sector receive higher compensation than private sector workers. This wage differential, commonly observed in empirical literature (i.e., even observed in countries with mixed delivery systems), is largely driven by differences in financial structures between public and private. Public facilities benefit from multiple revenue streams, including line-item budgets, legislated benefits, government subsidies, and PhilHealth reimbursements. Private hospitals depend more heavily on user fees and PhilHealth reimbursements, as shown by our analysis of hospital financial statements. Although public sector health workers receive higher wages, our analysis suggests higher workloads, as reflected in our human resource-to-volume estimates. As global literature suggests, working environments of HRH play a significant role in retention and overall job satisfaction (Hellín Gil et al. 2022; Kitsios and Kamariotou 2021; Othman and Khrais 2022; Wang et al. 2020). More research into this dimension is needed, in order to supplement and improve existing policies, following increasing evidence and global best practices (NHS 2020; Australian Government Department of Health 2022).

Looking into the revenue stream of health facilities allows us to paint a better picture of the effects of the public-private wage differential. PhilHealth reimbursements, which are a major source of revenue for public and private health facilities, uses a case rate payment system. The case rate system reimburses healthcare providers with a fixed amount based on each patient's specific

diagnosis or treatment. Although the reimbursement system is designed to cover the total cost of care, including professional fees, this is not the reality (Picazo et al. 2014; Uy et al. 2021). Because the rates are not regularly updated and cost transparency remains an issue, PhilHealth payments cannot make up the entirety of provider expenses. Additionally, because PhilHealth reimbursements are non-differentiated, the case rate amounts are the same between public and private facilities (Dayrit et al. 2018). This disproportionately affects private facilities, which operate with fewer financial buffers and face greater constraints than the public sector. As our analysis in this report shows, this manifests as lower wages for HRH in these private facilities. On the other hand, public facilities are able to leverage subsidies from both local and national governments, buoying their profitability as they would otherwise be operating on deficits (Uy et al. 2021).

In our assessment, while we were able to estimate the wage differential between the public and private sectors, the lack of available financial data and transparency limited our ability to examine certain cadres, particularly physician specialists in both sectors. Specialists in the public sector often engage in dual practice, which is not reflected in hospital financial statements. The lack of comprehensive financial data tracking various sources of income, including from dual practice and full-time equivalence in both public and private sector practice, makes it difficult to fully capture the incentive structure and assess certain policies in achieving their intended outcomes. Furthermore, the lack of available financial data on professional fees and user fees paid directly to providers presents a considerable gap in the possible analysis. This is an issue as well in the regulation and monitoring of broader HRH compensation in the sector, which may have negative repercussions on patient care (Arab et al. 2022; Lindkvist 2013). In 2003, the DOH issued a policy on dual practice to incentivize specialists to work in the public sector. However, with the increasing salaries of health workers in the public sector, it is worth reassessing how this policy aligns with its goal stipulated two decades ago. In the private sector, the non-existence of income data for non-salaried cadres (e.g., specialists), combined with market-driven professional fees with no standardized rates, makes capturing the full incentive structure challenging. This also complicates the assessment of wage differentials for specialists in private facilities.

HRH policies affect broader health system goals, particularly financial risk protection and improvements to health outcomes.

The unpredictability and lack of transparency in salaries and benefits due to fragmentation and limitations of financing sources, including the failure to fully capture the total cost of care in payment systems, have implications for patients (Lindkvist 2013). These limitations in provider payment systems often lead healthcare providers to charge user fees and rely on out-of-pocket payments, which can be financially catastrophic for patients. This contributes to the high, both in share and absolute value, OOP in the country despite significant increases in health expenditures. Therefore, we argue that HRH compensation is closely tied to the effectiveness of the health financing system, in which provider payments should be fully integrated.

This report comprehensively examines the different domains of HRH compensation and the issues and challenges present. Our findings cover a range of issues and concerns in HRH compensation in the country. These issues span the different levels of government from the national to local and encompass legislation, policies, and implementation. Due to the separation of the Philippine health system's public and private sectors, HRH legislation is inconsistently applied. This is most clearly seen in the MCPHW, which guarantees benefits to public sector HRH only. Additionally, efforts

to standardize and improve salaries in the public sector benefit public HRH but not their private counterparts. Our analysis in this report attempts to quantify the extent of this compensation gap, using the best available data. These findings align with existing literature on the public-private wage gap (Francisco and Macaranas 2014; Alibudbud 2023).

In this report, we also outline issues in the policy implementation, using compliance data and key informant interviews. We find that despite supposedly adequate coverage of compensation and benefits to public HRH, implementation leaves much to be desired (A2 2024; D2 2024). Compliance with the mandated MCPHW benefits has improved over the years but is still inconsistent and subject to local political priorities. This is true as well for other benefits, both specific to health workers and those for all government employees (Leyva et al. 2024; Saguinour). Given these findings, we propose the following recommendations:

The government should explore creating a national health human resource support system for the public sector. This system should include the following:

- To address the variability of compensation across local governments, which is common in a decentralized regime with varying capacities and priorities of local governments, the national government should develop a comprehensive support framework for local governments, ensuring equity and addressing local needs. This would include a "top-up" system where the national government supplements local governments that cannot fully cover health human resource salaries. Poorer LGUs would contribute what they can afford, and the national government would make the difference to ensure all health workers are paid the same rate in line with the Salary Standardization Law (SSL). **Local governments must be held accountable for providing these payments, and the Department of the Interior and Local Government (DILG) should actively ensure that every LGU employs health workers.** Failure to do so would be considered negligence, and legal action should be explored against LGUs that do not provide essential health services in their jurisdictions.
- Legislate a "GIDA (Geographically Isolated and Disadvantaged Areas) Allowance" to incentivize and support health workers in underserved regions. **The national government should provide funding for this allowance.**
- Legislate a "No Private Practice" allowance, with the national government incentivizing health workers to commit full-time to public healthcare services. This includes strengthening the monitoring of public HRH's dual practice and moonlighting practices of public HRH.
- Simple yet innovative non-cash benefits could be introduced to health workers. PAG-IBIG, a national savings and housing financing program, could implement a special housing track for health workers in the public and private sectors. CHED should explore scholarships specifically for deserving children of health workers.
- PhilHealth should explore incorporating pay-for-performance models based on the volume and quality of care, which could provide additional income for health workers. This approach should be integrated into their current and future provider payment system. The Special Health Fund, as envisioned in the UHC Act, could be used to fund P4P models. However, this requires the institutionalization of a robust health information system. Establishing P4P mechanisms within the benefit payment can ensure the provision of health services and eventually be transitioned into quality measures through outcomes-

based monitoring. These unique payouts can then be linked through the contracting of provider networks, wherein PhilHealth would require specific inputs before their engagement, such as the full-staffing of healthcare facilities and the provision of performance-based incentives to its health workers.

Fast-track the implementation of a well-costed global budget system, which is a fixed amount of money allocated to health facilities or the network of facilities to cover personnel and operating costs for a defined period (usually a year). This is a common payment approach in many advanced health systems, typically paying for the needed resources in advance. The Universal Healthcare Act (UHC) already provides the legal basis for this transition. A global budget, a comprehensive financial plan, addresses the unpredictability of expenses, including professional fees. However, its implementation should ensure several key factors:

- The global budget must be well-costed, capturing the total cost of care and ensuring non-discriminatory payment across different healthcare cadres. PhilHealth policies must be clear on how health workers (both physicians and allied health professionals) receive their compensation from PhilHealth.
- There must be a process for negotiating with healthcare providers (i.e., including cost-sharing rules) to incorporate them into the global budget system to ensure transparency.
- In calculating global budgets, the area's case mix of health facilities and other socio-demographic and economic characteristics must be considered. For example, adjustment rates could be applied to facilities in relatively poorer provinces.
- This global budget system should apply to both public and private sectors. However, the government must reconsider the non-differential payment structure between public and private providers to improve the efficiency and overlapping of payments. Public sector salaries are already covered through line-item budgets, so the global budget for private hospitals should be higher to account for their operational needs and personnel services. In advanced health financing systems like Thailand, countries have implemented systems that account for multiple financing streams by unbundling payments from the global budget. For instance, public sector salaries and capital expenditures are covered through separate budgetary sources, while the global budget is primarily used for operational costs.

6. Bibliography

- A1. 2024. "Key Informant Interview with the Dagupan City Health Office."
- A2. 2024. "Key Informant Interview with the Hernani Municipal Health Office."
- A3. 2024. "Key Informant Interview with the Mandaluyong City Health Office."
- A5. 2024. "Key Informant Interview with the Romblon Provincial Health Office."
- Abdelhafiz, Ibrahim Mbarak, Aladeen Mah'D Alloubani, and Mohammad Almatari. 2016. "Impact of Leadership Styles Adopted by Head Nurses on Job Satisfaction: A Comparative Study Between Governmental and Private Hospitals in Jordan." *Journal of Nursing Management* 24(3):384–92. doi:10.1111/jonm.12333.
- Aidalina, M., and I. Aniza. 2015. "Factors Associated with the Brain-Drain Phenomenon of Doctors from the Public Sector to the Private Sector in Selangor and Kuala Lumpur." *International Journal of Public Health and Clinical Sciences* 2(1).
- Alibudbud, Rowalt. 2023. "Addressing the Burnout and Shortage of Nurses in the Philippines." *SAGE Open Nursing* 9:23779608231195737. doi:10.1177/23779608231195737.
- Antwi, James, and David C. Phillips. 2013. "Wages and Health Worker Retention: Evidence from Public Sector Wage Reforms in Ghana." *Journal of Development Economics* 102:101–15. doi:10.1016/j.jdeveco.2012.10.004.
- Arab, Mohammad, Bahman Khosravi, Hossein Safari, Hojat Rahmani, Ghasem Rajabi Vasokolaei, Mohammadreza Mobinizadeh, and Farhad Habibi. 2022. "Reasons for Informal Payments from the Perspective of Health Care Providers and Recipients: A Qualitative Study in Iran."
- B1. 2024. "Key Informant Interview with the Quezon City General Hospital."
- Bautista, John Robert, Percy Aiggie S. Lauria, Maria Cecilia S. Contreras, Maheni Micarla G. Maranion, Hermeliza H. Villanueva, Robert C. Sumaguingsing, and Ronne D. Abeleda. 2020. "Specific Stressors Relate to Nurses' Job Satisfaction, Perceived Quality of Care, and Turnover Intention." *International Journal of Nursing Practice* 26(1):e12774. doi:10.1111/ijn.12774.
- Bimpong, Kweku Andrew Ampadu, Ausaf Khan, Robert Slight, Clare L. Tolley, and Sarah P. Slight. 2020. "Relationship Between Labour Force Satisfaction, Wages and Retention Within the Uk National Health Service: A Systematic Review of the Literature." *BMJ Open* 10(7):e034919. doi:10.1136/bmjopen-2019-034919.
- BIR. 2014. "Guidelines and Policies for the Monitoring of Service Fees of Professionals (Revenue Regulations No. 4-2014)."

- C1. 2024. “Key Informant Interview with the Department of Health - Bureau of Local Health Systems Development (DOH-BLHSD).”
- C2. 2024. “Key Informant Interview with the Department of Health - Health Human Resource for Development Bureau (DOH-HHRDB).”
- Cielo, Bernardo II, Melanie Santillan, and Vergil de Claro. 2024. “Effect of a Case-Capped, Fee-for-Service Payment Mechanism on Accessibility and Affordability of Health Care.” 2(2).
- CSC. 2012. “Rules and Regulations on the Grant of Step Increment/s Due to Meritorious Performance and Step Increment Due to Length of Service.”
- CSC. 2016. *Rules and Regulations on the Grant of Step Increments to Elective Officials Based on Length of Service.*
- CSC. 2023. *Grant of Career Service Eligibility - Preference Rating (CSE-PR) to Specific Workers in Government Agencies Based on Length of Service and Work Performance.*
- D2. 2024. “Key Informant Interview with the Provincial Health Officer Association of the Philippines.”
- Dayrit, M. M., L. P. Lagrada, O. F. Picazo, M. C. Pons, and M. C. Villaverde. 2018. *The Philippines Health System Review*. Vol. 8. World Health Organization. Regional Office for South-East Asia.
- DBM. 2012. “Chapter 3: The Compensation Plan.” in *Manual on Position Classification and Compensation*.
- DBM. 2022. “Guidelines on the Implementation of Personal Services (PS) Limitation on Local Government Budgets and Determination of Waived PS Items Pursuant to Section 93 of the General Provisions (GPs) of the Fiscal Year (FY) 2022 General Appropriations Act (GAA), Republic Act (RA) No. 11639, and Years Thereafter.”
- DBM. 2024a. “Guidelines on the Implementation of Personal Services (PS) Limitation on Local Government Budgets and Determination of Waived PS Items Pursuant to Section 95 of the General Provisions (GPs) of the Fiscal Year (FY) 2024 General Appropriations Act (GAA), Republic Act (RAs) No. 11975 and Years Thereafter.”
- DBM. 2024b. “Staffing Summary of the National Government - FY 2022, 2023, 2024.”
- DBM. 2025. *Local Budget Circular 163-2025 - Guidelines on the Implementation of Personal Services (PS) Limitation on Local Government Budgets and Determination of Waived PS Items Pursuant to Section 96 of the General Provisions (GPs) of the Fiscal Year (FY) 2025 General Appropriations Act (GAA), Republic Act (RA) No. 12116 and Years Thereafter.*

- DBM and COA. 2020. “Updated Rules and Regulations Governing Contract of Service (COS) and Job Order (JO) Workers in the Government.”
- DBM and DOH. 2012. “Rules and Regulations on the Grant of Compensation-Related Magna Carta Benefits to Public Health Workers.”
- Deriba, Beyazin Kebede, Shimele Ololo Sinke, Berhane Megersa Ereso, and Abebe Sorsa Badacho. 2017. “Health Professionals’ Job Satisfaction and Associated Factors at Public Health Centers in West Ethiopia.”
- Do, Ngan, and Young Kyung Do. 2018. “Dual Practice of Public Hospital Physicians in Vietnam.” *Health Policy and Planning* 33(8):898–905. doi:10.1093/heapol/czy075.
- DOF-BLGF. 2023. “2009-2022 LGU Statement of Receipts and Expenditures.”
- DOF-BLGF. 2024a. “2009-2022 LGU Annual Regular Income.”
- DOF-BLGF. 2024b. “2017-2023 LGU Capital Outlay and Personnel Services Expenditure.”
- DOF-BLGF. 2024c. “2017-2023 LGU Health, Nutrition, and Population Control Expenditures.”
- DOH. 1999. “Revised Implementing Rules and Regulations on the Magna Carta of Public Health Workers or R.A. 7305.”
- DOH. 2020. “Human Resources for Health Philippine Masterplan 2020-2040.”
- DOH. 2021. *National Human Resources for Health Master Plan: 2020-2040*.
- DOH. 2023. “2017-2022 Health Facility Statistics Report.”
- DOH. 2024a. “2014-2022 LGU Scorecard on Health.”
- DOH. 2024b. “National Health Facility Registry.”
- DOLE. 2017. “Guidelines Governing the Employment and Working Conditions of Health Personnel in the Private Healthcare Industry (D.O. 182).”
- Fadzil, Malindawati Mohd, Sharifa Ezat Wan Puteh, Azimatun Noor Aizuddin, and Zafar Ahmed. 2022. “Specialists’ Dual Practice within Public Hospital Setting: Evidence from Malaysia.” *Healthcare* 10(10):2097. doi:10.3390/healthcare10102097.
- Flores, Erika Louise, Edric Matthew Manahan, Miguel Paulo Lacanilao, Isabella Ma. Beatriz Ladaw, Mico Martin Mallillin, Nikolai Thadeus Mappatao, Juan Alfonso Leonardia, and Veincent Christian Pepito. 2021. “Factors Affecting Retention in the Philippine National Rural Physician Deployment Program from 2012 to 2019: A Mixed Methods Study.”
- Francisco, Jamil Paolo, and Federico Megino Macaranas. 2014. “Decomposing the Public-Private Wage Gap for Nurses in the Philippines.”

- González, Paula, Gabriel Montes-Rojas, and Sarmistha Pal. 2021. “Managing Dual Practice of Health Workers: Evidence from Indonesia.” *IZA: Institute of Labor Economics* (14899).
- Government of Malaysia. 2024. *Implementation of the Public Service Remuneration System for Federal Public Service Officers*.
- Government of Vietnam. 2005. No. 11/2005/TTLT-BNV-BLDTBXH: *Implementation of the Region-Based Allowance Regime*.
- Government of Vietnam. 2006. No. 43/2006/ND-CP: *Providing for the Right to Autonomy and Self-Responsibility for Task Performance, Organizational Apparatus, Payroll and Finance of Public Non-Business Units*.
- Government of Vietnam. 2011. No. 56/2011/ND-CP: *Prescribing the Occupation-Specific Preferential Allowance Applicable to Civil Servants and Public Employees at Public Health Facilities*.
- Government of Vietnam. 2015. No. 26/2015/TTLT-BYT-BNV: *Codes and Standards Applicable to Titles of Nurse, Midwife and Medical Technician*.
- Government of Vietnam. 2018. *Vietnam Health Statistics Yearbook 2018*.
- Government of Vietnam. 2019. No. 76/2019/ND-CP: *On Policies Towards Officials, Public Servants, Public Employees, Laborers and Wage Earners in the Armed Forces, Working in Areas with Exceptionally Difficult Socio-Economic Conditions*.
- Government of Vietnam. 2020. *Statistical Yearbook of Vietnam*.
- Government of Vietnam. 2023a. Decree No. 24/2023/ND-CP: *Prescribing Statutory Pay Rate for Officials, Public Employees and Armed Forces*.
- Government of Vietnam. 2023b. No. 05/2023/ND-CP: *On Particular Policies of Subsidies Paid to Officials, Public Employees and Employees Working for Public Healthcare Establishments, and Allowances Paid for Prevention and Control of Epidemics*.
- Hafez, Reem, Yurdhina Meilissa, and Yulia Nur Izati. 2023. “Indonesia’s Health Labor Market: A Descriptive Analysis.”
- Hellín Gil, María Fuensanta, José Antonio Ruiz Hernández, Francisco Javier Ibáñez-López, Ana Myriam Seva Llor, Maria Dolores Roldán Valcárcel, Marzena Mikla, and María José López Montesinos. 2022. “Relationship between Job Satisfaction and Workload of Nurses in Adult Inpatient Units.” *International Journal of Environmental Research and Public Health* 19(18):11701. doi:10.3390/ijerph191811701.
- Jaskiewicz, Wanda, Christophe Lemiere, David Phillips, Joanne Spetz, and Eric Keuffel. 2016. “Measuring and Analyzing Salaries and Incentives.” in *Health Labor Market Analyses in Low- and Middle-Income Countries: An Evidence-Based Approach*.

- Jinah, Norehan, Kun Yun Lee, Nor Haniza Zakaria, Nursyahda Zakaria, Munirah Ismail, and Shazwani Mohmad. 2023. "Contract Doctors' Strike in Malaysia: A Content Analysis of the Perception of Medical Fraternity and Stakeholders on Facebook" edited by P. B. Ooi. *PLOS ONE* 18(9):e0292213. doi:10.1371/journal.pone.0292213.
- Karaferis, Dimitris, Vassilis Aletras, and Dimitris Niakas. 2022. "Determining Dimensions of Job Satisfaction in Healthcare Using Factor Analysis."
- Kartika, Lentik Wienda. 2019. "Facilitators and Barriers to Health Workforce Retention in Rural and Remote Setting of Indonesia: A Literature Review."
- Kitsios, Fotis, and Maria Kamariotou. 2021. "Job Satisfaction Behind Motivation: An Empirical Study in Public Health Workers." *Heliyon* 7(4):e06857. doi:10.1016/j.heliyon.2021.e06857.
- Krishnamoorthy, Lalitha, Rajendran Muthuveloo, and Teoh Ai Ping. 2020. "The Impact of Non-Financial Incentives on Intention to Stay: A Study Among Nurses in Private Hospitals in Malaysia." *The Malaysian Journal of Nursing (MJN)* 12(1):123–34. doi:10.31674/mjn.2020.v12i01.015.
- Lamba, Shyam, Nikita Arora, Dorka Woldesenbet Keraga, Abiyou Kiflie, Birkety Mengistu Jembere, Della Berhanu, Mehret Dubale, Tanya Marchant, Joanna Schellenberg, Nasir Umar, Abiy Seifu Estafinos, and Matthew Quaife. 2021. "Stated Job Preferences of Three Health Worker Cadres in Ethiopia: A Discrete Choice Experiment." *Health Policy and Planning* 36(9):1418. doi:10.1093/heapol/czab081.
- Leyva, PhD Erwin William A., Misw Julianne Ivan D. Soberano, PhD Jenniffer T. Paguio, PhD Kathryn Lizbeth L. Siongco, PhD Earl Francis R. Sumile, and DrPH Sheila R. Bonito. 2024. "Pandemic Impact, Support Received, and Policies for Health Worker Retention: An Environmental Scan." *Acta Medica Philippina* 58(12). doi:10.47895/amp.v58i12.9346.
- Lindkvist, Ida. 2013. "Informal Payments and Health Worker Effort: A Quantitative Study from Tanzania." *Health Economics* 22(10):1250–71. doi:10.1002/hec.2881.
- Lu, Young, Xiao-Liang Huang, Xiaodong Zhuang, and Xiao-Min Hu. 2017. "The Relationship Between Job Satisfaction, Work Stress, Work-Family Conflict, and Turnover Intention Among Physicians in Guangdong, China: A Cross-Sectional Study." doi:10.1136/bmjopen-2016-014894.
- MOH Malaysia. 2023. *Human Resources for Health (HRH): Country Profiles 2019-2021 Malaysia*.
- MOH Malaysia and MOHA Malaysia. 2015. *Providing for Code and Criteria for Title of Doctor, Doctor of Preventive Medicine and Physician*.

