

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

Valerie Gilbert T. Ulep, Jereme Paolo K. Syling, Louie Iyar L. Dagoy, Yaddah Shalom R. Dollente, Lefi Daryl C. Tan, Clarisa Joy A. Flaminiano, Lyle Daryl D. Casas

November 20, 2025 | Marco Polo, Ortigas



**HEALTH ECONOMICS
AND FINANCE PROGRAM**

Contact us at hefp@pids.gov.ph

This discussion paper includes three (3) research studies that focuses on specific aspects of HRH remuneration

Policy scoping review:

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

Jereme Paolo Syling, Louie Iyar Dagoy, Yaddah Shalom Dollente, Leif Daryl Tan, Clarisa Joy Flaminiano, and Valerie Gilbert Ulep

Policy options and budgetary estimates for equitable remuneration

Standardizing Health Worker Salaries in the Philippines: Potential Options, Approaches and Costs

Yaddah Shalom Dollente, Jereme Paolo Syling, Leif Daryl Tan, Louie Iyar Dagoy, and Valerie Gilbert Ulep

Analysis on MCPHW implementation among LGUs

Compliance with the Magna Carta for Public Health Workers among Local Government Units in the Philippines

Louie Iyar Dagoy, Yaddah Shalom Dollente, Lyle Daryl Casas, Leif Daryl Tan, Jereme Paolo Syling, and Valerie Gilbert Ulep

HRH: A brief overview

Health and economy: HRH plays a vital role in our economy and society



2.69%

or 1.4 million jobs
in the country are
in the health
sector



5%

Average annual
growth rate in the
health sector
(2010-2023)



48%

Nurses account
for the largest
share of HRH



Most healthcare workers are women 67.4% (2023)

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



53% of HRH are in the private sector

*Some HRH practice in both public and private "Dual Practice"

Governance: Compensation for HRH differs in both sectors

Public Sector

Private Sector

Compensation and Position Classification System (RA 6758)

- More famously known as the Salary Standardization Law (SSL)
- Provides a comprehensive salary grade table to determine the salary rates of government employees



Basic Salary

- Formulation of the National Wages and Productivity Commission (NWPC) and Regional Tripartite Wages and Productivity Boards (RTWPB)
- Follows the minimum wage per region

Wage Realization Act (RA 6727)

Magna Carta of Public Health Workers (RA 7305)

- Provides cash and non-cash benefits to public health workers
- Supplemented by civil service benefits that are entitled to government employees



Bonuses

- Provides cash and non-cash benefits to public health workers
- Supplemented by civil service benefits that are entitled to government employees

Labor Code (PD 442) & Guidelines on Health Personnel (DOLE DO 182-2017)

LGU Code of 1991 (RA 7160) and PhilHealth

- Established the personnel services (PS) limitation
- Budgeted annually
- MCPHW fall under PS for LGUs
- Pooled funds in PhilHealth finance public health worker share



Financing

- Largely unregulated
- Market-driven
- Varies per facility

Governance: Fragmented regulatory entities.



Commission on Higher Education

- Administers qualifying licensure examinations
- Investigates and arbitrates professionals
- Formulates rules and policies to regulate

The Professional Regulation Commission (PRC)

- Administers qualifying licensure examinations
- Investigates and arbitrates professionals
- Formulates rules and policies to regulate



Medical societies

- Self-governance of the professional practice of HRH is done through various professional organizations; they do not set rates