- MOH Thailand. 2023. *Regulations of the Ministry of Public Health on the Payment of Compensation to Personnel Working in Units under the Ministry of Public Health: B.E. 2566 Guidelines, Methods, and Conditions for the Payment of Various Allowances, New Edition.*
- Moller, Arlen C., Andrew J. Jager, Geoffrey C. Williams, and Audiey C. Kao. 2019. "US Physicians' Work Motivation and Their Occupational Health: A National Survey of Practicing Physicians." *Medical Care* 57(5):334–40. doi:10.1097/MLR.0000000000001101.
- Ojakaa, David, Susan Olango, and Jordan Jarvis. 2014. "Factors Affecting Motivation and Retention of Primary Health Care Workers in Three Disparate Regions in Kenya." *Human Resources for Health* 12:33. doi:10.1186/1478-4491-12-33.
- Oladeji, Olusola, Andrew Brown, Maritza Titus, Maria Muniz, Alex Collins, Janet Muriuki, Bibilola Oladeji, Yejimmawork Ayalew, and Ann Robins. 2022. "Non-Financial Incentives for Retention of Health Extension Workers in Somali Region of Ethiopia: A Discrete Choice Experiment." *Health Services Insights* 15:11786329221127151. doi:10.1177/11786329221127151.
- Othman, Thaira, and Huthaifah Khrais. 2022. "The Relationship Between Transformational Leadership, Job Satisfaction, and Organizational Commitment in Jordanian Nurses." 26(3).
- PhilHealth. 2023. *Stats and Charts.*
- Picazo, Oscar, Valerie Gilbert Ulep, Ida Marie Pantig, and Beverly Lorraine Ho. 2014. "A Critical Analysis of Purchasing of Health Services in the Philippines: A Case Study of PhilHealth." *Philippine Institute for Development Studies.*
- PIDS. 2023. "2017-2020 Hospital Financial Statements."
- PMA. 2019. "Code of Ethics of the Medical Profession."
- Pongpisut, Jongudomsuk, Samrit Srithamrongsawat, Walaiorn Patcharanarumol, Supon Limwattananon, Supasit Pannarunothai, Patama Vapatanavong, Krisada Sawaengdee, and Piniy Fahamnuaypol. 2024. *Thailand Health System Review*. 2nd edition. edited by Viroj Tangcharoensathien. Manila: World Health Organization on behalf of the Asia Pacific Observatory on Health Systems and Policies.
- PSA. 2023a. "2015, 2018, & 2021 Poverty Statistics and Small Area Estimates."
- PSA. 2023b. "2020 Annual Survey of Philippine Business and Industry."
- PSA. 2023c. "2020 Census on Population and Housing."
- PSA. 2023d. "2023 Philippine National Health Accounts."

- PSA. 2023e. *Labor Force Survey (LFS) May 2023 Preliminary Results*.
- PSA. 2024a. "2024 Philippine Standard Geographic Code."
- PSA. 2024b. "Occupational Wages Survey (2014, 2016, 2018, 2020)."
- Reluao, Anne Justin, Maria Cecilia Calbasa, Hsien Mai Loteyro, Florinda Vigonte, and Marmelo V. Abante. 2023. "A Comparative Study of the Retirement Benefits of Private and Government Employees Towards An Information Awareness Campaign."
- Rispel, Laetitia C., Duane Blaauw, Tobias Chirwa, and Katinka de Wet. 2014. "Factors Influencing Agency Nursing and Moonlighting Among Nurses in South Africa." *Global Health Action* 7:10.3402/gha.v7.23585. doi:10.3402/gha.v7.23585.
- RP. 1954. *Republic Act No. 1161 - An Act to Create a Social Security System Providing Sickness, Unemployment, Retirement, Disability and Death Benefits for Employees*.
- RP. 1987. *Executive Order No. 292 - Instituting the "Administrative Code of 1987" (E.O. 292)*.
- RP. 1989a. *Republic Act No. 6727 - An Act to Rational Wage Policy Determination by Establishing the Mechanism and Proper Standards Therefor, Amending for the Purpose Article 99 of, and Incorporating Articles 120, 121, 122, 123, 124, 126 and 127 Into, Presidential Decree No. 442, As Amended, Otherwise Known as the Labor Code of the Philippines, Fixing New Wage Rates, Providing Wage Incentives for Industrial Dispersal to the Countryside, and for Other Purposes*.
- RP. 1989b. *Republic Act No. 6758 - An Act Prescribing a Revised Compensation and Position Classification System in the Government and for Other Purposes*.
- RP. 1991. *Republic Act No. 7160 - An Act Providing For A Local Government Code of 1991*.
- RP. 1992. *Republic Act No. 7305 - The Magna Carta of Public Health Workers*.
- RP. 1994. "Executive Order No. 164 - Adopting a Revised Compensation and Position Classification System in the Government (E.O. 164)."
- RP. 1997. *Republic Act No. 8291 - An Act Amending Presidential Decree No. 1146, as Amended, Expanding and Increasing the Coverage and Benefits of the Government Service Insurance System, Instituting Reforms Therein and for Other Purposes*.
- RP. 2006. "Administrative Order No. 144 - Granting Additional Compensation in the Amount of One Thousand Pesos (P1,000.00) Per Month to All Employees of the National Government (A.O 144)."
- RP. 2008. "Executive Order No. 719 - Compensation Adjustments for Government Personnel."

- RP. 2009. *Joint Resolution No. 4 - Joint Resolution Authorizing the President of the Philippines to Modify the Compensation and Position Classification System of Civilian Personnel and the Base Pay Schedule of Military and Uniformed Personnel in the Government, and for Other Purposes.*
- RP. 2016. “Executive Order No. 201 - Modifying the Salary Schedule for Civilian Government Personnel and Authorizing the Grant of Additional Benefits for Both Civilian and Military and Uniformed Personnel.”
- RP. 2019. *Republic Act No. 11199 - An Act Rationalizing and Expanding the Powers and Duties of the Social Security Commission to Ensure the Long-Term Viability of the Social Security System, Repealing for the Purpose Republic Act No. 1161, as Amended by Republic Act No. 8282, Otherwise Known as the “Social Security Act of 1997.”*
- RP. 2020a. *Local Budget Circular 121-2020: Implementation of the First Tranche of the Modified Salary Schedule for Local Government Personnel Pursuant to Republic Act (RA) No. 11466.*
- RP. 2020b. *Republic Act No. 11466 - An Act Modifying the Salary Schedule for Civilian Government Personnel and Authorizing the Grant of Additional Benefits, and for Other Purposes (RA 11466).*
- RP. 2023. *General Provisions: Fiscal Year 2023.*
- Saguil, Noel, Horacio Saguil, Jimiwell Bernabe, and Marian Jeremy Aggabao. 2023. “A Quality Healthcare Model: Job Satisfaction and Motivation Attributes of Hospital-Based Nursing Personnel.” *ResearchGate*. doi:10.17605/OSF.IO/THDPR.
- Serra, Danila, Pieter Serneels, and Abigail Barr. 2011. “Intrinsic Motivations and the Non-Profit Health Sector: Evidence from Ethiopia.” *Personality and Individual Differences* 51(3):309–14. doi:10.1016/j.paid.2010.04.018.
- Soewondo, Prastuti, Retno Pujisubekti, Ade Widyati Prastyani, and Nurul Maretia Rahmayanti. 2022. “Interprofessional Collaborative Practice and Health Workers Retention at Remote Primary Health Care: Case Study from Nusantara Sehat Team-Based Program.” *Kesmas: Jurnal Kesehatan Masyarakat Nasional* 17(2). doi:10.21109/kesmas.v17i2.5796.
- Takemura, T., K. Kielmann, and D. Blaauw. 2016. “Job Preferences Among Clinical Officers in Public Sector Facilities in Rural Kenya: A Discrete Choice Experiment.” *Human Resources for Health* 14. doi:10.1186/s12960-015-0097-0.
- Toure, Hapsatou, Maria Aranguren Garcia, Juana Paola Bustamante Izquierdo, Seydou Coulibaly, Benjamin Nganda, and Pascal Zurn. 2023. “Health Expenditure: How Much Is Spent on Health and Care Worker Remuneration? An Analysis of 33 Low- and Middle-Income African Countries.” *Human Resources for Health* 21(1):96. doi:10.1186/s12960-023-00872-y.

- Uy, Jhanna, Ulep Valerie Gilbert, Lyle Daryll Casas, and Christian Edward Nuevo. 2021. "The Financial Health of Select Philippine Hospitals and the Role of the Philippine Health Insurance Corporation as the National Strategic Purchaser of Health Services."
- Wang, Haipeng, Yinzi Jin, Dan Wang, Shichao Zhao, Xingang Sang, and Beibei Yuan. 2020. "Job Satisfaction, Burnout, and Turnover Intention Among Primary Care Providers in Rural China: Results from Structural Equation Modeling." *BMC Family Practice* 21(1):12. doi:10.1186/s12875-020-1083-8.

7. Annex: General HRH remuneration policies in ASEAN

Most health systems in ASEAN traditionally rely on public and private healthcare workers. Health workers in the public sector are salaried and receive additional allowances or incentives. All are entitled to a base salary supplemented by monthly allowances, which include remote-assignment allowances, hazard pay, and travel allowances, provided at varying rates and according to different criteria. We identified "unique" allowances or remuneration schemes exclusive to a member country's public health workforce. These include higher monthly salaries for temporary employees, exclusive public practice allowances for health workers who do not engage in dual practice, and other incentive schemes. A common feature across ASEAN is dual practice, where health workers are employed in the public and private sectors, with remuneration typically higher in the private sector. Public sector health workers often engage in private practice to supplement their income.

7.1. Indonesia

In the public health system, the MOH of Indonesia employs health personnel as either permanent or temporary staff. Permanent staff are civil servants hired by central and local governments, who are mandated to provide healthcare personnel to publicly owned facilities. Their salaries are funded through central and regional government budgets. The MOH or local health budgets may contract temporary staff. In addition to employing civil servants, the MOH launched a deployment program in 2015 called *Nusantara Sehat* to strengthen staffing in underserved areas (Soewondo et al. 2022).

Civil servants are paid a base salary determined by a unified civil service pay scale. This base salary is supplemented by a functional allowance based on the type of job (e.g., doctor, nurse), a family allowance, an income tax allowance, an office travel allowance, and a holiday bonus. Health personnel's take-home pay may be augmented by regional cash benefits, in-kind benefits such as accommodation, and a share of the capitation allowance distributed to primary healthcare facilities serving members of the national health insurance program (JKN). In the public sector, primary healthcare facilities contracted by the insurance can use up to 60% of their capitation budget to supplement staff salaries. Although salaries make up most of the public health workers' income, regional allowances and BPJS payments contribute significantly, accounting for nearly half of doctors' income, about one-third of midwives' income, and more than 40% of nurses' income (Hafez et al. 2023). Given the relatively low pay of civil servants compared to the private sector, dual practice is essential for recruiting and retaining public sector health professionals, particularly in remote and rural areas (González, Montes-Rojas, and Pal 2021). Temporary employees hired under the government's system receive the same base salary as regular civil servants at the same rank, but do not receive the same range of benefits. *The Nusantara Sehat* program participants receive a monthly salary higher than regular civil servants of the same rank, along with similar incentives and accommodation support (see Table A1).

In contrast, healthcare workers in the private sector primarily derive their income from the social insurance reimbursements and user fees for services not covered under JKN (Hafez et al. 2023).

Table A1 provides an overview of the monthly base salary of public HRHs in different cadres and the prescribed functional allowance rates.

Table A1. Monthly salary of a civil servant in the public HRH in Indonesia, 2019

Starting Rank	Health Personnel	Education	Civil Servant (PNS) in IDR			Nusantara Sehat	In \$US
			Base salary (assuming 0 years in grade)	Functional Allowance	Base Salary + Functional Allowance	Total Salary	
3B	GP/ Dentist	Bachelor (S1)	2,688,500	4,595,150	7,283,650	5,766,000 - 14,424,000	409.08 - 1,023.34
2C	Midwife	Diploma (D3)	2,301,800	3,134,250	5,436,050	4,567,000 - 6,654,000	270.86 - 394.64
2D		Diploma (D4)	2,579,400	3,915,950	6,495,350	4,981,000 - 8,498,000	295 - 504
3A		Bachelor (S1)	2,579,400	3,915,950	6,495,350	4,981,000 - 8,498,000	295 - 504
3B		Bachelor (S2)	2,688,500	3,915,950	6,604,450	N/A	N/A
2C	Nurse	Diploma (D3)	2,301,800	3,134,250	5,436,050	4,567,000 - 6,654,000	270.86 - 394.64
3A		Bachelor (S1)	2,301,800	3,915,950	6,495,350	4,981,000 - 8,498,000	295 - 504
3B		Bachelor (S2)	2,301,800	3,915,950	6,604,450	N/A	N/A
3B		Specialist Nurse (S1 + Professional education)				5,316,000 - 10,316,000	315 - 611.84
2D	Environmental Health	Diploma (D4)	2,579,400	3,915,950	6,495,350	4,981,000 - 8,498,000	295 - 504
2C	Nutritionist	Diploma (D3)	2,301,800	3,134,250	5,436,050	4,567,000 - 6,654,000	270.86 - 394.64
3A		Bachelor (S1)	2,301,800	3,915,950	6,495,350	4,981,000 - 8,498,000	295 - 504
3B		S1 + Professional education	2,688,500	3,915,950	6,604,450	5,316,000 - 10,316,000	315 - 611.84
3B		Bachelor (S2)	2,688,500	3,915,950	6,604,450	N/A	N/A
3B		Medical Nutrition Specialist	2,688,500	5,079,200	7,767,700	5,316,000 - 10,316,000	315 - 611.84
2C	Health Analyst	Diploma (D3)	2,301,800	3,134,250	5,436,050	4,567,000 - 6,654,000	270.86 - 394.64
3A		Bachelor (S1)	2,579,400	3,915,950	6,495,350	4,981,000 - 8,498,000	295 - 504
3A	Pharmacist	Bachelor (S1)	2,579,400	3,915,950	6,495,350	4,981,000 - 8,498,000	295 - 504
3B		S1 + Professional education	2,688,500	3,915,950	6,604,450	5,316,000 - 10,316,000	315 - 611.84
3A	Public Health	Bachelor (S1)	2,579,400	3,915,950	6,495,350	4,981,000 - 8,498,000	295 - 504
3B		Bachelor (S2)	2,688,500	3,915,950	6,604,450	4,981,000 - 8,498,000	295 - 504

Source: Hafez et al (2023)'s analysis on the following policies: Attachment to the Government Regulation of the Republic of Indonesia No. 15/2019 Regarding the Eighteenth Amendment to Government Regulation No. 7/1977 Concerning Employee Salary Regulations for Civil Servants. Ministry of Health Regulation No. 73/2013 on General Functional Structure at MOH; Attachment to the Regulation of the President of the Republic of Indonesia No. 127/2018 on Employee Performance Allowance Within the MOH.

Deployed temporary employees (i.e., *The Nusantara Sehat*) receive a higher monthly salary than permanent employees.²⁰ The MOH finances and manages the salaries and incentives of temporary employees contracted to the deployment programs (Kartika 2019). The monthly remuneration package provided to temporary employees in these deployment programs is higher than that of their permanent counterparts, since the participating health workers will be assigned to rural and remote areas. The cadres only included in this scheme are doctors, dentists, and midwives, since these are considered priority health professionals for deployment. The rates vary depending on the classification of their assigned areas, from common, remote, and very remote. However, HRHs that will be deployed in common areas have more potential to earn more in common areas since healthcare facilities in these areas provide a capitation incentive to supplement their monthly earning (Kartika 2019).

7.2. Malaysia

Malaysia has a mixed healthcare system. The backbone of the health system is the government-led and heavily subsidized public sector. In 2021, most of the selected HRH, i.e., doctors (medical officers), dental practitioners, pharmacists, nurses, and assistant medical officers, are employed in the public sector. Most health professionals, including doctors (72%), dentists (62%), pharmacists (65%), nurses (68%), and assistant medical officers (82%), are employed in the public sector, with smaller shares in the private sector (MOH Malaysia 2023)

The remuneration of health workers in the public sector follows a standardized salary scheme, with base pay determined by job grade and supplemented by various allowances. While public sector salaries are modest, especially for entry-level positions, they are supplemented by incentives such as critical service allowances, rural hardship allowances, and housing benefits. However, this might be different for contractual workers. In 2016, the Malaysian government hired contractual health workers, such as medical officers, dentists, pharmacists, and allied health professionals. However, wages, unequal benefit disparity, and job security remain major issues, facing significant disparities compared to their permanent counterparts (Jinah et al. 2023). **Table A2** shows the range of base salaries of different health workers. In the private sector, salaries are market-driven, with specialists typically earning more than their public sector counterparts. Data indicates that approximately 10% of public sector doctors in Malaysia leave government service annually (Aidalina and Aniza 2015). To address this, the Malaysian government has allowed dual practice within public hospitals since 2007, enabling specialists to earn additional income while remaining in the public system (Fadzil et al. 2022).

Table A2. Base monthly salary of Malaysian health workers in the public system (2024)

	MYS RM
Medical Officer (MD) or Pegawai Perubatan	GradeU10: RM3,840 to Grade U14: 6,560
Medical Officer (MD)	RM7,030
Nurse or Jururawat	RM 2,580
Dental Officer or Pegawai Pergigian	Grade UG10: RM3,840-Grade UG14: RM7,030
Pharmacy Officer or Pegawai Farmasi	Grade UF10: RM3,840-Grade UF14: RM6,560

²⁰ This is only applicable to specialist doctors, specialist dentists, medical doctors, dentists, and midwives since the government identified these as priority public HRH for the deployment programs.

Assitant Medical Officer or Penelong Pegawai Perubatan	Grade U5: RM1,974
Medical Laboratory Technologist or Juruteknologi Makmal Perubatan	GradeU5: RM1,974
Community nurse	Grade U1: RM1,561

Source: Authors' analysis on public service remuneration in Malaysia (Government of Malaysia 2024)

Table A3 summarizes the allowances provided to public health workers in Malaysia as of 2024. These include critical service incentives, on-call allowances, after-hours duty payments, and position-based allowances for administrative roles. Additional payments are provided based on specialization, location (e.g., Sabah, Sarawak, Labuan), and expert incentive schemes for health workers without postgraduate degrees: regional/relocation and housing-based remuneration, to support equitable health workforce distribution and retention across regions. In addition, Malaysian civil servants, including health workers, and their dependents are entitled to free medical facilities at government hospitals and clinics. They also receive various health-related benefits such as maternity and paternity leave, sick leave, and employment injury coverage through the Social Security Organization (SOCSO).

Table A3. Summary of allowances of public health workers (2024)

Incentive/Allowance	Value
Incentive scheme for critical services (e.g., medical officers and dental officers)	RM750 per month
On-call allowance (for public clinics)	RM100 per day
After-hours duty allowance (MO, HO, Pharmacy)	RM85/day for MO and HO, RM25/day for pharmacy
Position allowance for hospital administration (e.g., medical director)	RM250 (without degree), RM1280–RM2,250 (with degree)
On-call duty allowance for Medical Officers (MDs)	RM150–RM240 per day (depending on shift)
Expert Payment Scheme (medical specialists with postgraduate degrees)	RM1,600–RM3,100 per month (depending on grade)
Health Officers without postgraduate degrees in public health	RM250 per month
Payment to medical officer and dental officer (Clinical/Public Health) in Sabah, Sarawak, Labuan	RM500–RM2,100 per month (depending on grade)
Incentive for Care of Elderly, Disabled, and Mental Health Patients in Welfare Homes	RM200 per month
Fixed Remuneration Rate for Public Service Housing	RM300–RM3,000 per month (depending on grade)
Regional Remuneration Payment (BIW)	RM250–RM960 per month

Source: Authors' analysis on public service remuneration in Malaysia (Government of Malaysia 2024)

7.3. Vietnam

Vietnam's health system is a mix of public and private providers but has a dominant public sector. Public facilities, including hospitals and clinics, rely on government funding. In 2020, there were 13,316 public health facilities, including 1,235 hospitals, 11,810 health stations (or public

clinics), and health units. Private health facilities include 228 hospitals, accounting for only 6% of the nationwide hospital beds (Government of Vietnam 2018, 2020). While data on the distribution of health workers across the public and private sectors is limited, the relatively small number of private beds and facilities suggests that most health workers are employed in the public sector. However, public sector doctors are permitted to engage in private practice, with 48% reportedly doing so either within or outside their public hospital settings. In a separate study, Do and Do (2018) suggest that physicians engaged in dual practice, especially those working outside public hospitals, earn significantly more, up to 6.52 million VND in base salary and 2.90 million VND from autonomous hospital funds, compared to just 5.21 million VND and 1.61 million VND for non-dual practitioners (Do and Do 2018). Salary in the private sector is market driven.

In Vietnam, the salary of health workers is based on the salary scale used for the civil service. The base salary of health workers in the public sector is determined by multiplying a standardized statutory rate (currently 2.34 million VND in 2024) by a coefficient assigned according to the worker's position, grade, and qualification. This coefficient reflects the level of expertise and responsibility, ranging from 1.86 for entry-level physicians to 8.00 for senior doctors in advanced roles, resulting in monthly salaries from approximately 4.35 million to 18.72 million VND. Educational attainment also influences these coefficients. For example, nurses and midwives with doctoral degrees earn a coefficient of 3.00, while those with college-level qualifications fall under Class IV with a coefficient of 2.06, highlighting how rank and education directly affect salary levels in the health system.

Table A4. Base salary of physicians, doctors, and senior doctors (2024)

Health worker	Level of Expertise/Role*	Coefficient	Base monthly salary (using Statutory pay rate of 2.34** million VND)	
			Min	Max
Physician	Entry-level medical professional, typically with basic medical training;	1.86 – 4.06	4,352,400	9,500,400
Doctor	Basic-level doctor; typically, recent graduates or junior public doctors.	2.34 – 4.98	5,475,600	11,653,200
Primary Doctor	Mid-level doctor, with additional years of service, qualifications, or specialization.	4.40 – 6.78	10,296,000	15,865,200
Senior Doctor	Highest rank: experienced specialists or senior consultants in leadership or advanced roles.	6.20 – 8.00	14,508,000	18,720,000

Source: Authors' analysis on Joint Circular No. 10/2015/TTLT-BYT-BNV (MOH Vietnam and MOHA Vietnam 2015)

Note: *For classification

Table A5. Base salary of nurses and midwives (2024)

Qualification	Title Class	Level	Coefficient	Base monthly salary (2.34 million VND statutory rate)
Doctorate (Nursing)	Class III	Level 3	3.00	7,020,000
Doctorate (Midwife)	Class III	Level 3	3.00	7,020,000
Master's (Nursing)	Class III	Level 2	2.67	6,247,800
Master's (Midwife)	Class III	Level 2	2.67	6,247,800
College (Nursing)	Class IV	Level 2	2.06	4,820,400
College (Midwife)	Class IV	Level 2	2.06	4,820,400

Source: Authors' analysis on Joint Circular No. 26/2015/TTLT-BYT-BNV (MOH Vietnam and MOHA Vietnam 2015)

Vietnam's health workforce allowance system offers various financial incentives tied to risk exposure, location, and job function. On-call duty pays VND 65,000 to 90,000 per shift, with higher rates for infectious disease units, while epidemic control activities can earn up to VND 200,000 per day. Meal allowances (VND 15,000 per shift), surgery-related payments (up to VND 1.5 million per case), and professional allowances ranging from 30% to 70% of base salary are based on role and exposure, with higher rates for those treating HIV/AIDS or working in forensic medicine. Additional support is offered through a one-time attraction allowance (equal to 70% of base salary) for deployment to extremely difficult areas and a regional allowance tied to location-based coefficients. Other remuneration includes leadership allowance and pension, which are common among civil servants.

Table A6. Allowances for health workers (2024)

Incentive/Allowance	Value
On-call duty allowance*	VND 65,000 to 90,000 per person per shift in normal areas, depending on the facility type The regular allowances for medical staff working in detoxification and recovery or infectious disease isolation areas are 1.5 times the allowances.
Meal allowance*	VND 15,000 per shift
Epidemic control allowance (i.e., health worker handling specimens and patients, and conducting surveillance)*	VND 20,000 per day
Allowance for surgeries and procedures*	VND 28,000 to VND 1,500,000 per case, depending on the level of surgery or procedures
Professional / Preferential Allowance**	30% to 70% of base salary, depending on the health worker's role and exposure- highest for those treating infectious diseases like HIV/AIDS or working in forensic medicine, and lower for those in support roles, health education, or preventive care
Attraction allowance for health workers in extremely difficult areas***	70% of the current salary for health workers in extremely difficult areas, including a first-time allowance, equals 10 months upon receipt of the position, transportation costs, and clean water subsidy.

Regional Allowance*****	Provided to civil servants (including health workers) in identified zones from one to seven, starting with a coefficient of 0.1 in Zone 1 and a maximum of 1.0. The coefficient is multiplied by the regional minimum wage (i.e., VND 290,000).
Additional Incentives*****	In 2006, public facilities were granted autonomy. Hence, facilities may allocate additional wages for its health worker, but this might vary per facility.

Source: Authors' analysis on public HRH remuneration policies of Vietnam (Government of Vietnam 2005, 2006, 2011, 2019, 2023b, 2023a).

7.4. *Thailand*

In Thailand, there are approximately 12,000 health facilities, with private facilities comprising less than 5% of the total. Nearly all primary care units are publicly owned. In terms of health workers, 54.3% of doctors are employed by the Ministry of Public Health (MoPH), 21.3% work full-time in the private sector, and 19.4% are employed by other ministries, with the remainder working in other government agencies. Dual private practice during off-hours by public-sector doctors is allowed. Among dentists, 74.3% are based in MoPH hospitals, 5.4% in the private sector, and the rest in facilities operated by other government entities. Similarly, 68.1% of professional nurses work in MoPH facilities, followed by 12.4% in other ministries, 14.1% in the private sector, 3.3% in local government agencies, 3.1% in independent organizations, and 0.01% in state enterprises (Pongpisut et al. 2024).

Table A7 outlines the compensation structures for health workers in public and private facilities. Significant discrepancies exist in salary levels across various public sector entities and between public and private providers. In the public sector, salaries for health workers of MOH facilities (including PHC facilities) are centrally determined and financed through a line-item budget under the Ministry of Public Health (MoPH), ensuring standardized base pay nationwide. In addition to their base salary, health workers receive various supplementary payments, such as non-private practice allowances, hardship allowances, and lump-sum incentives, which may vary depending on the type of hospital. Medical doctors are given the non-private practice allowance as an effort to increase productivity and resolve retention issues.

Table A7. Health worker compensation in Thailand

Category of Professional	PHC Centre	MOPH District Hospital	MOPH Provincial / Regional Hospital	University Hospital	Private Sector: Private Clinic	Private Sector: Hospital
Medical Doctor in Clinical Services	No MD at this level of care	They are mostly non-specialists and are salary-paid (the salary scale is standard for all civil servants across sectors, based on grade on entry into service). Additional pay includes a non-private practice allowance, overtime, hardship, lump sum, and specialty allowance.	Mostly specialists, salaries are paid on a salary scale similar to that of a civil servant. Due to seniority and specialist training, grades are higher than those of district hospital doctors. Other allowances are similar to those of district hospital doctors, though neither hardship nor lump sum allowance are payable.	Mostly specialists, recent reforms have seen most university hospitals become autonomous bodies, with a higher salary scale than civil servants (1.4B higher), and other allowances.	Private clinics provide diagnosis and the dispensing of medicines. Service charges include doctor fees and dispensing medicines.	There are different modes. The most common is a fee-for-service with a minimum monthly guarantee. Rate of pay varies by seniority and specialty, e.g., fee per consultation, surgical fees, or anaesthesiologist fees. Other modes are payment per service session, e.g., 4 hours of outpatient consultation.

Source: WHO (2024)

Tables A8 and A9 present the compensation structure for health workers in Thailand as of 2024. **Table A8** details the base salary ranges by cadre, showing notable variation by position and required education, ranging from THB 10,000 for assistant nurses and dental assistants with certificates, to THB 60,000 for specialist doctors and dentists with advanced degrees. **Table A9** summarizes the additional allowances and incentive payments that supplement base salaries, including routine duty and night shift allowances, professional role allowances differentiated by profession, and targeted payments for working in high-risk units, performing procedures, serving in remote border areas, or providing community health services. The system also includes supervisory allowances for nurses and health officers. These allowances aim to address workload complexity, location-specific hardship, and leadership roles.

Table A8. Base salary of health workers in the government in Thailand (2024)

Position	Max Salary (THB/month)	Min Salary (THB/month)	Education Requirement
Assistant Nurse / Dental Assistant	23,000	10,000	Certificate
Technical Nurse (e.g. provincial/academic hospitals)	45,000	15,000	Associate degree or higher
Professional Nurse / Allied Health Professions	50,000	19,500	Bachelor's degree or higher (5-year program)
Dentist	54,800	19,800	Bachelor's degree or higher (6-year program)
Doctor	50,000	19,800	Bachelor's degree or higher (6-year program)
Specialist Doctor / Dentist	60,000	23,000	Bachelor's degree or higher

Source: Authors' analysis on B.E. 2556 (MOH Thailand 2023).

Table A9. Additional allowances and incentives in the government Thailand (2024)

Allowance Type	Key Provisions
Routine Duty Allowance	THB 600/month for inpatient care; THB 600/month for outpatient or primary care; THB 400/month for general service units
Professional Role Allowance	THB 1,500 for doctors, THB 1,000 for dentists, THB 800 for pharmacists/psychologists, THB 600 for public health tech staff
Night Shift / Risk Duty / On-Call	THB 120–240/shift for night duty based on hospital size; THB 60–120/hour for on-call duty; THB 120/shift for high-risk infectious disease units
Procedure-Based Incentives	THB 200–600 per medical procedure (e.g., casting, endoscopy); dental procedures THB 70–

	300 per case (e.g., surgical extraction, root resection)
Remote/Border Area Allowance	THB 6,000/month for specialists, THB 3,000 for dentists, THB 2,000 for pharmacists, THB 1,000 for nurses and allied health in border/remote areas
Community and Health Promotion Services	Allowance for outreach services, including maternal-child health, family planning, home visits, and community follow-up
Management/Supervisory Allowance	THB 400/month for senior nurses and health officers in supervisory roles; THB 250–260/month for EMTs and technical support staff

Source: Authors' analysis on B.E. 2556 (MOH Thailand 2023).

‘Standardizing’ Health Worker Salaries in the Philippines: Potential Options, Approaches, and Costs²¹

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Abstract

Significant wage differentials exist in the Philippine health sector. Leaders and legislators have increasingly called for the standardization of salaries, with several bills filed to address the issue. However, implementing such reforms is fraught with challenges, especially in a highly decentralized regime with varying fiscal capacities of local governments. This report is part of a bigger endeavor to examine health sector remuneration in the Philippines. It provides policy options for equitable remuneration within the context of health sector reforms, particularly the implementation of the Universal Health Care (UHC) Act and the potential costs of some of these options. We draw lessons from other countries with similar reform features in the *Act*, including shifts in provider payments, care integration, decentralization, and pay-for-performance strategies to improve quality.

Keywords: Salary standardization, fiscal capacity, decentralization, remuneration, healthcare

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1. Introduction

There has been a growing call in the Philippines to establish consistent and uniform pay scales and benefits for healthcare workers in recent years. Several health sector leaders have supported this call (Montemayor 2023). Several bills were filed in Congress to amend the Magna Carta of Public Health Workers (MCPHW) Act to address wage disparity. (RP 2020a, 2021b). The public-private wage differential in the Philippines is significant. Syling (2024) estimate that wages for public health workers are, on average, 17% higher than those of their private sector counterparts. This estimate is significantly higher than those reported in other empirical studies on public-private wage differential (Christofides and Michael 2013). With health services decentralized and human resources for health (HRH) management falling under local government units (LGUs), salary-related differences persist across national subunits. For instance, the ratio between the government health sector's lowest—and highest-paying regions is 1.5. In some health systems, wage disparities between sectors and across sub-national units have been identified as a primary contributor to high attrition rates, workforce maldistribution, declining morale, and productivity among health workers.

Salary standardization, at least in the public sector, is fraught with challenges and feasibility issues, which require decision-makers to navigate, especially the complex political economy inherent in a decentralized regime. Standardization has fiscal implications for local government units (LGUs), where personnel salaries (PS) account for a significant share of their expenditures (Cuenca, 2018; Syling et al., 2024). Our analysis using DOF-BLGF data suggests that, on average, PS in the healthcare sector accounts for about 12.2% of the total PS expenditure of LGUs. Amid the growing call to standardize salaries of health workers, particularly within the public sector, the government must assess its fiscal capacity and ensure equitable implementation. Dagoy and colleagues (2024) indicate that wage differentials within the government sector are primarily driven by the inability of the LGUs to fully implement mandates such as the MCPHW, which provides additional cash and non-cash benefits. These challenges are exacerbated by a Salary Standardization Law (SSL) provision of a lower pay scale for LGUs in lower income tiers. In addition to the fiscal implications for LGUs, case studies have highlighted the challenges of standardizing salaries for health workers without aligning with sectors within the local government, as this could create tension among public sector employees within LGUs, leading to resistance to the reform (Cuenca 2018). This report explores policy options for standardizing the salaries of health workers in the public sector, including potential costs. We argue that any reform in health worker remuneration must be viewed in the context of broader health reforms, particularly the provisions of the Universal Health Care Act of 2019, as these have profound implications on how health workers are remunerated (RP 2019b). Key provisions of the Act, *inter alia*, a shift in provider payments to diagnosis-related groupings (DRGs), global budgets for hospitals, capitation for primary care facilities, and pay-for-performance.

2. Background: wage differentials in the health sector

While wage differentials among healthcare workers are not unique to the Philippines, the disparity between the public and private sectors in the country is large. Wage differentials in the public and private health sectors have been documented in numerous empirical studies in high-income and low-income countries, and government salaries are more competitive than those of the private sector. Our analysis suggests that it is large compared to other studies conducted in other countries. The results from our pooled Ordinary Least Squares (OLS) regression analysis of the 2021-2023 Labor Force Survey (LFS) show that the wage differential between public and private health workers is statistically significant. On average, wages in the public sector are 17.6% higher compared to the private sector, holding other variables constant. These differences are more pronounced among females. The positive and sufficient correlation suggests that public health workers are better compensated than their private counterparts. This wage premium in the public sector could reflect better job security, benefits, or other institutional factors typically found in the public sector.

Table 34. Results of Ordinary Least Squares Regression (OLS)

VARIABLE	log(wage)		
	(1) All	(2) Male	(3) Female
Public (Reference: 0=Private)	0.176*** (0.0149)	0.145*** (0.0250)	0.190*** (0.0186)

Source: Authors' analysis of pooled 2021-2023 Labor Force Survey (LFS). The coefficients of other control variables were excluded from the table

Note(s): Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.

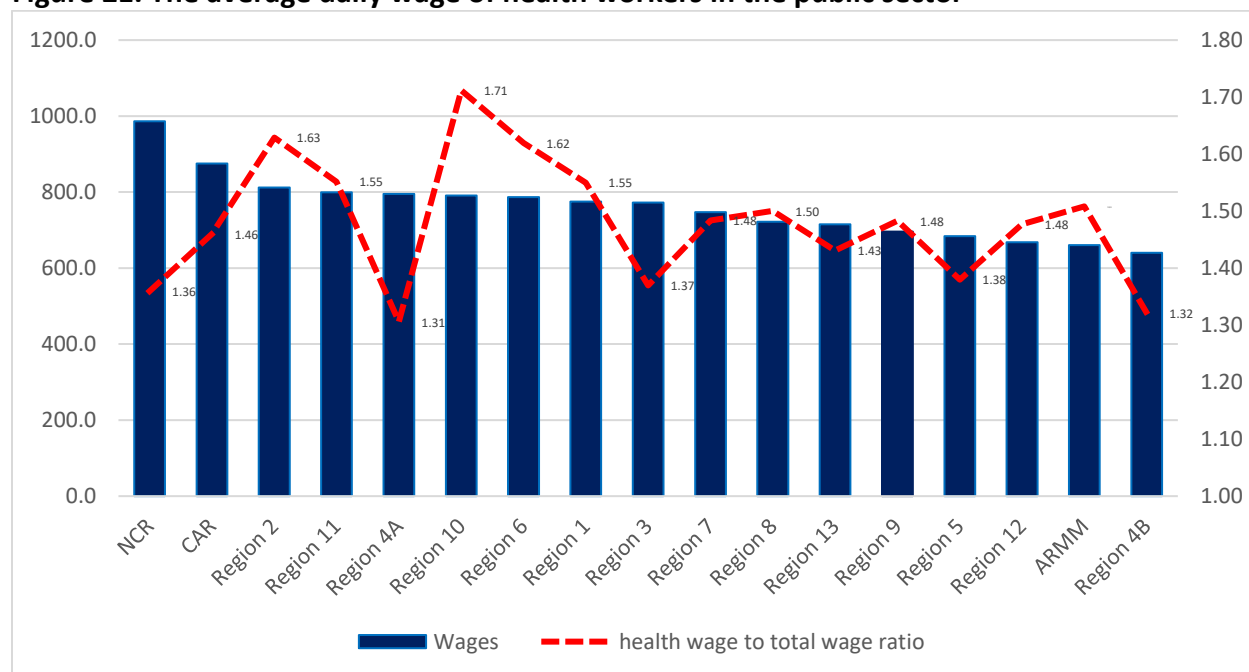
Empirical studies have highlighted wage differentials within the government sector in high-income and low-middle-income countries. For example, Sellers et al. (2019) and have shown variations in earnings between government public health workers across states. Also, similar patterns within the government sector have been observed in low-middle-income countries (LMICs). These differences in salaries among government workers have been documented as an important driver of human resources for health (HRH) maldistribution and identified as significant factors contributing to poor motivation and difficulties attracting and retaining workers (Nwankwo et al. 2022).

The inter-regional variation of government salaries among healthcare workers is significant. Our analysis of regional data shows salary-related differences. **Figure 21** shows the average salary of health workers in the public sector using the Labor Force Survey (LFS) across regions, suggesting inter-regional differences in earnings. These differences may be attributed to a wide range of factors. While national pay scales often exist for different health cadres, adjustments are made to account for the cost of living (i.e., the national pay scale is weighted based on the income class of the LGU).²³ However, the decentralized structure of the health system leads to LGU-

²³We were not able to disaggregate by type of cadre because of data limitation. Regions typically have systematic differences in terms of HRH composition, which could also contribute to the differences.

specific variations in implementing benefits, allowances, and incentives, which can create differences within the public sector.

Figure 21. The average daily wage of health workers in the public sector



Source: Authors' analysis of the Philippine Labor Force Survey (2022)

Wage policies and their variable implementation primarily influence these wage differentials in the public sector. The Compensation and Position Classification Act of 1989, known as the Salary Standardization Law (SSL), provided a comprehensive and standardized salary process for government employees (Hortillo 2022; RP 1989b). It established a Salary Grade table that determines the monthly salary rates of all government positions that correspond to the roles and responsibilities of their profession to provide fair and competitive salary rates. Aside from providing a comprehensive salary framework, SSL also established the salary rates of LGUs based on their financial capacity and income classification. **Table 35** depicts the salary differentials stipulated in the SSL. Although these salary differentials consider the finite monetary resources of LGUs, they have negative implications for health worker retention.

Table 35. Salary grade rates by LGU income classification

Income Classification	Provinces/Cities	Municipalities
Special Cities	100%	-
1 st Class LGU	100%	90%
2 nd Class LGU	95%	85%
3 rd Class LGU	90%	80%
4 th Class LGU	85%	75%
5 th Class LGU	80%	70%
6 th Class LGU	75%	65%

Source: Republic Act No. 6758

The SSL created a pay disparity among public health workers, as HRH employees in higher-income LGUs earn more than those employed in lower-income LGUs. The Local Government Code of 1991 (LGC) transferred the responsibility of delivering basic health services from the national government to the LGUs (RP 1991b). This transfer included devolving the central government's resources, such as health facilities, to the local level to ensure that LGUs can provide healthcare from the primary level to the tertiary health services. A major reform led to the transfer of 46,080 out of 78,080 health workers from the central government to their respective LGUs in 1992 (Cuenca 2018). Therefore, the responsibility of retaining, hiring, and providing their salaries and benefits was also part of the devolution, which LGUs must now consider in their annual budget deliberations. Following this decentralization, the LGC established the personnel services (PS) limitation, which refers to the limit to which LGUs can spend their budget on salaries, wages, and other monetary compensation for their employees. 1st to 3rd class LGUs have a limitation of 45%, while 4th to 6th class LGUs are limited to 55% of their annual internal revenue. Lastly, the LGC stipulated that LGUs must also follow the salary scheme under the SSL, making the monthly salary rates of employees dependent on the income classification of their respective LGUs, as illustrated above (RP 1991b). The PS limitation was enacted to ensure that LGUs will not overspend their salaries and benefits budget and avoid fiscal mismanagement. Still, by integrating the devolved health workers into their local health system, LGUs must allocate more resources for PS to retain these absorbed health workers with their finite resources while ensuring compliance with the PS limitation.

Table 36. The estimated salary of a health worker based on SSL

	Medical Specialist II (SG 23)	Medical Officer III (SG 21)	Nurse I (SG 15)	Midwife I (SG 9)
Entry-level salaries (100%) *	88,345.88	61,563.64	39,836.75	22,879.25
Autonomous Region in Muslim Mindanao (ARMM)	68,263.13	47,569.02	30,781.08	17,678.35
Cordillera Administrative Region (CAR)	66,890.45	46,612.47	30,162.11	17,322.86
MIMAROPA Region	71,221.30	49,630.41	32,114.97	18,444.44
National Capital Region (NCR)	87,566.36	61,020.43	39,485.25	22,677.38
Region I (Ilocos Region)	71,136.10	49,571.04	32,076.55	18,422.37
Region II (Cagayan Valley)	71,579.16	49,879.79	32,276.33	18,537.11

Region III (Central Luzon)	75,195.94	52,400.13	33,907.20	19,473.76
Region IV-A (CALABARZON)	73,756.37	51,396.97	33,258.07	19,100.95
Region IX (Zamboanga Peninsula)	70,124.55	48,866.14	31,620.42	18,160.40
Region V (Bicol Region)	70,754.20	49,304.91	31,904.34	18,323.47
Region VI (Western Visayas)	71,706.30	49,968.38	32,333.66	18,570.04
Region VII (Central Visayas)	69,773.17	48,621.29	31,461.98	18,069.41
Region VIII (Eastern Visayas)	66,908.11	46,624.77	30,170.07	17,327.43
Region X (Northern Mindanao)	69,869.24	48,688.23	31,505.30	18,094.29
Region XI (Davao Region)	76,085.63	53,020.11	34,308.38	19,704.17
Region XII (SOCCSKSARGEN)	77,744.38	54,176.00	35,056.34	20,133.74
Region XIII (Caraga)	69,284.95	48,281.07	31,241.83	17,942.97

* Salary grade equivalents are averaged across salary steps 1 to 8.

Note: Rates are adjusted based on the percentage of the Salary Schedule corresponding to the LGU's income classification.

Source: Authors' calculation based on the National Budget Circular No. 594 (SSL VI, First Tranche, 2024).

LGUs had difficulty absorbing their devolved health workers. The effects of devolution highlighted the insufficient capacity of lower-income LGUs to pay the salaries of their health workers due to budget constraints and the high salary rates, which is exacerbated by the entitled benefits they must provide under the Magna Carta of Public Health Workers (MCPHW) which wasn't even factored in the cost of devolution (Cuenca 2018). With each iteration of the SSL and the implementation of the MCPHW, the issue of financing the salaries and benefits of health workers became more apparent. This resulted in LGUs selectively hiring their health workers based on their capacity to pay their salaries, leaving Plantilla positions of health workers unfilled, leading to inadequate health staff in local health facilities and compromising their quality of care (Cuenca 2018; USAID 2020). A common practice identified is that LGUs would deliberately make a Plantilla health worker position unfilled to have the capacity to hire additional personnel that would cost them less to hire (i.e., leave a medical officer position vacant to hire three additional admin personnel) (USAID 2020). Aside from the financial implications of a devolved health workforce to LGUs, it also created political tension during the first few years of devolution. LCEs cited the high salaries of health workers as an issue because, at times, it would result in a higher salary than they and their peers in their respective LGUs (Cuenca 2018). There were even some LGUs that initially resisted hiring their devolved health workers, which required intervention from the national government to resolve the issue (Perez 1998). These impacts underline how expensive hiring and retaining health workers in LGUs is, especially for those with lower-income classifications. Although there were policy initiatives, such as waiving the PS limitation in the fiscal years of 2022 and 2024 by the DBM to allow LGUs to provide the MCPHW benefits and ensure the payment of salaries to local health workers (DBM 2022b, 2024b). The pay disparity of health workers within the public sector will persist if there continues to be no monetary augmentation or capacity-building of LGUs to finance the salaries of health workers in this devolved health system (L. P. D. Carpio, Cayabyab, and Te 2021; USAID 2020).

The inadequacy of the local budget highlighted the implementation issues of MCPHW, leading to health worker dissatisfaction. The MCPHW was implemented to provide additional benefits, incentivize health workers to practice in the government sector (RP 1992a), and even hire or retain health workers in geographically isolated disadvantaged areas (GIDAs) with the entitled cash and non-cash benefits provided under the MCPHW (Lorenzo et al. 2005). However, empirical

studies on MCPHW show that the fiscal capacity of LGUs is a huge factor in its implementation. The MCPHW was passed in 1992, a year after the LGC was passed into law, which stipulated that LGUs would be responsible for providing the benefits to their health workers. Perez 1998) noted that LGUs felt that the MCPHW was an “unfunded mandate” by the national government, requiring them to comply with providing the benefits using their local budget. Since the MCPHW benefits are under the PS item expenditures of LGUs, it would be too costly for localities to provide as they would have to balance their spending with their other non-health staff while observing their PS limitation (Cuenca 2018; Carpio et al. 2021). A common practice by public hospitals and LGUs to comply with the provision of benefits was to maintain unfilled vacant Plantilla positions to produce savings and limit the costs of MCPHW under PS, as postulated earlier (Cuenca 2018; Lavado 2011). Additionally, implementing MCPHW depends on the LCE's priorities and political will. Even if there are funds to finance these benefits, the LCE determines the allocation of the budget, which can create tension between health workers and their LCE and, at times, even lead to some legal disputes (Cabegin et al. 2007; L. P. D. Carpio et al. 2021; Syling et al. 2024). Ultimately, the MCPHW highlighted the inequities across LGUs. Health workers who practice in higher-income LGUs have more earning potential due to the rates in the SSL and have a higher chance of receiving the MCPHW benefits than health workers in lower-income LGUs. This disappointed public health workers and is an enabling factor influencing internal and external migration (Lorenzo et al. 2005).

3. Methods: Case Study

This section explores strategies for addressing wage gaps among public health workers. However, these strategies must be considered with other objectives, such as improving HRH productivity and performance and overall health sector goals. We argue that the compartmentalized view of standardizing salaries and benefits is not fully compatible with remuneration policy options in the literature for improving HRH goals. Striking the right balance is essential. Efforts to reduce wage gaps must be contextualized within the overarching goals of the health system envisioned in the Universal Health Care (UHC) Act of 2019, which envisages the following reform areas: (1) integrated care through the creation of healthcare provider network (HPCNs); (2) provider payment reforms, including the shift to DRGs and global budget; (3) movement towards primary care; (4) payment for quality (RP 2019b). These reform areas have profound effects on how health providers are managed and remunerated. Therefore, the call to standardize salaries must be carefully examined within the context of broad health reform.

We conducted a comparative health system assessment to examine how countries deal with HRH management, including remuneration practices, in the context of a health sector-wide reform. We reviewed published literature, government reports, and other secondary data sources to critically examine how countries manage HRH, particularly remuneration practices, within sector-wide health reforms. We selected upper-middle-income and high-income countries with mature health systems that exhibit structural features of the Universal Health Care (UHC) Act. We identified upper-middle-income and high-income countries with mature health systems, some of which share similarities with the reforms envisioned in the UHC Act. All the selected countries for comparative assessment have achieved universal coverage (UHC).²⁴ Integrated care (e.g., the

²⁴ Here, there is explicit government policy to cover everyone with healthcare.

NHS in the UK) is at the forefront of the reform agenda. These countries have mature provider payment systems with some semblance of a purchaser-provider split (e.g., the UK, Thailand, and Germany) (Tynkkynen et al. 2013).²⁵ Lastly, all the health systems have a degree of decentralization. In principle, governments decentralized their health systems, including HRH management, based on the theory that local governments (LGUs) understand their needs better, and that decentralization provides flexibility to respond to those needs. From a fiscal perspective, decentralization was intended to address public sector fiscal constraints. One of the main fiscal constraints on healthcare financing is the fixed level of funds that national governments allocate to the health wage bill. As a result, many countries decentralized their HRH management, addressing budgetary constraints by ‘delinking’ human resources for health, to be separated from the overall public sector personnel costs and the rest of the civil service.

This provides national governments (i.e., ministries of health/finance) with the “autonomy to control the use and size of the salary budget for health and enables the health workforce to be employed directly by decentralized entities” (i.e., LGUs or their counterparts) that typically enjoy a level of independence from the national government (Haji et al. 2010). In the Philippines, the health system is decentralized. As noted in the earlier section and corresponding reports (see reports by Syling et al. (2024) Dagoy et al. (2024)). At least within the government sectors, the primary drivers of wage disparity are existing SSL policies and local governments' variable fiscal capacity to provide mandated functions.

Table 37. Characteristics of country case studies

	England	Thailand	Spain	Germany	Australia
Population	60.9 million	71.7 million	47.6 million	84.0 million	26.0 million
GNI per capita (USD)	47,800	7,180	32,180	53,970	63,140
Share of public spending to health spending	84%	71%	72%	79%	76%
Public spending on health per capita	4,805	256	2,315	5,237	5.364
Federal/unitary	Unitary	Unitary	Federal	Federal	Federal
Health system	Tax-based	Tax-based	Tax-based	SHI	Tax-based

Source: World Bank database

3.1. *Thailand*

Thailand's universal coverage scheme (UC Scheme) operates under a model of "selective" decentralization with a clear purchaser-provider split, where the National Health Security Office (NHSO) functions as the purchaser and the Ministry of Public Health (MOPH) serves as the provider. Unlike England, where public and private providers coexist within the health

²⁵ The purchaser-provider split (PPS) is "a service delivery model in which third-party payers are kept organizationally separate from service providers." (Tynkkynen et al 2013, p. 221)

system, Thailand's system is publicly delivered and financed.²⁶ The NHSO reimburses public clinics (owned by the MOPH) through capitation and public hospitals using DRG. This shift from supply-side financing in the 1990s to a purchaser-provider model gave the NHSO a more distinct role as a health services purchaser. Global budgets are allocated to public hospitals, and capitation payments are to primary care facilities. What is unique about the Thai health system is that during the transition from supply-side financing to demand-side financing, the global budget for hospitals and capitation payments for primary care facilities excluded the salaries of health workers, ensuring they were not affected. **Salaries are secured through line-item budgets, while the global budget and capitation are allocated for operating costs. Health workers remained part of the civil service, with their salaries adhering to civil service pay scales. This decision created a path dependency, as even now, health workers' salaries remain unbundled from the global budget and capitation.** This approach differs from other health systems, such as those in England and Germany, which introduced global budgets that include health worker salaries. In Thailand, global budgets allocated to hospitals and capitation payments to primary care facilities are excluded from NHSO payment rates. However, performance-based pay programs have been introduced to enhance care quality (Gill et al. 2016). Thailand's health system remains highly centralized despite repeated attempts to decentralize over the past decades. The “selective” decentralization policy imposes strict criteria, allowing only facilities capable of managing their health systems to decentralize, leading to limited decentralization. **The salaries of health workers remain centralized and are funded through a line-item budget under MOPH, ensuring standard pay across the country. In addition to the base salary, health workers receive additional payments, such as non-private practice allowances, hardship allowances, and lump-sum allowances, albeit these may vary depending on the type of hospital (see Table 38 below).**

Table 38. Health worker compensation in Thailand

Category of Professional	PHC Centre	MOPH District Hospital	MOPH Provincial / Regional Hospital	University Hospital	Private Sector: Private Clinic	Private Sector: Hospital
Medical Doctor in Clinical Services	No MD at this level of care	They are mostly non-specialists and are salary-paid (the salary scale is standard for all civil servants across sectors, based on grade on entry into service). Additional pay includes a non-private practice allowance, overtime, hardship, lump sum, and specialty allowance.	Mostly specialists, salaries are paid on a salary scale similar to that of a civil servant. Due to seniority and specialist training, grades are higher than those of district hospital doctors. Other allowances are similar to those of district hospital doctors, though neither hardship nor lump sum	Mostly specialists, recent reforms when most university hospitals become autonomous bodies, higher salary scale than civil servants (1.4B higher), other allowances.	Private clinics provide diagnosis and the dispensing of medicines. Service charges include doctor fees and dispensing medicines.	Different modes, most common is fee for service with minimum monthly guarantee. Rate of pay varies by seniority and specialty, e.g., fee per consultation, surgical fees, or anaesthesiologist fees. Other modes are payment per service session, e.g., 4 hours of outpatient consultation.

²⁶ The Thai Health System has three schemes: the Civil Servant Medical Benefit Scheme (CSMBS) for government employees, Social Health Insurance (SHI) for formal employees in the private sector, and UCS for the rest.

		allowance are payable.
Professional Nurse	Depending on the availability of civil service posts, they can be civil servants or non-civil servants. This means they will be introduced to the same payment mechanisms as professional nurses in district hospitals.	Civil servants are paid salary plus other allowances, such as a hardship allowance, an allowance for deficit health professions, and overtime payments.

Source: Jongudomsuk, et al. (2024)

3.2. *England*

England’s National Health Service (NHS) operates as a tax-funded and decentralized health system. About two-thirds of the NHS budget is allocated as block grants to Clinical Commissioning Groups (CCGs), semi-autonomous government bodies (formerly called trusts before 2012)²⁷ tasked with planning and purchasing integrated health services for specified localities. With the clear purchaser-provider split, CCGs commission or purchase community care (e.g., immunization, screening) and primary care services delivered mainly by general practitioners (GPs) who function as private contractors and are paid through capitation with performance-based incentives. The capitation is a refined weighted capitation formula that considers the sex and age of the patients, the number of new patients, the morbidity profile of the population, rurality, and the market forces factor. Like most systems with a purchaser-provider split, the capitation includes HRH salary and operating costs. Hospitals providing acute care are a different story. Most hospital beds are publicly owned, and entities in localities called NHS Trusts or NHS Foundation Trusts manage these hospitals. NHS England funds hospitals through “a blended payment system, which includes a combination of a fixed block payment, a quality-based or outcomes-based element, and a variable element” (Anderson et al. 2022, p.79) based on certain quality and efficiency indicators. **The block grant already includes hospital salaries and operating costs.** In addition to Payment by Results (PbR), Pay-for-Performance schemes have been introduced to improve the quality of care. NHS consultants (hospital specialists) are salaried employees permitted to work in private practice alongside their NHS roles. Full-time consultants can earn up to 10% of their NHS pay through private practice, while part-time consultants are unrestricted in dual practice, provided they relinquish one-eleventh of their NHS salary. To avoid creating perverse incentives that could lead to a relative oversupply or undersupply of the workforce within each constituent country, the terms and conditions of healthcare professionals are broadly standardized. In summary, **the primary difference in the salaries of health workers in England arises from variations in provider performance, which are deliberately designed to enhance quality and outcomes** (Anderson et al. 2022; Buchan 2000; Thorlby 2020).

²⁷ Clinical commissioning groups (CCGs) were established as part of the Health and Social Care Act in 2012 and replaced primary care trusts on 1 April 2013.

3.3. *Spain*

The Spanish National Health System (SNS) is a tax-funded and decentralized health system organized across 17 federal states, called Autonomous Communities (ACs), each with significant self-governance in public healthcare services. These ACs are responsible for planning and providing public health and healthcare services. While the system exhibits a semblance of a purchaser-provider split, public provision plays a central role. AC health departments act as purchasers, contracting services primarily from their respective Regional Health Services (RHS), which manage all inpatient and outpatient care facilities. ACs sometimes contract the private sector, but for only a few select services (e.g., a palliative care program to reduce the surgical waitlist in the public sector). These contracts with public providers are based on annual budgets and cover hospital care, primary care, preventive activities, and long-term care services. Public hospitals are financed through global budgets, using historical expenditures to adjust for quality improvements. The main part of the budget is fixed using a formula that accounts for the number of discharges and the case-mix weight (i.e., DRGs). Primary care services operate on a global budget tailored to demographic and geographic factors, with specific objectives for prioritizing preventive and care programs. Incentives tied to prescription targets aim to promote the appropriate use of medications. The global budget covers all major expenses, including personnel, infrastructure, and operational activities.

Most primary healthcare professionals and personnel in Spain have civil servant status, although in a few ACs, up to 30% of professionals work under alternative contractual arrangements. The workforce is primarily salaried, with supplemental payments based on geographic dispersion, teaching responsibilities, and transportation. While the Ministry of Public Administration regulates basic salaries and working conditions for SNS civil servants, AC health departments can adjust specific remuneration components. **These variations often stem from regional trade union negotiations and localized human resource policies rather than productivity or quality differences.** For health professionals, remuneration includes basic pay (salary and seniority bonuses), on-duty payments, and supplementary stipends tied to position characteristics, performance, or professional achievements. Family doctors' salaries incorporate a capitation component (10–15% of total pay), reflecting their population size, demographic profile, and small performance-based incentives for their respective catchment areas. Hospital specialists may receive additional fee-for-service payments linked to programs like waiting list reduction. While pay-for-performance schemes exist, their implementation varies significantly across ACs and tends to reward complementary activities (e.g., participation in quality control or research) rather than clinical outcomes (Bernal-Delgado et al. 2024; Dedeu et al. 2015; López-Casasnovas and Arolas 2020).

3.4. *Germany*

The German health system operates under a social health insurance (SHI) model within a decentralized framework, with administration managed by nongovernmental insurers known as sickness funds. While private health insurance (PHI) is available, it is typically limited to high-income earners opting out of the SHI system. Healthcare providers accommodate SHI and PHI patients, ensuring broad access to services. The Federal Joint Committee, the highest decision-making body in the healthcare system, includes representatives from various stakeholders. This committee determines the services covered by sickness funds and regulates the quality of care.

General practitioners (GPs) and specialists in ambulatory care often work in private practices, with 56% in solo practices and 33% in dual practices. Public hospitals account for about half of all hospital beds, while private non-profit hospitals, often operated by organizations, comprise a third. Though smaller and often specialized, private for-profit hospitals now account for about one-sixth of all beds. Most hospitals treat SHI and PHI patients; large hospitals are typically state- or municipally funded.

At least at the primary healthcare level, paying physicians through the SHI in the German system is a complex process following a highly regulated fee schedule. SHI does directly pay the physician, but it is a two-step process. First, sickness funds transfer total payments to Regional Physicians' Associations (RPAs), which act as intermediaries, distributing funds to SHI-affiliated doctors. Payments are allocated based on the Uniform Value Scale (EBM), a national catalog assigning point values to medical services. Physicians are allocated a specific volume of standard services per quarter, calculated using historical data, patient morbidity, and regional factors. Services within this volume are reimbursed at fixed rates, while those exceeding the limit are paid at reduced rates to manage costs. Remuneration includes morbidity-based payments tied to patient needs and regional demographics, supplementary funds for unforeseen/unpredictable healthcare demands, and fixed-price payments for specific “predictable” services (e.g., immunizations and screenings). Physicians also earn income from privately insured patients, who pay higher rates. **This structured system will lead to variations in salaries. Still, it will be brought about by policies to promote fairness, predictability, and a focus on quality and volume while providing flexibility through regional agreements and additional payments for performance and specialized services.**

In hospitals, there are two streams through which the facility can receive resources. Capital investments are financed through the states (through budgets), while operating costs are financed through the SHI and other reimbursements (e.g., private health insurers and self-paid patients). Sickness funds pay hospitals through a global budget based on DRG and finance most operating costs and salaries of health workers. **Prices for services provided by physicians, dentists, pharmacists, midwives, and other health professionals are set by a fee schedule. Physicians and other health professionals working in hospitals are paid salaries** (InformedHealth.org 2018).

3.5. *Australia*

The Australian healthcare system operates under a tax-based mandatory public health insurance system with decentralized service delivery. The Australian healthcare system operates as a hybrid model, where patients can opt to purchase PHI coverage to supplement the mandatory public health insurance operated by the government (Glover and Woods 2020). The mandatory public health insurance, called Medicare, is funded from general tax revenues and a government levy (i.e., income-based tax surcharge). Medicare payments to the health system are split into two components: direct payments to doctors and select other health professionals, and payments to public hospitals through states and territories (i.e., LGUs). While the national federal government provides funding, support, and regulation, states and territories own and manage public service delivery through hospitals. The majority of health services are provided by privately owned facilities such as GP clinics and surgeries, specialist clinics, and private hospitals (Australian Institute of Health and Welfare 2024). Supplementary private insurance allows patients

to access public and private health facilities and covers services such as ambulance and dental services beyond Medicare coverage (Glover and Woods 2020).

Physicians and other HRH working in public hospitals are salaried, constituting most of hospital expenditures (Glover and Woods 2020). On the other hand, GPs, the majority of whom are self-employed, are primarily paid on a fee-for-service (FFS) basis through the Medicare Benefits Schedule (MBS) model. Additionally, GPs can receive top-ups from performance-based incentives specified by the federal government through Medicare. While some specialists, such as surgeons and anesthesiologists, are likewise salaried in public hospitals, most work as visiting specialists and not as hospital employees (Australian Institute of Health and Welfare n.d.-a). Public facilities are funded primarily through the government, both at the federal level and at the state and territory levels. On the other hand, private facilities are funded by the national government, state and territory governments, and non-government sources. However, non-government sources such as PHI and patient OOP make up most of the private hospital financing (Australian Institute of Health and Welfare n.d.-b).

4. Policy options for the Philippines

Healthcare worker remuneration approaches lie on a spectrum. It ranges from a fully centralized system to a fully decentralized system. At one extreme, a fully decentralized system places the responsibility for the salaries and benefits of health workers entirely on the sub-national unit (i.e., local governments), semi-autonomous bodies or entities (e.g., trust/clinical commissioning groups), or facilities. On the other hand, a fully centralized system involves the national government covering all salaries of health workers in the country. Between these two extremes lie hybrid approaches, such as those with national subsidies and ‘top-ups’, which aim to balance equity and efficiency. In this section, we present policy options based on this framework and explore how to work within the context of the financing reforms outlined in the UHC Act of 2019.

Figure 22. An illustrative example of policy options



Source: Authors' illustration on the spectrum of decentralization

Table 39. Summary of Policy Options for the Philippines

	Purely Decentralized	Hybrid	Purely Centralized
Advantages	<ul style="list-style-type: none"> • Full local autonomy on healthcare worker remuneration • More local autonomy on resource mobilization • More responsive health systems 	<ul style="list-style-type: none"> • More flexible and adaptable strategies to address healthcare worker remuneration • Avoid pitfalls associated with either purely centralized or decentralized models 	<ul style="list-style-type: none"> • Complete control of healthcare worker remuneration and deployment by the national government • Ability to address equity concerns through deployment programs
Disadvantages	<ul style="list-style-type: none"> • Highly dependent on fiscal capacity of local units • May lead to maldistribution of healthcare workers and equity concerns 	<ul style="list-style-type: none"> • Less levers of control by the national government • May require complex incentivization or dis-incentivization strategies to ensure local compliance 	<ul style="list-style-type: none"> • Significant budgetary impact on the national government • Rigidity in strategy and deployment due to information asymmetry
Policy Options for the national government	<ul style="list-style-type: none"> • Strengthen monitoring of LGU compliance and benchmarking • Address inequities in remuneration through demand-side generation 	<ul style="list-style-type: none"> • Subsidies for LGUs with limited fiscal capacity for healthcare worker remuneration • Top-ups for healthcare workers in low supply areas or GIDA 	<ul style="list-style-type: none"> • Nationalization of all healthcare worker cadres • Expansion of existing health workforce deployment programs

Source: Authors' illustration

4.1. *Purely Decentralized*

In a purely decentralized regime, healthcare worker remuneration is the sole responsibility of the decentralized unit. The decentralization mode determines the decentralized unit's characteristics, typically in the form of either a sub-national or local government unit or semi-autonomous bodies such as local health boards or hospitals (Kolehmainen-Aitken 2004). The decentralized unit will then be responsible for the salary budget and pay determination (e.g., salary scale) of healthcare workers employed. In cases where the decentralized unit is a local health board or facility (or network of facilities), healthcare workers such as GPs may be self-employed or independent contractors and are paid through capitation or a fixed fee schedule. In these cases, the decentralized units have full autonomy over the remuneration of their healthcare workers.

With full autonomy on healthcare worker remuneration, the decentralized units should be able to more effectively use resources by having better proximity and thus more information on preferences and needs of the constituent population (Juco et al. 2023; Oates 2008). Theoretically, this should allow for a more responsive and flexible health system. However, such a model would exacerbate socioeconomic differences between LGUs or local health boards. With no national government mechanisms to promote equity, poorer LGUs may be unable to compete with their higher-income counterparts regarding healthcare worker hiring and retention. This may lead to significant maldistribution of healthcare workers and consequent accessibility issues. In the Philippines, the health sector is decentralized. LGUs are responsible for the remuneration of their health workers. However, as noted in earlier sections and associated reports (Dagoy et al. 2024; Syling et al. 2024), this has resulted in significant wage disparities. The following are policy options to reduce inequities in remuneration in the current decentralized regime:

- a. **A stronger monitoring system, which includes empowering and equipping the national government (through the Department of Health) to monitor LGU compliance and benchmark LGU performance.** In many health systems, especially in decentralized regimes (mostly OECD countries), this could be done by performing a nationally run monitoring system that tracks LGU practices and compliance regarding healthcare worker salaries, retention, and hiring, which remains weak. Currently, efforts to hire and retain healthcare workers are left to the LGUs, with little intervention from the national government. Monitoring systems are critical because, in a decentralized regime, the role of the national government as the "principal" and LGUs as the "agents" involves the national government setting broad mandates that LGUs must comply with (T. Bossert 1998). Implementing a nationally run monitoring system reduces asymmetric information in a principal-agent model, enhancing accountability and enabling timely course corrections.
- b. **Address inequities in remuneration through demand-side (PhilHealth).** Under the UHC Act of 2019, provincial governments must strengthen their Provincial Health Boards and establish Special Health Funds (SHFs). PhilHealth reimbursements can be channeled through these funds, which function similarly to semi-autonomous bodies in the UK. Since these reimbursements are intended to cover the full cost of care, including personnel spending (PS), PhilHealth must unbundle PS from its reimbursements to public facilities, which is already accounted for in the budget line items. However, PhilHealth could integrate additional salary

adjustments through the DRG global budget and capitation,²⁸ offering higher rates for underserved or poorer areas, which could be determined through a criterion. These adjustment factors could be folded in as additional benefits and incentives, recognizing the higher cost of care in relatively challenging and poorer areas.

Table 40. Possible roles of LGU and PhilHealth in HRH Remuneration in a highly decentralized regime

LGUs	PhilHealth
LGUs shoulder personnel salaries (PS) based on the SSL pay scale (tiered based on income), including mandated benefits (e.g., MCPHW)	PhilHealth must unbundle PS from its reimbursements to public facilities, as this is accounted for in the budget line items. However, PhilHealth could integrate additional salary adjustments through its provider payment system with an equity framework, such as DRG rates adjusted for geography (e.g., the Thailand UCS model).
	Pay-for-performance (P4P) based on volume and quality (e.g., Thailand and United Kingdom models)

Source: Authors' illustration on the policy option for financing HRH remuneration

4.2. Hybrid models

The hybrid model encompasses different health system types and modalities between extremes. While the Philippines operates within a decentralized framework, it is not purely decentralized, as the DOH has the NHWSS and national policies on salary standardization and civil service protections offered to healthcare workers. In the hybrid model, the national government may support poorer or disadvantaged LGUs by providing incentives or “top-ups” for their healthcare workers. In this way, the government can promote equity and prevent the maldistribution of healthcare workers, issues that persist in decentralized systems across multiple countries. In its selective or limited decentralization, the Thai model provides additional payments and benefits to healthcare workers, including one for those practicing in rural and underserved areas. Similar efforts were made in Indonesia and many African LMICs to induce healthcare workers, particularly rural physicians, to work in far-flung areas. However, international literature has shown that these initiatives have mixed results at best (Syling et al. 2024).

A hybrid model gives governments more flexibility in determining policy directions to achieve health outcomes through more adaptable healthcare worker strategies. This may allow

²⁸ Development of global budget and capitation mechanisms that have unbundled healthcare worker salaries. As UHC act reforms are implemented in the Philippines, PhilHealth must shift towards prospective payment models such as global budget and capitation. Following the experience in Thailand, where health worker salaries were kept unbundled from the NHSO payment schemes. This means that healthcare worker salaries must still be appropriated through national budgets and that the global budget and capitation payments will be allocated primarily for operating costs. Unlike the Thai experience, one expected complication however would be the need to create differential payment schemes for PhilHealth payments to public and private providers, as private facilities will not have line-item budgets from the national government to pay for their healthcare worker compensation (Syling et al 2024).

governments to avoid pitfalls associated with a centralized or decentralized system. On the other hand, because the policy options are less absolute, this may limit the levers of control that the national government may have in a fully centralized system. The national government, for example, may provide targeted support to lower-income LGUs by subsidizing the SSL-induced wage differential for healthcare workers. Government workers in lower-income LGUs receive lower base pay as stipulated in the SSL. Likewise, LGUs face fiscal and budgeting constraints that prevent them from paying the full SSL amounts. The national government may subsidize the difference between full SSL and the respective lower-income LGU salary amounts to address this.

The Philippine government may explore policy options to shore up its current decentralized system and address the myriad problems that HRH faces.

National government subsidy for lower-income LGUs to buoy healthcare worker salaries as an incentive to practice in underserved and far-flung areas. This option would entail national appropriations to support poorer and disadvantaged LGUs. Rather than direct payments to providers, coursing payments through LGUs would allow the national government to impose conditions to foster better LGU health governance and service delivery. This may include requirements that LGUs improve inputs to their health systems, such as counterpart investments in health facility development or improving service delivery metrics. **Table 42** and **Table 43** summarizes the expected budgetary impact on the national government of providing this subsidy to 4th, 5th, and 6th-class municipalities.

Table 41. Possible roles of LGU and national government in Health Worker Remuneration in a hybrid model

LGU	National government
LGUs will shoulder personnel salaries (PS) based on the SSL (tiered based on income), including mandated benefits (e.g., MCPHW)	<p>The national government shoulders the salaries/benefits of local government with limited fiscal space (e.g., Thailand's selective decentralization model)</p> <p>The national government should cover non-private practice allowance (e.g., Thailand)</p> <p>The national government shoulders the salaries/benefits of local government with fiscal space challenges (e.g., Thailand's selective decentralization)</p>

Source: Authors' illustration on the hybrid model for HRH remuneration

Table 42. The estimated cost of full compliance with the Magna Carta of Public Health Workers (in millions PHP)

Province	Compliant and Non-compliant Municipalities		Non-compliant Municipalities	
	4th-6th class LGUs	All, 100%	4th-6th class LGUs	All, 100%
Abra	137.8	148.8	82.7	93.7
Agusan del Norte	33.1	55.1	22.0	38.6
Agusan del Sur	0.0	71.7	0.0	11.0
Aklan	60.6	93.7	33.1	55.1
Albay	22.0	82.7	5.5	22.0
Antique	55.1	99.2	27.6	27.6
Apayao	11.0	38.6	5.5	11.0
Aurora	5.5	44.1	0.0	0.0
Basilan	5.5	60.6	5.5	38.6
Bataan	5.5	60.6	5.5	33.1
Batanes	33.1	33.1	27.6	27.6
Batangas	49.6	165.4	27.6	66.1
Benguet	38.6	71.7	33.1	55.1
Biliran	38.6	44.1	33.1	33.1
Bohol	198.4	259.1	16.5	16.5
Bukidnon	11.0	110.2	0.0	0.0
Bulacan	0.0	115.8	0.0	44.1
Cagayan	44.1	154.3	33.1	93.7
Camarines Norte	16.5	66.1	0.0	5.5
Camarines Sur	88.2	192.9	5.5	5.5
Camiguin	22.0	27.6	11.0	16.5
Capiz	38.6	88.2	11.0	16.5
Catanduanes	44.1	60.6	16.5	22.0
Cavite	27.6	82.7	5.5	11.0
Cebu	115.8	242.5	16.5	16.5
Cotabato	0.0	93.7	0.0	5.5
Davao Occidental	5.5	27.6	0.0	0.0
Davao Oriental	0.0	55.1	0.0	0.0
Davao de Oro	0.0	60.6	0.0	5.5
Davao del Norte	11.0	44.1	0.0	0.0
Davao del Sur	0.0	49.6	0.0	0.0
Dinagat Islands	33.1	38.6	0.0	0.0
Eastern Samar	93.7	121.3	27.6	27.6
Guimaras	11.0	27.6	5.5	5.5
Ifugao	49.6	60.6	44.1	49.6
Ilocos Norte	60.6	115.8	16.5	27.6
Ilocos Sur	115.8	176.4	66.1	77.2
Iloilo	93.7	231.5	16.5	38.6

Isabela	82.7	187.4	55.1	99.2
Kalinga	27.6	38.6	5.5	5.5
La Union	49.6	104.7	5.5	5.5
Laguna	66.1	132.3	22.0	38.6
Lanao del Norte	88.2	121.3	55.1	66.1
Lanao del Sur	148.8	215.0	0.0	0.0
Leyte	132.3	220.5	55.1	88.2
Maguindanao	88.2	198.4	0.0	0.0
Marinduque	5.5	33.1	0.0	0.0
Masbate	60.6	110.2	11.0	11.0
Metro Manila	0.0	5.5	0.0	0.0
Misamis Occidental	66.1	77.2	5.5	5.5
Misamis Oriental	82.7	126.8	22.0	22.0
Mountain Province	44.1	55.1	38.6	49.6
Negros Occidental	22.0	104.7	11.0	55.1
Negros Oriental	38.6	104.7	0.0	16.5
Northern Samar	99.2	132.3	55.1	82.7
Nueva Ecija	38.6	148.8	27.6	82.7
Nueva Vizcaya	22.0	82.7	16.5	66.1
Occidental Mindoro	11.0	60.6	11.0	11.0
Oriental Mindoro	5.5	77.2	0.0	0.0
Palawan	38.6	126.8	11.0	16.5
Pampanga	22.0	104.7	0.0	0.0
Pangasinan	49.6	242.5	33.1	126.8
Quezon	104.7	215.0	38.6	60.6
Quirino	5.5	33.1	0.0	11.0
Rizal	11.0	71.7	0.0	0.0
Romblon	82.7	93.7	0.0	0.0
Samar	104.7	132.3	27.6	38.6
Sarangani	0.0	38.6	0.0	5.5
Siquijor	33.1	33.1	5.5	5.5
Sorsogon	33.1	77.2	16.5	27.6
South Cotabato	0.0	55.1	0.0	5.5
Southern Leyte	88.2	99.2	5.5	5.5
Sultan Kudarat	0.0	60.6	0.0	0.0
Sulu	60.6	104.7	0.0	0.0
Surigao del Norte	104.7	110.2	22.0	22.0
Surigao del Sur	49.6	93.7	0.0	0.0
Tarlac	27.6	93.7	27.6	88.2
Tawi-Tawi	16.5	60.6	0.0	0.0
Zambales	16.5	71.7	0.0	0.0
Zamboanga Sibugay	22.0	88.2	0.0	0.0

Zamboanga del Norte	60.6	137.8	11.0	22.0
Zamboanga del Sur	99.2	143.3	16.5	22.0
PHILIPPINES	3,786.8	8,196.4	1,212.6	2,160.7

Source: Authors' calculation based on the National Budget Circular No. 594 (SSL VI, First Tranche, 2024).

Note: Based on the DOH's Primary Care Facility (PCF) ratios (1 Rural Health Physician per 20,000 population and 1 Public Health Nurse per 10,000 population), each RHU- based on an average municipal population of ~43,000 (CPH 2020)- is assumed to need 2 MDs and 4 PHRNs. Costs use minimum salary grades (SG 24 for MDs, SG 15 for PHRNs) with full Magna Carta benefits (1st-class LGU rates - 100% of the SSL). Totals were scaled per RHU and aggregated by province.

Table 43. Estimated cost of full compliance with the Magna Carta of Public Health Workers (continuation)

Provinces	Non-compliant LGUs			
	4th-6th class municipalities		100% of municipalities	
	% of PS/Total Income (Before)	% of PS/Total Income (After)	% of PS/Total Income (Before)	% of PS/Total Income (After)
Abra	22.4%	23.8%	20.4%	21.6%
Agusan del Norte	28.8%	30.3%	29.0%	30.4%
Aklan	38.2%	40.0%	35.8%	37.3%
Albay	40.4%	42.5%	29.6%	30.5%
Antique	30.9%	32.3%	30.9%	32.3%
Apayao	33.3%	35.1%	31.8%	33.4%
Basilan	37.8%	39.2%	35.9%	37.5%
Bataan	29.1%	30.2%	24.9%	25.5%
Batanes	38.4%	41.9%	38.4%	41.9%
Batangas	24.1%	25.5%	33.3%	34.4%
Benguet	36.7%	38.5%	33.5%	34.9%
Biliran	75.1%	77.4%	75.1%	77.4%
Bohol	27.5%	29.2%	27.5%	29.2%
Cagayan	34.4%	36.1%	29.4%	30.5%
Camarines Sur	37.1%	39.4%	37.1%	39.4%
Camiguin	38.3%	41.3%	34.4%	36.4%
Capiz	35.9%	37.6%	34.1%	35.5%
Catanduanes	39.0%	41.2%	36.9%	38.7%
Cavite	39.3%	40.7%	36.3%	37.6%
Cebu	25.6%	27.3%	25.6%	27.3%
Eastern Samar	38.4%	40.8%	38.4%	40.8%
Guimaras	34.0%	35.8%	34.0%	35.8%
Ifugao	37.4%	39.1%	36.3%	37.9%
Ilocos Norte	20.5%	21.7%	14.1%	14.8%
Ilocos Sur	15.6%	16.4%	15.7%	16.5%
Iloilo	31.1%	32.9%	31.2%	32.5%
Isabela	15.9%	16.9%	20.7%	21.6%

Kalinga	41.6%	43.3%	41.6%	43.3%
La Union	29.2%	30.9%	29.2%	30.9%
Laguna	37.1%	38.8%	35.0%	36.4%
Lanao del Norte	36.4%	38.3%	33.0%	34.6%
Leyte	36.5%	38.4%	32.1%	33.4%
Masbate	38.6%	40.4%	38.6%	40.4%
Misamis Occidental	34.2%	36.2%	34.2%	36.2%
Misamis Oriental	28.0%	29.4%	28.0%	29.4%
Mountain Province	44.8%	46.6%	46.0%	47.6%
Negros Occidental	36.9%	38.7%	33.7%	35.0%
Northern Samar	37.8%	40.1%	37.1%	38.6%
Nueva Ecija	36.3%	37.7%	30.0%	30.9%
Nueva Vizcaya	44.0%	45.4%	39.8%	40.9%
Occidental Mindoro	35.8%	37.9%	35.8%	37.9%
Palawan	32.8%	34.7%	16.0%	16.8%
Pangasinan	33.6%	35.2%	28.5%	29.5%
Quezon	38.8%	40.8%	30.0%	31.2%
Quirino			31.4%	32.5%
Samar	34.0%	36.0%	31.8%	33.3%
Sarangani			31.8%	32.9%
Siquijor	42.3%	44.2%	42.3%	44.2%
Sorsogon	31.6%	33.2%	31.1%	32.3%
South Cotabato			26.5%	27.8%
Southern Leyte	40.9%	42.8%	40.9%	42.8%
Surigao del Norte	36.1%	38.3%	36.1%	38.3%
Tarlac	33.3%	35.0%	29.1%	29.9%
Zamboanga del Norte	38.3%	41.0%	28.3%	29.4%
Zamboanga del Sur	38.0%	39.8%	34.8%	36.3%

Source: Authors' calculation based on the National Budget Circular No. 594 (SSL VI, First Tranche, 2024) and the DOF-BLGF LGU PS Expenditure and Statements of Receipts and Expenditures (SRE) data.

Note: Based on the DOH's Primary Care Facility (PCF) ratios (1 Rural Health Physician per 20,000 population and 1 Public Health Nurse per 10,000 population), each RHU -- based on an average municipal population of ~43,000 (CPH 2020) -- is assumed to need 2 MDs and 4 PHRNs. Costs use minimum SGs (SG 24 for MDs, SG 15 for PHRNs) with full Magna Carta benefits (1st-class LGU rates - 100% of the SSL). Totals were scaled per RHU and aggregated by province.

4.3. *Purely Centralized*

The national government would hire and compensate healthcare workers. Like the Philippines SSL, healthcare worker compensation would be standardized across the health system. Implementing this scheme would have implications depending on the delivery service model of the health system. In the current Philippine context, this would entail a deployment program like the current National Health Workforce Support System (NHWSS) employed by the DOH.

However, a purely centralized Philippine health workforce would require re-nationalizing all health workers. In this system, the salaries and benefits of healthcare workers would be sourced through national line-item budgets, like the Thai and Malaysian health systems.

Expanding the NHWSS to cover all healthcare workers in the country, with the national government determining where all healthcare workers are deployed. Hiring all the needed healthcare workers at full SSL rates and with full benefits would have significant budget impacts on the national government. The national government would need robust monitoring mechanisms and an equity allocation framework to ensure appropriate and effective deployment of healthcare workers. While a fully centralized system will have rigidity issues associated with inefficiencies, this recommendation has been postulated because it has precedent: uniformed personnel (Armed Forces of the Philippines and Philippine National Police) and school teachers. This means that the salaries of these civil servants for each rank are implemented uniformly across the board, irrespective of their work assignment or geographic location. **Table 44** depicts the policies and mechanisms to finance the PS of these uniformed personnel and public school teachers.

Table 44. Policies to finance the PS of civil servants (healthcare workers, AFP, PNP, and public-school teachers) in the Philippines

Profession	Policies	Institutions	PS Source
Public health workers	Local Government Code (RA 7160) (RP 1991b); Magna Carta of Public Health Workers (RA 7305) (RP 1992a)	Department of Health & LGUs	PS for public health workers in their local government are sourced from their respective LGUs due to devolution, while health workers in DOH-owned facilities are sourced from DOH.
Public school teachers	Governance of Basic Education Act (RA 9155) (RP 2001); Magna Carta for Public School Teachers (RA 4670) ((RP 1966)	Department of Education	The PS (salaries and benefits) of all public school teachers from primary to secondary education are sourced from DepEd
Police (PNP)	Department of the Interior Local Government Act of 1990 (RA 6975) (RP 1990)	Department of Interior and Local Government	Absorbed the Philippine National Police within the DILG, and sourced all PS (salaries and benefits) appropriations from DILG
Military (AFP)	The National Defense Act (Commonwealth Act No. 1, 1935) (RP 1935)	Department of National Defense	Created the AFP and stipulated that all salaries and benefits to service members is sourced from the DND

Source: Authors' illustration on the policies governing PS of civil servants across sectors

For teachers, the Magna Carta for Public School Teachers postulated pay equality, which is reinforced by sourcing the appropriations for the salaries and benefits of public school teachers through the DepEd. The LGC even stipulated that if an LGU has any additional funds, it may provide additional bonuses to the public teachers assigned in their respective locality (RP 1991b).

Similarly, the uniformed personnel of PNP and AFP sources their salaries and benefits through direct appropriations from DILG and DND, respectively, under their PS items. Even the civilian employees and health workers from each organization are sourced through these government organizations. This policy mechanism depicts that these civil servants are sourced nationally compared to public health workers. Currently, the DOH has programs for nationally hired public health workers who get paid the national rates and are assigned to different regions across the Philippines. Still, these health workers are hired through contractual employment. This means they do not enjoy the benefits and job security of a Plantilla position. These deployed public health workers may even cause some friction among the local health staff in their assigned LGUs since they are getting paid more compared to their local counterparts (DOH 2021b; Syling et al. 2024; USAID 2020).

Notwithstanding the possible negative consequences of centralization, such as rigidity issues as discussed, moving toward a more centralized compensation system would, in theory, improve equitable access to healthcare services. Standardizing salaries may address perennial challenges of geographic disparities in staffing. Some areas often struggle to attract and retain qualified health workers. By increasing salaries in these areas to match those in higher-paying areas, the system may redistribute human resources more equitably. This can translate into increased service capacity.

To illustrate this, we simulate the possible effect of salary standardization on demand, in this case, in inpatient care. To estimate the potential impact of this policy on healthcare utilization, we applied a logic that follows a two-step causal pathway: salary increases lead to an increase in full-time equivalent (FTE) health workers. This relationship is captured through the elasticity²⁹ of FTE with respect to salary ($e_{FTE,salary}$), which we estimated at 0.10. We further assume that a higher number of FTEs results in more inpatient demand, with the elasticity of admissions with respect to FTE ($e_{admission,FTE}$), set at 0.88. We calculated these elasticities using hospital-level data from the DOH, specifically the 2022 Hospital Statistical Report, which we merged with financial statements. The HSR provides information on the number of full-time health workers per hospital, while salary data were derived by dividing total salary expenditures, extracted from each financial statement. PIDS maintained hospital financial statements sourced from the Securities and Exchange Commission, government hospital submissions, and publicly available hospital websites. This elasticity was then applied to each region's admissions (extracted from the 2022 DHS) to project the new expected demand, while the salary level for the public sector was obtained from the 2022 Labor Force Survey.

Our results show that standardizing salaries to the highest region (*that is*, NCR) could increase demand in lower-wage regions such as MIMAROPA and BARMM. These areas are projected to see the largest increases in demand due to substantial wage adjustments. The results suggest that salary equalization may improve healthcare access in underserved areas by attracting more health workers and expanding service capacity. While our analysis highlights potential demand increases from such a policy, it does not account for supply-side constraints such as limited hospital beds, outdated infrastructure, or staffing ceilings. Increased admissions can only be realized if facilities have the physical and operational capacity to absorb higher patient volumes. Without investments

²⁹ Here we conducted a simple regression model: $\log(FTE)_i = a + \log(salary \text{ per health worker}) + e_i$

in infrastructure, equipment, and management systems, the projected improvements in access may not fully materialize.

Table 45. Results of the simulation on the possible impact of standardizing salaries on demand

Region	Total Admissions	Wages (PHP)	%Δ Salary	New Admissions	Increase in Admissions (demand)
Cordillera Administrative Region (CAR)	12,120	874	13%	12,742	621
National Capital Region (NCR)	75,781	986	0%	75,781	-
Region I (Ilocos Region)	36,054	775	27%	39,980	3,926
Region II (Cagayan Valley)	17,751	812	21%	19,273	1,522
Region III (Central Luzon)	60,663	773	28%	67,349	6,686
Region IV-A (CALABARZON)	57,346	795	24%	62,857	5,511
Region IV-B (MIMAROPA)	22,771	641	54%	27,674	4,902
Region IX (Zamboanga Peninsula)	28,069	696	42%	32,747	4,678
Region V (Bicol Region)	34,052	685	44%	40,037	5,985
Region VI (Western Visayas)	52,754	679.3	45%	62,282	9,527
Region VII (Central Visayas)	41,116	722.3	37%	47,120	6,004
Region VIII (Eastern Visayas)	31,140	715.6	38%	35,847	4,707
Region X (Northern Mindanao)	28,573	791	25%	31,391	2,818
Region XI (Davao Region)	30,739	800	23%	33,598	2,859
Region XII (SOCCSKSARGEN)	22,519	661	49%	26,948	4,429
Region XIII (Caraga)	18,622	716	38%	21,430	2,809
BARMM	20,021	641	54%	24,332	4,310

Source: Authors' analysis of the DOH Hospital Statistical Report (2022), PSA National Demographic and Health Survey (2022), PIDS Hospital Financial Statements, and PSA Labor Force Survey (2022) data

To quantify the fiscal impact of implementing salary standardization, we estimated the additional costs required to align HRH wage rates with that of NCR, the highest paying region. Total cost difference amounts to approximately PHP 6.2 billion annually, with the largest increases concentrated in regions with historically lower wage rates (i.e. Western Visayas, Central Visayas, and MIMAROPA). Meanwhile, BARMM, SOCCSKSARGEN, and Caraga also show notable increases in costs relative to their baseline despite having a smaller health workforce size, highlighting the magnitude of wage inequality in these areas.

Table 46. Estimated budgetary impact of standardizing HRH salary rates

Region	Average Annual Salary of HRH	Total FTE	In millions PHP		
			Estimated annual salary cost	Adjusted annual salary cost* (NCR benchmark)	Cost difference
Cordillera Administrative Region (CAR)	227,240.00	3,547	806.0	909.3	103.3
National Capital Region (NCR)	256,360.00	24,675	6,325.7	6,325.7	-
Region I (Ilocos Region)	201,500.00	7,567	1,524.8	1,939.9	415.1
Region II (Cagayan Valley)	211,120.00	7,324	1,546.2	1,877.6	331.3
Region III (Central Luzon)	200,980.00	9,028	1,814.4	2,314.4	500.0
Region IV-A (CALABARZON)	206,700.00	7,535	1,557.5	1,931.7	374.2
Region IV-B (MIMAROPA)	166,660.00	4,784	797.3	1,226.4	429.1
Region IX (Zamboanga Peninsula)	180,960.00	4,721	854.3	1,210.3	356.0
Region V (Bicol Region)	178,100.00	3,915	697.3	1,003.6	306.4
Region VI (Western Visayas)	176,618.00	11,041	1,950.0	2,830.5	880.4
Region VII (Central Visayas)	187,798.00	7,068	1,327.4	1,812.0	484.6
Region VIII (Eastern Visayas)	186,056.00	4,296	799.3	1,101.3	302.0
Region X (Northern Mindanao)	205,660.00	5,435	1,117.8	1,393.3	275.6
Region XI (Davao Region)	208,000.00	13,873	2,885.6	3,556.5	670.9
Region XII (SOCCSKSARGEN)	171,860.00	3,335	573.2	855.0	281.8
Region XIII (Caraga)	186,160.00	2,214	412.2	567.6	155.4
BARMM	166,660.00	3,541	590.1	907.8	317.6
TOTAL	3,318,432.0	123,899.0	25,579.0	31,762.7	6,183.8

* Computed as: Total FTE × average annual salary × %Δ salary

Source: Authors' analysis of the DOH Hospital Statistical Report (2022), PSA National Demographic and Health Survey (2022), PIDS Hospital Financial Statements, and PSA Labor Force Survey (2022) data

5. Bibliography

Anderson, Michael, Emma Pitchforth, Nigel Edwards, Hugh Alderwick, Alistair McGuire, and Elias Mossialos. 2022. “United Kingdom: Health System Review 2022.” *Health Systems in Transition* 24(1).

Australian Institute of Health and Welfare. 2024. “Australia’s Health 2024: In Brief.”

Australian Institute of Health and Welfare. n.d.-a. “Hospital Workforce.”

Australian Institute of Health and Welfare. n.d.-b. “Spending on Hospitals.”

Bernal-Delgado, Enrique, Ester Angulo-Pueyo, Manuel Ridao-López, Rosa Urbanos-Garrido, Juan Oliva-Moreno, Daniel García-Abiétar, and Cristina Hernández-Quevedo. 2024. “Spain: Health System Review.” *Health Systems in Transition* 26(3).

Bossert, T. 1998. “Analyzing the Decentralization of Health Systems in Developing Countries: Decision Space, Innovation and Performance.” *Social Science & Medicine* (1982) 47(10):1513–27. doi:10.1016/s0277-9536(98)00234-2.

Buchan, James. 2000. “Health Sector Reform and Human Resources: Lessons from the United Kingdom.” *Health Policy and Planning* 15(3):319–25. doi:10.1093/heapol/15.3.319.

Cabegin, Emily Christi, Marissa Garcia, Sandy Vicente, and Minda Valencia. 2007. “An Assessment of the Implementation of Magna Carta of Public Health Workers (Final Report).” *Philippine Journal of Nursing* 77(1):15–20.

Carpio, Louella Patricia D., Hanna Thea F. Cayabyab, and Danielle Marie Irish T. Te. 2021. “Determining the Implementation Status of Benefits Under Magna Carta of Public Health Workers (RA 7305) in the Philippines.” *Acta Medica Philippina* 55(1). doi:10.47895/amp.v55i1.2950.

Christofides, Louis, and Maria Michael. 2013. “Exploring the Public-Private Sector Wage Gap in European Countries.”

Cuenca, Janet. 2018. “Health Devolution in the Philippines: Lessons and Insights.”

Dagoy, Louie Iyar, Yaddah Shalom Dollente, Lyle Daryll Casas, Jereme Paolo Syling, and Valerie Gilbert Ulep. 2024. “Compliance with the Magna Carta for Public Health Workers Act among Local Government Units in the Philippines.” *Philippine Institute for Development Studies*.

DBM. 2022. *Local Budget Circular 145-2022 - Guidelines on the Implementation of Personal Services (PS) Limitation on Local Government Budgets and Determination of Waived Ps Items Pursuant to Section 93 of the General Provisions (GPS) of the Fiscal Year (FY) 2022 General Appropriations Act (GAA), Republic Act (RA) No. 11639, and Years Thereafter*.

DBM. 2024. *Local Budget Circular 156-2024 - Guidelines on the Implementation of Personal Services (PS) Limitation on Local Government Budgets and Determination of Waived Ps Items Pursuant to Section 95 of the General Provisions (GPS) of the Fiscal Year (FY) 2024 General Appropriations Act (GAA), Republic Act (RA) No. 11975 and Years Thereafter*.

- Dedeu, T., B. Bolibar, J. Gené, C. Pareja, and C. Violan. 2015. “Building Primary Care in a Changing Europe: Case Studies.” European Observatory on Health Systems and Policies.
- DOH. 2021. *National Human Resources for Health Master Plan: 2020-2040*.
- Gill, Paramjit, Rachel Foskett-Tharby, Francoise Cluzeau, Sripin Tantivess, and Yot Teerawattananon. 2016. “Improving Quality of Primary Care Through Financial Incentives: The Case of Thailand.” *Journal of the Royal Society of Medicine* 109(8):292–93. doi:10.1177/0141076816655475.
- Glover, Lucinda, and Michael Woods. 2020. “International Health Care Systems Profiles: Australia.”
- Haji, Mahjabeen, Varatharajan Durairaj, Pascal Zurn, Laura Stormont, and Maximillian Mapunda. 2010. “Emerging Opportunities for Recruiting and Retaining Rural Health Workforce Through Decentralized Health Financing Systems.” *Bulletin of the World Health Organization* 88:397–99.
- Hortillo, Jose Neil. 2022. “Comparative Analysis of Salary Standardization Law under Four Administrations: The Philippine Experience.” *Philippine Journal of Public Administration* 66.
- InformedHealth.org. 2018. “Health Care in Germany: Learn More – the German Health Care System.” Institute for Quality and Efficiency in Health Care (IQWiG).
- Jongudomsuk, Pongpisut, Samrit Srithamrongsawat, Walaiporn Patcharanarumol, Supon Limwattananon, Supasit Pannarunothai, Patama Vapatanavong, Krisada Sawaengdee, and Pinij Fahamnuaypol. 2015. “Thailand: Health System Review.” *World Health Organization Regional Office for the Western Pacific* 5(5).
- Juco, Marianne, Ricxie Maddawin, Robert Hector Palomar, Mark Gerald Ruiz, and Charlotte Justine Diokno-Sicat. 2023. “Baseline Study on the State of Devolution in the (Pre-Mandanas) Philippines.” *Philippine Institute for Development Studies*.
- Kolehmainen-Aitken, Riitta-Liisa. 2004. “Decentralization’s Impact on the Health Workforce: Perspectives of Managers, Workers and National Leaders.” *Human Resources for Health* 2(1):5. doi:10.1186/1478-4491-2-5.
- Krasna, Heather, Malvika Venkataraman, and Isabella Patino. 2024. “Salary Disparities in Public Health Occupations: Analysis of Federal Data, 2021–2022.” *American Journal of Public Health* 114(3):329–39. doi:10.2105/AJPH.2023.307512.
- Lavado, Rouselle. 2011. “Magna Carta of Public Health Workers: Does It Really Fulfill Its Intent?”
- López-Casasnovas, Guillem, and Héctor Pifarré Arolas. 2020. “The Spanish Healthcare System.” *Health Policy Papers Collection*.
- Lorenzo, Fely Marilyn, Jennifer Frances Dela Rosa, Glenn Roy Paraso, Susan Villegas, Cynthia Isaac, Julie Yabes, Florante Trinidad, Grace Fernando, Atienza Joel, Kenneth Ronquillo, Lilibeth David, Nilda Silvera, and Lourdes Rebullida. 2005. “Migration of Health Workers: Country Case Study Philippines.” *International Labour Office*.

Montemayor, Ma. Teresa. 2023. "DOH Working on Salary Standardization, More Benefits for Hcws." *Philippine News Agency*.

Nwankwo, Ogonna N. O., Chukwuebuka I. Ugwu, Grace I. Nwankwo, Michael A. Akpoke, Collins Anyigor, Uzoma Obi-Nwankwo, Sunday Andrew Jr, Kelechukwu Nwogu, and Neil Spicer. 2022. "Republic Act No. 6758 A Qualitative Inquiry of Rural-Urban Inequalities in the Distribution and Retention of Healthcare Workers in Southern Nigeria." *PLOS ONE* 17(3):e0266159. doi:10.1371/journal.pone.0266159.

Oates, Wallace. 2008. "On the Evolution of Fiscal Federalism: Theory and Institutions." *National Tax Journal* 61(2).

Perez, Juan. 1998. "Health Worker Benefits in a Period of Broad Civil Service Reform: The Philippine Experience."

RP. 1935. *Commonwealth Act No. 1 - An Act to Provide for the National Defense of the Philippines, Penalizing Certain Violations Thereof, Appropriating Funds Therefor, and for Other Purposes*.

RP. 1966. *Republic Act No. 4670 - The Magna Carta for Public School Teachers*.

RP. 1989. *Republic Act No. 6758 - An Act Prescribing a Revised Compensation and Position Classification System in the Government and for Other Purposes*.

RP. 1990. *Republic Act No. 6975 - An Act Establishing the Philippine National Police Under a Reorganized Department of the Interior and Local Government, and for Other Purposes*.

RP. 1991. *Republic Act No. 8553 - An Act Providing for a Local Government Code of 1991*.

RP. 1992. *Republic Act No. 7305 - Magna Carta of Public Health Workers*.

RP. 2001. *Republic Act No. 9155 - An Act Instituting a Framework of Governance for Basic Education, Establishing Authority and Accountability, Renaming the Department of Education, Culture and Sports as the Department of Education, and for Other Purposes*.

RP. 2019. *Republic Act No. 11223 - An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System, and Appropriating Funds Therefor*.

RP. 2020. "De Lima Urges Congress to Review Disparities in Salaries and Benefits of Public Health Workers."

RP. 2021. "Magna Carta Amendments Pangilinan Seeks P10,000 Monthly Hazard Pay, Raise in Ot and Night Differential for Public Health Workers." *Senate of the Philippines*.

RP. 2023. *General Provisions: Fiscal Year 2023*.

Sellers, Katie, Jonathon P. Leider, Kyle Bogaert, Jennifer D. Allen, and Brian C. Castrucci. 2019. "Making a Living in Governmental Public Health: Variation in Earnings by Employee Characteristics and Work Setting." *Journal of Public Health Management and Practice: JPHMP* 25 Suppl 2, Public Health Workforce Interests and Needs Survey 2017(2 Suppl):S87–95. doi:10.1097/PHH.0000000000000935.

Syling, Jereme Paolo, Louie Iyar Dagoy, Yaddah Shalom Dollente, Leif Daryl Tan, Clarissa Flaminiano, and Valerie Gilbert Ulep. 2024. “Underpaid Heroes? A Comprehensive Assessment of Human Resources for Health Compensation in the Philippines.” *Philippine Institute for Development Studies*.

Thorlby, Ruth. 2020. “International Healthcare Systems Profile: England.”

USAID. 2020. “Health Labor Market Analysis of the Philippines.”

Compliance with the Magna Carta of Public Health Workers Act among Local Government Units in the Philippines³⁰

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Abstract

The Magna Carta of Public Health Workers (*MCPHW*) Act of 1992 mandates the provision of cash and non-cash benefits to health workers in the public sector to improve their socioeconomic well-being. While the law has existed for over thirty (30) years, its implementation has been inconsistent, as many local government units (LGUs) cannot provide these mandated benefits. In this study, we estimated the compliance of LGUs with the *MCPHW* over the years and estimated the effect of the fiscal capacity of LGUs and compliance. We performed a fixed-effect regression model to estimate the effect of fiscal capacity and MCWH compliance using administrative data from the Department of Health, a merged dataset on MCPHW, and auxiliary data from various administrative sources. Our findings reveal that only 74% of LGUs provided *MCPHW* benefits in 2022, which is considered an improvement if we examine the historical data. However, compliance comes with a substantial socio-economic gradient, with wealthier local governments more likely to comply. Our results show a positive association between fiscal capacity and compliance with *MCPHW*, albeit we only observed a significant association in municipalities, not cities. The source of local government revenue does not appear to impact compliance for most LGUs significantly. Our findings demonstrate that as the fiscal capacity of LGUs grows, so does their probability of compliance with *MCPHW*. This paper offers insight into improving equitable compliance with *MCPHW* benefits in a decentralized setting. We recommend that policy measures focus on strengthening the fiscal capacity of LGUs and incentivizing them to prioritize mandated health worker benefits.

Keywords: Magna Carta of Public Health Workers (*MCPHW*), human resource for health (HRH), personnel services (PS), decentralization, Philippines

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1. Introduction

Governments have introduced cash and non-benefits for health workers on top of their wages or salaries to improve their social and economic well-being. These additional benefits are often in the form of hazard pay, transportation subsidies, and other allowances (Saguil et al. 2023). In the Philippines, a national law, *the Magna Carta of Public Health Workers (MCPHW) Act* of 1992, was institutionalized to provide these additional benefits for health workers in the public sector (RP 1992a).

The Philippine health system is decentralized, where Local Government Units (LGUs) are mandated to finance healthcare services, including the salaries and *MCPHW* benefits of healthcare workers. However, implementing the *MCPHW* Act has been inconsistent, as many LGUs cannot provide these mandated benefits. During the COVID-19 pandemic, health workers, unions, and advocacy groups have actively called for increased compliance with the *MCPHW* (Leyva et al. 2024).

While there are studies on *MCPHW* compliance, a comprehensive analysis that determines the level of compliance and factors that influence it remains limited. Perez (1998) discusses the political economy and the birthing pains of *MCPHW*'s local implementation. He examined the administrative and political implications to LGUs caused by the devolution and provision of *MCPHW* benefits. The study emphasized the fiscal demands *MCPHW* has towards LGUs, suggested implementation issues, and policy actions attempted by the national government to augment the LGU budget. This has caused the *MCPHW* to be perceived as an unfunded mandate that was transferred over for LGUs to bear. Case studies have examined the different practices of LGUs regarding *MCPHW* implementation (Villalobos 2006). Lavado (2011) examined the specific practices of the source of funding specialty hospitals in Metro Manila to fund *MCPHW* benefits. They found that unobligated salaries from unfilled Plantilla positions were used to provide *MCPHW* benefits and savings from MOOE. Lorenzo et al. (2006) identified the partial and inequitable implementation of *MCPHW* benefits as a push factor for health worker migration. In more recent studies, Carpio et al. (2021) measured the compliance of LGUs to *MCPHW*, but they did not measure the distribution of compliance and factors that affect it. In this study, (a) we aim to fill this gap by estimating the compliance of LGUs with the *MCPHW* over the years and identifying the factors that determine compliance amongst local governments, *i.e.*, municipalities and cities, and (b) estimate the effect of the fiscal capacity of LGUs and compliance. Using a fixed effects regression model, we analyze a merged dataset on *MCPHW* from the Department of Health (DOH) and auxiliary data from various administrative sources. Our research aims to provide insights into implementing health and labor policies, particularly in a decentralized system.

2. Review of Related Literature

2.1 *Magna Carta of Public Health Workers*

The Magna Carta of Public Health Workers (Republic Act No. 7305), enacted in 1992, was designed to promote and improve the social and economic well-being and working conditions of health workers (RP 1992a). The law mandates financial and non-financial benefits, ranging from hazard pay and subsistence allowances to providing housing and career development

opportunities. The law and its implementing rules and regulations (IRR) define health workers as people providing health services within public health facilities, including administrative and support personnel. They include employees involved in health-related work in government health facilities.³² The law stipulates that all public-sector health workers are entitled to monetary and non-cash benefits in the *MCPHW* regardless of employment status (RP 1992a). This means that health workers not under a Plantilla position (i.e., contractual, casual, contract service, and job orders) should also receive these benefits. The law excludes private-sector health sector workers (DOLE 2017; RP 1974).³³

The *MCPHW* includes monetary and non-cash benefits to improve the socioeconomic welfare of public health workers, enhance their skills and competencies, and encourage qualified health workers to work and retain their positions in the government sector. **Table 47** depicts the benefits that supplement the basic salary of public health workers stipulated in the *MCPHW Act* and its IRR in 1999 and 2012.

Table 47. Monetary benefits of MCPHW according to IRR 1999 and IRR 2012

No.	Monetary Benefits	Rates/Implementation (IRR 1999)	Rates/Implementation (IRR 2012)
1	Equality in Salary Scale	All public health workers shall receive national rates for their respective salary grades.	-
2	Night-Shift Differential Pay	10% increase in the hourly rate	10% increase in the hourly rate
3	Overtime Pay	125% increase in the hourly rate	25% increase in the hourly rate / Compensatory Overtime Credits
4	Hazard Pay	5%-25% increase to base salary	5%-25% increase to base salary
5	Highest Basic Salary upon Compulsory Retirement	1 salary grade increase 3 months before compulsory retirement	1 salary grade increase 3 months before compulsory retirement
6	Longevity Pay	5% increase of base salary for every 5 years of continuous rendered service	5% increase of base salary for every 5 years of continuous rendered service
7	On-call Pay	50% increase of the hourly rate	-
8	Subsistence Allowance	PhP50 per day or PhP1,500 per month	PhP50 for each day of full-time service and PhP25 for part-time
9	Laundry Allowance	PhP150 monthly allowance	PhP150 monthly allowance

³² Sec. 3: "...health workers that are employed in **subsidize the amount necessary to pay the difference between** rural health units, barangay health stations, clinics and other health-related establishments that are owned and operated by the government..." (RA 7305).

³³ Private health workers are covered by the Department of Labor and Employment (DOLE) and are covered by the Labor Code (Presidential Decree No. 442) and the Guidelines Governing the Employment and Working Conditions of Health Personnel in the Private Healthcare Industry (DOLE D.O. 182-2017).

10	Representation and Transportation Allowance (RATA)	PhP2,200 per month (MHOs & RHPs only)	PhP2,200 per month (RHPs only)
11	Remote Assignment Allowance	25%-50% to their base salary for public HRH & a one-time allocation of PhP20,000 for relocating in their assigned area	-
12	Pay for working on a Rest Day/Holiday	150% increase of the hourly rate	50% increase of the hourly rate
13	Medico-Legal Allowance	PhP200 – Slight physical injury PhP300 – Less serious physical injury PhP500 – Serious physical injury PhP1,000 – Necropsy/Autopsy PhP600 – Per appearance in court (RHPs/Resident Physician only)	PhP500 – Slight physical injury PhP500 – Less serious physical injury PhP1,000 – Serious physical injury PhP2,000 – Rape victim PhP2,000 – Child sexual and/or physical abuse victim PhP2,500 – Necropsy/Autopsy PhP1,500 – Per appearance in court (PHO/CHO/MHO/RHP/MHO only)
14	Salary Increase After Post-Graduate Studies for a Degree Course	2% increase of their basic salary	1 salary step increment
15	Housing Allowance	Housing allowance or housing facilities for public health workers	Housing allowance or housing facilities for public health workers

Note: Monetary benefits that are blank in the 2012 IRR are not cited in the guidelines

Source: Authors' compilation of the monetary benefits of the MCPHW (DBM and DOH 2012, 2016)

2.2 Implementation issues leading to (Non)-compliance with MCPHW

The *MCPHW* specifies fifteen (15) monetary benefits and cash allowances provided to public health workers. However, the 2012 IRR needed to provide comprehensive guidelines for these benefits. Beyond the housing allowance, which may be fulfilled by offering living quarters, the *MCPHW* includes cash incentives to encourage public healthcare workers to stay in government service. The 2012 IRR, however, provided guidelines for only a subset of the benefits cited in the 1999 IRR and the *MCPHW*. Key provisions were absent, such as equity in salary scales, on-call pay, and allowances for remote assignments. The law revised the amounts or rates for several benefits, decreasing overtime pay, holiday pay, and subsistence allowance while increasing the medico-legal allowance.³⁴ This ambiguity in the benefits contributed to the implementation challenges of the *MCPHW*. Also, while public health workers in government, whether in regular, contractual, or casual positions, are entitled to these benefits, the 2012 IRR lacked explicit

³⁴ Section 19(b) of the MCPHW stated that the national government will “subsidize the amount necessary to pay the difference between nationally paid health workers and locally paid health workers”.

language affirming that public health workers, regardless of employment status, are eligible for these benefits (DBM and DOH 2012).

DOH and DBM released another IRR in 2016 for the *MCPHW*. However, it only established guidelines on hazard pay and the salary step increment for completion of a post-graduate degree. The latest IRR of the *MCPHW* only cites the two benefits, but does not mention or clarify the other benefits stipulated in the 1999 IRR (DBM and DOH 2016). The DOH and DBM revised the provision of hazard pay by determining the rates using the salary grade of a public health worker and expanding the rules on granting a salary step increment for completing a postgraduate degree. **Table 48** describes health worker benefits stipulated in the IRR of the *MCPHW* released in 2016.

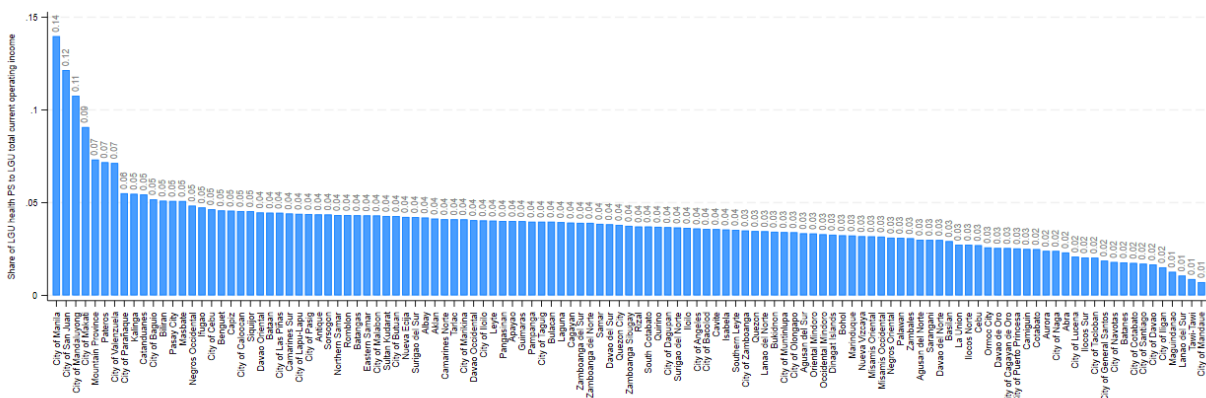
Table 48. Latest MCPHW IRR, 2016

MCPHW benefits	Rates/Implementation (IRR 2016)	
	Salary Grade (SG)	% of Monthly Basic Salary
Hazard Pay	19 and below	25%
	20	15%
	21	13%
	22	12%
	23	11%
	24-25	10%
	26	9%
	27	8%
	28	7%
	29	6%
	30	5%
Salary Step Increment for Completion of a Postgraduate Degree	Granting a salary step increment shall not be more often than every two years; if a public health worker is at the last step (step 8), the salary step increment will only apply once they've received a higher salary grade.	

Source: Authors' illustration on the DBM-DOH Joint Circular No.1-2016 (DBM and DOH 2016)

The 1999 and 2012 IRR established that granting *MCPHW* benefits is subject to the availability of funds of LGUs. The benefits of the *MCPHW* are listed under the personnel services (PS) category of local and national government budgets. However, the funding policies for national government agencies and LGUs differ. LGUs are expected to shoulder the costs of *MCPHW* benefits from their own budgets (RP 1991b). This setup created financial strain and distortions in local pay structures, further exacerbated by the implementation of the Salary Standardization Law, which raised the salaries of all government personnel and required LGUs to comply with each tranche (Capuno 2017). These salary increases are charged to the annual budgets of LGUs, forcing them to manage pay adjustments within limited resources and under PS expenditure caps. While the Department of Budget and Management (DBM) has waived the inclusion of MCPHW benefits in PS limitation calculations starting from fiscal year 2022 to 2025 (DBM 2022a, 2024a, 2025; RP 2023), the actual provision of these benefits still depends on whether LGUs have available funds. Cuenca (2018) discussed the effects of devolution in the Philippines and its implications on local health financing.

MCPHW benefits were not factored into the cost of devolved functions, making it costly for LGUs to provide higher salaries along with the other monetary benefits, causing a reduction in the hiring of public health workers and unfilled Plantilla positions within LGUs. However, the Philippine Institute for Development Studies (2009) identified issues with the equal and uneven provision of *MCPHW* benefits, and its implementation is subject to local government priorities, not just their financial capacities. **Figure 23** shows the share of PS for healthcare workers in terms of the total operating income of LGUs.



2.3 Statutory limitations: the PS cap

The LGU Health Scorecard of the DOH monitors the compliance of LGUs in providing *MCPHW* benefits, but it only covers hazard pay, subsistence allowance, and laundry allowance. The LGU Health Scorecard is a tool used by DOH to track the local health performance of LGUs to ensure that they are aligned with the national health agenda in achieving their local health outcomes and

determine areas for improvement (DOH 2021a). It consists of multiple indicators that measure the health system of an LGU (DOH 2022). The scorecard considers an LGU fully compliant if it provides hazard pay, subsistence allowance, and laundry allowance to its physicians, nurses, and midwives who hold permanent positions.³⁵ The DOH provided criteria for measuring *MCPHW* compliance across various levels of LGU and the national target according to the LGU Health Scorecard.

Table 49. LGU HSC indicators and targets for MCPHW benefits

Indicator	Mun/CC	HUC/ICC	Province	National Target
Indicator 3. Provision of FULL hazard pay, subsistence, and laundry allowances to permanent public health workers under the Magna Carta for Public Health Workers	LGU provides full hazard pay, subsistence, and laundry allowances to its health workers (Physician, Public Health Nurse & Midwife) by RA7305 (Magna Carta of Public Health Workers)			LGUs provided full Magna Carta benefits to their public health workers.

Source: Authors' illustration of the MCPHW indicator on Table 1 of LGU Health Scorecard Indicators and Targets (DOH 2022)

Given these stipulations, it is apparent that the *MCPHW* benefits are only mandatory for the three cadres cited above and are only given to public health workers holding permanent positions. This also affirms that LGUs must only provide the three benefits mentioned in the department memorandum to be considered fully compliant, providing no further guidelines on the other monetary benefits mentioned in the *MCPHW*.

3. Methodology

3.1 Theoretical model

We examine the compliance of LGUs, *i.e.*, municipalities and cities, to implement national mandates to provide healthcare worker benefits using a principal-agent approach (Bossert and Beauvais 2002a). As the 'principal,' the DOH sets the goals and mandates for local governments to follow. Because of information asymmetry, where the national government or DOH is less aware of on-the-ground realities, the DOH delegates authority to LGUs as agents responsible for implementing specific objectives. In this approach, the national government (*i.e.*, the principal) delegates the responsibility of implementing national policies to LGUs (*i.e.*, agents). Here, we assume that without direct incentives, compliance is influenced by financial capacity, binding budget constraints, and statutory PS spending limits (*i.e.*, 45%-55% of PS to total income). As agents, LGUs often prefer different sets of activities. They respond to their constituencies, which could differ from the priorities of national governments. LGUs may have reason to evade the mandates established by the national government, using this information advantage (*i.e.*, local governments know the needs and pulse of their locality more than the national government) and discretionary space (*i.e.*, autonomy status of local governments) to evade nationally defined

³⁵ The LGU HSC monitors these benefits through a 'yes' or 'no' checklist on all three benefits, with a 'Remarks' section to note down any issues on implementation (Annex B – H of DOH D.M. No. 2022-0569)

mandates in favor of local interests. The principal, i.e., the national government, uses mechanisms to address potential non-compliance and effectively guide LGU behavior, including monitoring, inspections, and performance reviews (Bossert 1998; Bossert and Beauvais 2002b).

3.2 Budget constraints

We argue that compliance of LGUs with *MCPHW* is a function of their fiscal capacity, i.e., their ability to generate and allocate revenue effectively. Fiscal capacity is linked to the effectiveness of public expenditures and the responsiveness of LGUs to mandated requirements from the national government. Bird and Wallich (1993) argued that decentralization enhances efficiency when LGUs have adequate fiscal resources to meet local needs and mandates. When LGUs face binding budget constraints, they must make difficult choices about allocating scarce resources. In a decentralized regime, LGUs operate under limited financial resources, and the trade-offs between discretionary expenditures, mandated expenditures, and fixed obligations shape their decisions. (Oates 1999). Variation in fiscal capacity across LGUs can lead to heterogeneous compliance outcomes, as wealthier LGUs are better positioned to fund policy mandates. One important aspect of the budget constraints faced by LGUs is the statutory limit on personnel spending (RP 1991b). The presence of a policy that limits PS at 45% or 55% of total revenue (depending on the income) introduces a binding constraint on LGUs' budgetary decisions. This statutory cap is designed to enforce fiscal discipline and prevent LGUs from overextending their personnel expenditures (Potrafke 2023). This study modeled compliance with national mandates as a function of LGUs fiscal capacity, budgetary trade-offs, and adherence to statutory PS limits. The compliance decision to provide *MCPHW* benefits can be expressed as:

$$C = f \left(Z, \partial, \frac{S}{I} \right)$$

Where:

Z_t = represents the LGU's total income per capita.

∂_{it} = represents the share of income allocated to mandated expenditures.

$\frac{S}{I}$ = represents the PS cap imposed by the government

3.3 Data

We analyze data from the annual DOH LGU health scorecard from 2014 to 2022 to assess the compliance of municipalities and cities with the *MCPHW* (DOH 2024a). The DOH LGU health scorecard provides binary data (i.e., 1 for compliance, 0 for non-compliance) for municipalities and cities, showing whether these LGUs followed the provisions of the *MCPHW*. The number of LGUs in the DOH LGU health scorecard data varies yearly. In 2022, there were 1,714 municipalities and cities. The DOH LGU health scorecard defines compliance with the *MCPHW* by specific provisions related to non-cash benefits, hazard pay, and other legally mandated entitlements for public health workers. The LGU health score card defines compliance with the *MCPHW* by specific provisions on hazard pay, subsistence, and laundry allowances for the select cadre of physicians, nurses, and midwives who hold a permanent position in their respective LGUs.

We linked the DOH scorecard data with auxiliary datasets using the Philippine Statistical Geographical Code (PSGC) as the common identifier (PSA 2024a). The PSGC codes uniquely identify each municipality and city to match financial, demographic, and compliance data accurately. We performed multiple checks to verify that each municipality or city was correctly tagged and aligned with the auxiliary data entries. This approach ensured that the datasets were merged for each municipality across the study period from 2014 to 2021. The auxiliary datasets include financial data from the **Statement of Receipts and Expenditure (SRE)**, sourced from the Bureau of Local Government Finance (BLGF) of the Department of Finance (DOF) (DOF-BLGF 2023). The SRE provides information on LGU finances, including PS for health and other sectors, public spending on health, and total local income. (DOF-BLGF 2024c, 2024b). The DOF collects this financial data from LGUs annually. We merged poverty data and municipal and city-level population counts from the Philippine Statistical Authority (PSA) (PSA 2023a). The poverty data is based on small area estimation and allows for a more granular analysis of economic conditions across municipalities. Since the PSA provides population data only for local governments at semi-decadal intervals, we performed linear projections of annual population estimates.

3.4 Model

Using the following model, we use a fixed effects regression model to examine compliance with MCPHW.

$$Y_{it} = a + \beta \log R_{it} + \sum_{r=1}^5 \partial_r Sh_{rt} \log R_{it} + \rho X_{it} + \varphi_i + \tau_j + e_{it}$$

i refers to the municipality/city and *t* the year. With this specification, the β indicates the probability of compliance for a one-unit increase in the log of local government revenue, holding other variables constant. A positive coefficient suggests that higher revenue is associated with a higher probability of compliance. A negative coefficient suggests that higher revenue is associated with a lower probability of compliance. **We incorporated in the model the source of local revenue w.r.t compliance by introducing interaction terms of the shares of each revenue source, with log overall revenue. In the context of our model, ∂ presents the coefficients for interaction terms or category-specific effects involving the variable $Sh_{rt} \log R_{it}$, where Sh_{rt} represent different shares or proportions (of revenue categories) across years indexed by *r*.** The SRE data classifies the following sources of local government revenues: (a) local taxes - refers to all taxes that accrue to the LGU, including property and all forms of business taxes; (b) local non-taxes – this includes fees derived from the exercise of the regulatory powers and business income of local governments (e.g., franchise fees, licensing fees); (c) **external sources such as national transfer** (e.g., Internal Revenue Allotment, Other Shares from Other National Tax Collection, Inter-Local Transfer, Loans, Grants/Aids, and Donations) (DOF-BLGF 2015, 2017). IRA pertains to the share of LGUs from the national taxes collected and received from the national government. We posit that the source of local revenue could affect LGUs' MCPHW compliance mandate. When LGUs rely on self-generated revenue, they may show greater fiscal autonomy and accountability, motivating them to prioritize spending on **the needs of their constituency, including health worker benefits. This suggests that the composition of revenue sources could be critical in shaping compliance with MCPHW.** The control variables are the following: (a)

log public spending on health, (b) share of PS expenditure to total income, (c) population, and (d) poverty incidence. τ is the year variable. Controlling these time-varying variables allows us to account for factors that may affect compliance: the priorities to health sector spending, priorities to PS spending (i.e., PS cap), demand for resources due to population size, and poverty. Including these variables in the model will determine the effect of revenue on compliance, which provides us with a better picture of how fiscal capacity influences the ability of LGUs to meet health sector mandates.

The study aims to examine the relationship between local revenues on compliance with *MCPHW* by incorporating, φ_i into the model to address time non-varying variables, which could result in biased estimates. We include two specifications for, φ_i in the form of random-effect or fixed-effect models. The former assumes unobserved municipal and city time non-varying variables are normally distributed, while the latter assumes no distributional assumptions. We conducted a Hausman test to determine which is applicable.

4. Results

Based on our analysis of the LGU Health Scorecard of DOH, we estimated that only 75% of LGUs provide *MCPHW*. **Table 50** illustrates the improvement in compliance across. On the national average, compliance improved from 45% in 2014 to 75% in 2022, a significant growth in the last ten (10) years. Compliance rates started at 58% in 2014 and increased steadily, reaching 79% in 2022. First-class LGUs consistently kept higher compliance rates than lower-income classes, showing an upward trend with a large increase in 2020. Compliance rates for fifth-class LGUs were significantly lower in 2014, at 29%, and improved over time, reaching 61% by 2022. **Figure 24** illustrates the distribution of *MCPHW* compliance across cities and municipalities in the Philippines over the years. Non-compliant LGUs are found mostly in Luzon.

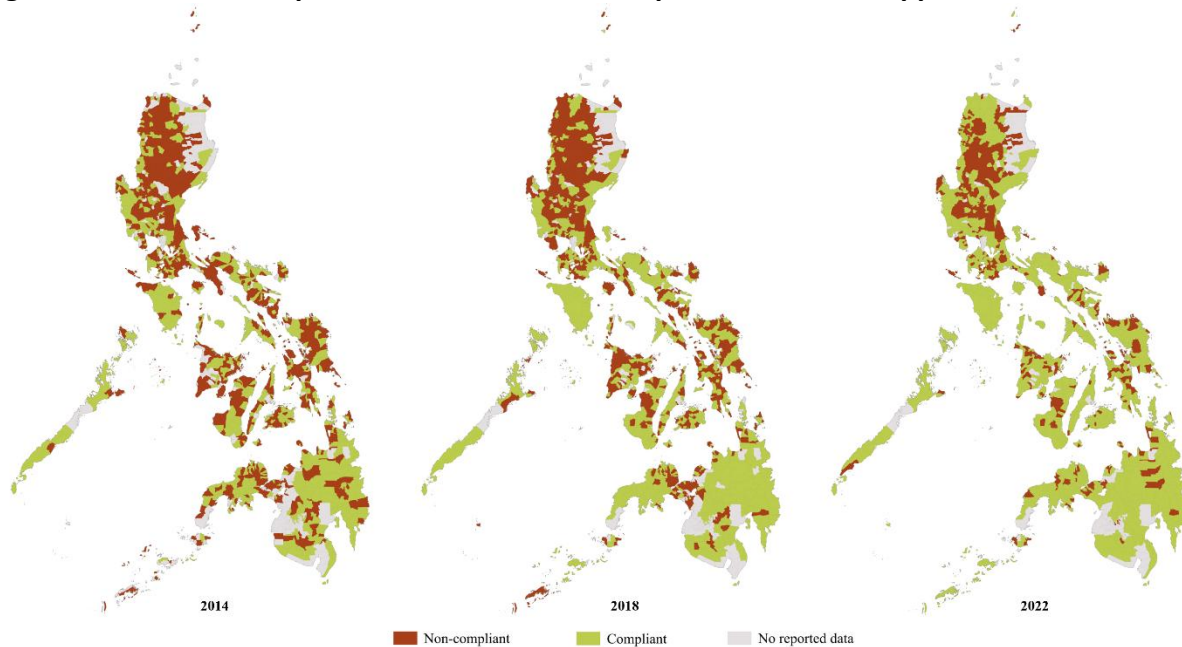
Table 50. Number of LGUs providing the Magna Carta of Public Health Worker benefits by income classification per year, 2014-2022

LGU Income Class	Magna Carta compliance, n (%)								
	2014	2015	2016	2017	2018	2019	2020	2021	2022
1	202 (58.4%)	205 (56.6%)	213 (58.8%)	231 (60.6%)	248 (65.8%)	263 (68.8%)	289 (75.9%)	308 (80.2%)	305 (79.4%)
2	91 (49.5%)	91 (51.4%)	96 (53.0%)	110 (56.4%)	117 (60.0%)	130 (66.0%)	146 (74.1%)	153 (76.9%)	162 (81.0%)
3	125 (46.1%)	123 (44.6%)	128 (45.7%)	144 (48.8%)	154 (52.0%)	174 (58.6%)	187 (63.6%)	216 (72.5%)	229 (76.3%)
4	157 (42.2%)	150 (40.7%)	161 (42.9%)	170 (42.1%)	189 (46.6%)	214 (51.8%)	259 (63.2%)	292 (69.9%)	304 (72.6%)
5	76 (29.1%)	73 (29.0%)	72 (28.3%)	92 (33.6%)	97 (35.3%)	116 (42.0%)	144 (52.0%)	176 (62.2%)	183 (64.7%)

6	11 (44.0%)	9 (47.4%)	8 (38.1%)	11 (44.0%)	13 (50.0%)	18 (66.7%)	13 (52.0%)	16 (59.3%)	17 (63.0%)
Philippines	666 (45.3%)	651 (44.7%)	678 (46.1%)	761 (47.7%)	820 (51.6%)	917 (57.1%)	1051 (65.8%)	1179 (72.3%)	1218 (74.5%)

Source: Authors' tabulation of DOH LGU Health Scorecard MCPHW compliance by income classification (DOH 2024a)

Figure 24. MCPHW compliance of cities and municipalities in the Philippines, 2014, 2018, 2022



Source: Authors' illustration of the DOH LGU Health Scorecard; *MCPHW* compliance across regions (DOH 2024a)

In our inferential analysis, we examine the impact of local government revenue on compliance with *MCPHW*. We hypothesize that as the fiscal space of LGUs increases, that is, they have more financial resources available to allocate toward policy mandates, the probability of compliance with *MCPHW* increases. The source of revenue may play a role. Revenue generated locally gives LGUs greater autonomy and flexibility in spending, leading to higher compliance. Hence, the general idea is that the amount and source of LGU revenue is shaped to the extent to which LGUs can effectively fulfill *MCPHW* mandates.

Table 51 shows the coefficient of compliance with respect to LGU revenue. Our first model is estimated without the interaction terms, separately for cities and municipalities, and a Hausman Test is performed to determine whether fixed effects are more appropriate than random effects. The Hausman test rejected the random effects model in favor of the fixed effects model except for the cities.

Table 51. Regression results without interaction terms

	Fixed effects	Random effects	Hausmann (p-value)
Compliance (All)	0.174***	0.169***	p-value<0.000
Compliance (Municipalities)	0.177***	0.215***	p-value<0.000
Compliance (Cities)	0.0297	0.086	p-value>0.000

Note: The Hausman test reports p-values for rejecting the hypothesis that the coefficient difference is not systematic for all LGU groups and municipalities.

Table 52 shows the average LGU revenue by cities and municipalities. Most of the local revenue remains the internal revenue allotment (IRA) from the national government, with a higher share of municipalities than cities. As expected, cities have a higher share of local government revenues from taxes and local tax revenues. Municipalities are highly dependent on national tax revenues. After controlling for time-varying variables, statutory limit (i.e., PS as a share of income), poverty incidence, health spending, health prioritization (share of health relative to expenditure), **Table 53** shows a positive association between total local government revenue and compliance with *MCPHW* mandates for all LGUs and municipalities, with statistically significant coefficients of 0.174 and 0.177, respectively. We did not observe statistically significant differences in cities. This finding indicates that as the total revenue of LGUs increases, the probability of compliance improves, highlighting the importance of fiscal capacity for LGUs to meet such a mandate. However, the interaction terms with various revenue sources—such as local tax revenue, local non-tax revenue, IRA, other national transfers, and interlocal transfers—show insignificant effects on compliance. This suggests that the specific sources of local revenue streams, whether from local or national streams, do not substantially impact the probability of compliance. One exception, however, is found in cities, where local non-tax revenue has a negative and statistically significant coefficient of -0.0664. This suggests a slight negative association with compliance. In general, our findings suggest that the total local revenue matters more than its specific sources, as the ability of LGUs to comply with *MCPHW* mandates appears unaffected by the composition of their local government revenue.

Table 52. Mean LGU revenue (in PHP millions) from various sources and its share to total, 2021

	All	Municipalities	Cities
<i>Local tax revenues</i>	87.5 (6.7%)	14.5 (5.2%)	826.6 (21.5%)
<i>Local non-tax</i>	27.2 (5.9%)	12.7 (5.7%)	173.8 (7.9%)
<i>IRA</i>	241.5 (85.9%)	158.4 (87.7%)	1,082.4 (67.9%)
<i>Other national transfers</i>	0.1 (0.0%)	0.1 (0.0%)	0.7 (0.0%)
<i>Interlocal transfers</i>	2.5 (0.5%)	0.9 (0.5%)	19.1 (0.9%)
<i>Aid/grants</i>	5.2 (1.0%)	1.7 (1.0%)	40.9 (1.8%)

Source: Authors' analysis of 2021 Statement of Receipts and Expenditures (BLGF 2021)

Table 53. Regression results on the association of compliance with MCPHW and total revenues with different interaction terms

	All	Municipalities	Cities
Total revenue	0.174*** (0.0203)	0.2150 (0.0193)	0.0297 (0.0655)
Interaction terms with revenue shares			
<i>Local tax revenues</i>	-0.0019 (0.0066)	-0.0093 (0.0070)	0.00169 (0.0169)
<i>Local non-tax</i>	0.00459 (0.0077)	0.0081 (0.0074)	-0.0664** (0.0224)
<i>IRA</i>	0.00216 (0.0049)	-0.0028 (0.0051)	-0.00767 (0.0161)
<i>Other national transfers</i>	0.00689 (0.0167)	0.0026 (0.0167)	-0.087 (0.1924)
<i>Interlocal transfers</i>	-0.0212 (0.0110)	-0.0133 (0.0115)	-0.0197 (0.0265)
<i>Aid/grants</i>	0	0	0

Note: The panel included 1,603 LGUs and 7,629 observations. Of these, 1,456 are municipalities with 6,913 observations, and 147 are cities with 716 observations. All models control demographic and economic variables and time effects. The Hausman test reports p-values to reject the hypothesis that the coefficient difference is not systematic for all LGU groups and municipalities. Standard errors are in brackets.

5. Discussion and recommendations

In this report, we examine the prevalence of compliance of LGUs with *MCPHW* over the years, estimate the effect of fiscal capacity on compliance, and assess whether the source of local government revenue matters. Based on the LGU Health Scorecard of the DOH, we observe that only 74% of LGUs provide Magna Carta benefits to their health workers. Compliance across the years has improved, and the non-compliant localities are spread across the country. The majority of non-compliant LGUs in the country are found in Luzon. However, this improvement varies significantly across local government income classifications. The poorer the LGU, the lower the compliance. These findings are corroborated by a similar study by Syling et al. (2024), which also confirmed these implementation issues of *MCPHW* with national government agencies (i.e. DOH-HHRDB and DOH-BLHSD) and LGUs. The findings of Syling et al (2014) DOH-BLHSD supported the empirical data that the number of LGUs complying with the *MCPHW* provision has increased yearly. Despite this positive finding, this trend may be attributed to limited monitored benefits to only hazard pay, laundry allowance, and subsistence allowance, which makes it more feasible for LGUs to comply (Syling et al. 2024).

The large variation in compliance across LGUs is consistent with other evaluations of *MCPHW* compliance, finding that the financing of benefits depends on the political and financial landscape of the LGU (L. P. Carpio et al. 2021; Chavez et al. 2023). One of the important features of the Local Government Code (LGC) was to devolve the provision of health and other basic government services to the LGU (RP 1991b). Therefore, local government executives' political will influences the implementation of health sector programs. Carpio et al. (2021) found that providing *MCPHW* benefits to health workers depended upon the LCE's knowledge of the law and their prioritization of health services. Chavez et al. (2023) found that monitoring and assessment are significant in determining the success of LCE programs. Tejero et al. (2022) Found that LGU financial constraints, particularly regarding the ability to pay for compensation, limit the ability of rural LGUs to retain their health workers. In general, the mandate of decentralization provided autonomy and empowered local officials. However, implementing basic services is typically easier for local governments with higher income, while poorer municipalities cannot provide the full range of services due to financial constraints (Atienza and Go 2023).

Our regression analysis shows a positive association between LGU revenue and compliance with *MCPHW*. However, we only observed a significant association in municipalities, not cities. Our results suggest that as the fiscal capacity of LGUs grows, so does their probability of compliance with *MCPHW*. As expected, greater financial resources enable LGUs to allocate funds toward fulfilling mandated benefits for health workers. Compliance with *MCPHW* likely requires higher funding, so LGUs with higher revenue have more flexibility to meet these requirements. As noted in one of our papers, PS poses a significant source of expenditure in many local governments. The source of revenue—whether from local taxes, non-tax sources, or national transfers—does not appear to impact compliance for most LGUs significantly. We aimed to examine revenue sources to provide insight considering the Mandanas-Garcia ruling of the Supreme Court, as enacted in Executive Order No. 138 (RP 2021a), which will increase IRA transfers to LGUs. The insignificant coefficients for the interaction terms with various revenue sources suggest that the total amount of revenue matters more than its specific sources. This could indicate that LGUs prioritize *MCPHW* compliance based on their fiscal space rather than specific revenue streams. Our findings provide less insight, requiring more future discernment and analysis. The insignificant coefficients for the interaction terms with various revenue sources suggest that the total revenue matters more than its specific sources. The policy implications of these findings could provide perspective in improving equitable compliance with *MCPHW*. In a decentralized regime where LGUs manage their finances, increasing total revenue may enhance compliance with mandates like *MCPHW*. Policies should revolve around strengthening the fiscal capacity of LGUs while developing strategies to promote equitable compliance among LGUs. This may include assisting poorer LGUs in meeting *MCPHW* requirements and ensuring increased revenue translates to consistent and higher compliance. We argue that increasing revenue does not guarantee compliance, as LGUs' spending priorities also play a role. Policies are needed to guide or incentivize LGUs to prioritize mandated health worker benefits when their fiscal space expands. This is a possible reality in the era of a more decentralized health system because of EO 138.

Our recommendations center around two possible options in addressing the common concerns for compliance with providing *MCPHW* benefits. First, improvements in monitoring compliance across LGUs are certainly needed. The DOH LGU Health Scorecard should be updated to track all benefit entitlements of public health workers. Furthermore, disaggregation of the metric is

necessary for proper monitoring, as the current binary indicator makes compliance evaluation difficult. With proper monitoring, the DOH could follow and evaluate the compliance of LGUs across time, allowing for more sophisticated analysis in the future.

Second, to promote equitable compliance with the *MCPHW* without undermining local autonomy, the national government should consider designing targeted financial and technical support mechanisms that reinforce LGU discretion. Our study shows compliance is associated with fiscal capacity, suggesting that poorer LGUs require additional support to meet mandates. An example intervention includes national subsidies provided to LGUs (4th to 5th class municipalities) with demonstrated fiscal constraints. Complementing financial aid with technical assistance, such as cost planning, benefit prioritization, and compliance monitoring, can help build LGU capacity.

6. Bibliography:

Atienza, Maria Ela, and Jan Robert Go. 2023. "Assessing Local Governance and Autonomy in the Philippines: Three Decades of the 1991 Local Government Code."

Bird, Richard, and Christine Wallich. 1993. "Fiscal Decentralization and Intergovernmental Relations in Transitions Economies: Toward a Systematic Framework of Analysis."

Bossert, Thomas. 1998. "Analyzing the Decentralization of Health Systems in Developing Countries: Decision Space, Innovation and Performance." *Social Science & Medicine* 47(10):1513–27. doi:10.1016/S0277-9536(98)00234-2.

Bossert, Thomas J., and Joel C. Beauvais. 2002a. "Decentralization of Health Systems in Ghana, Zambia, Uganda and the Philippines: A Comparative Analysis of Decision Space." *Health Policy and Planning* 17(1):14–31. doi:https://doi.org/10.1093/heapol/17.1.14.

Bossert, Thomas J., and Joel C. Beauvais. 2002b. "Decentralization of Health Systems in Ghana, Zambia, Uganda and the Philippines: A Comparative Analysis of Decision Space."

Capuno, Joseph. 2017. "Tugs of War: Local Governments, National Government." 16–17.

Carpio, Louella Patricia, Hanna Cayabyab, and Danielle Marie Irish Te. 2021. "Determining the Implementation Status of Benefits Under Magna Carta of Public Health Workers (RA 7305) in the Philippines." *Acta Medica Philippina* 55:47–53. doi:10.47895/amp.v55i1.2950.

Chavez, Jason, Marti Gregorio, Aracelie Araneta, and Cristie Bihag. 2023. "Magna Carta for Women Health Workers, Teachers, and Minimum-Wage Earners in the Workplace: Policy Awareness and Organizational Compliance." *Environment and Social Psychology* 9. doi:10.54517/esp.v9i1.1735.

Cuenca, Janet. 2018. "Health Devolution in the Philippines: Lessons and Insights."

DBM. "Guidelines on the Implementation of Personal Services (PS) Limitation on Local Government Budgets and Determination of Waived PS Items Pursuant to Section 93 of the General Provisions (GPs) of the Fiscal Year (FY) 2022 General Appropriations Act (GAA), Republic Act (RA) No. 11639, and Years Thereafter."

DBM.

DBM. 2025. *Local Budget Circular 163-2025 - Guidelines on the Implementation of Personal Services (PS) Limitation on Local Government Budgets and Determination of Waived PS Items Pursuant to Section 96 of the General Provisions (GPs) of the Fiscal Year (FY) 2025 General Appropriations Act (GAA), Republic Act (RA) No. 12116 and Years Thereafter.*

DBM and DOH. 2012. "Rules and Regulations on the Grant of Compensation-Related Magna Carta Benefits to Public Health Workers."

DBM and DOH. 2016. *Amendment to DBM-DOH Joint Circular No. 1 s. 2012 Regarding the Rules and Regulations on the Grant of Compensation-Related Magna Carta Benefits to Public Health Workers (PHWs).*

DOF-BLGF. 2015. “The Statement of Receipts and Expenditures: Systems, Concepts, Input Preparation and Reporting.”

DOF-BLGF. 2017. “Electronic Statement of Receipts and Expenditures (eSRE): Primer.”

DOF-BLGF. 2023. “2009-2022 LGU Statement of Receipts and Expenditures.”

DOF-BLGF. 2024a. .”

“2017-2023 LGU Health, Nutrition, and Population Control Expenditures.”

DOH. 1999. “Revised Implementing Rules and Regulations on the Magna Carta of Public Health Workers or R.A. 7305.”

DOH.

DOH. 2022. *Department Memorandum 2022-0569 - Implementation of the 2022 Local Government Unit Health Scorecard (LGU HSC) Performance Results.*

DOH. .”

DOLE. 2017. “Guidelines Governing the Employment and Working Conditions of Health Personnel in the Private Healthcare Industry (D.O. 182).”

Lavado, Rouselle. 2011. “Magna Carta of Public Health Workers: Does It Really Fulfill Its Intent?”

Leyva, PhD Erwin William A., Misw Julianne Ivan D. Soberano, PhD Jenniffer T. Paguio, PhD Kathryn Lizbeth L. Siongco, PhD Earl Francis R. Sumile, and DrPH Sheila R. Bonito. 2024. “Pandemic Impact, Support Received, and Policies for Health Worker Retention: An Environmental Scan.” *Acta Medica Philippina* 58(12). doi:10.47895/amp.v58i12.9346.

Lorenzo, Fely Marilyn, Jennifer Frances Dela Rosa, Glenn Roy Paraso, Susan Villegas, Cynthia Isaac, Julie Yabes, Florante Trinidad, Grace Fernando, Atienza Joel, Kenneth Ronquillo, Lilibeth David, Nilda Silvera, and Lourdes Rebullida. 2005. “Migration of Health Workers: Country Case Study Philippines.” *International Labour Office*.

Oates, Wallace. 1999. “An Essay on Fiscal Federalism.” 37:1120–49.

Perez, Juan. 1998. “Health Worker Benefits in a Period of Broad Civil Service Reform: The Philippine Experience.”

Philippine Institute for Development Studies. 2009. “Improving Local Service Delivery for the MDGs in Asia: The Case of the Philippines.”

Potrafke, Niklas. 2023. “The Economic Consequences of Fiscal Rules.”

PSA. “2015, 2018, & 2021 Poverty Statistics and Small Area Estimates.”

2023. *General Provisions: Fiscal Year 2023.*

Saguil, Noel, Horacio Saguil, Jimiwell Bernabe, and Marian Jeremy Aggabao. 2023. "A Quality Healthcare Model: Job Satisfaction and Motivation Attributes of Hospital-Based Nursing Personnel." *ResearchGate*. doi:10.17605/OSF.IO/THDPR.

Syling, Jereme Paolo, Louie Iyar Dagoy, Yaddah Shalom Dollente, Leif Daryl Tan, Clarissa Flaminiano, and Valerie Gilbert Ulep. 2024. "Underpaid Heroes? A Comprehensive Assessment of Human Resources for Health Compensation in the Philippines." *Philippine Institute for Development Studies*.

Tejero, Lourdes Marie S., Erwin William A. Leyva, Peter James B. Abad, Diana Montorio, and Ma Leoant Santos. 2022. "Production, Recruitment, and Retention of Health Workers in Rural Areas in the Philippines." *Acta Medica Philippina* 56(8). doi:10.47895/amp.vi0.1510.

Villalobos, Elvie. 2006. "An Assessment of the Implementation of the Magna Carta of Public Health Workers Among Local Government Units in the Province of Iloilo."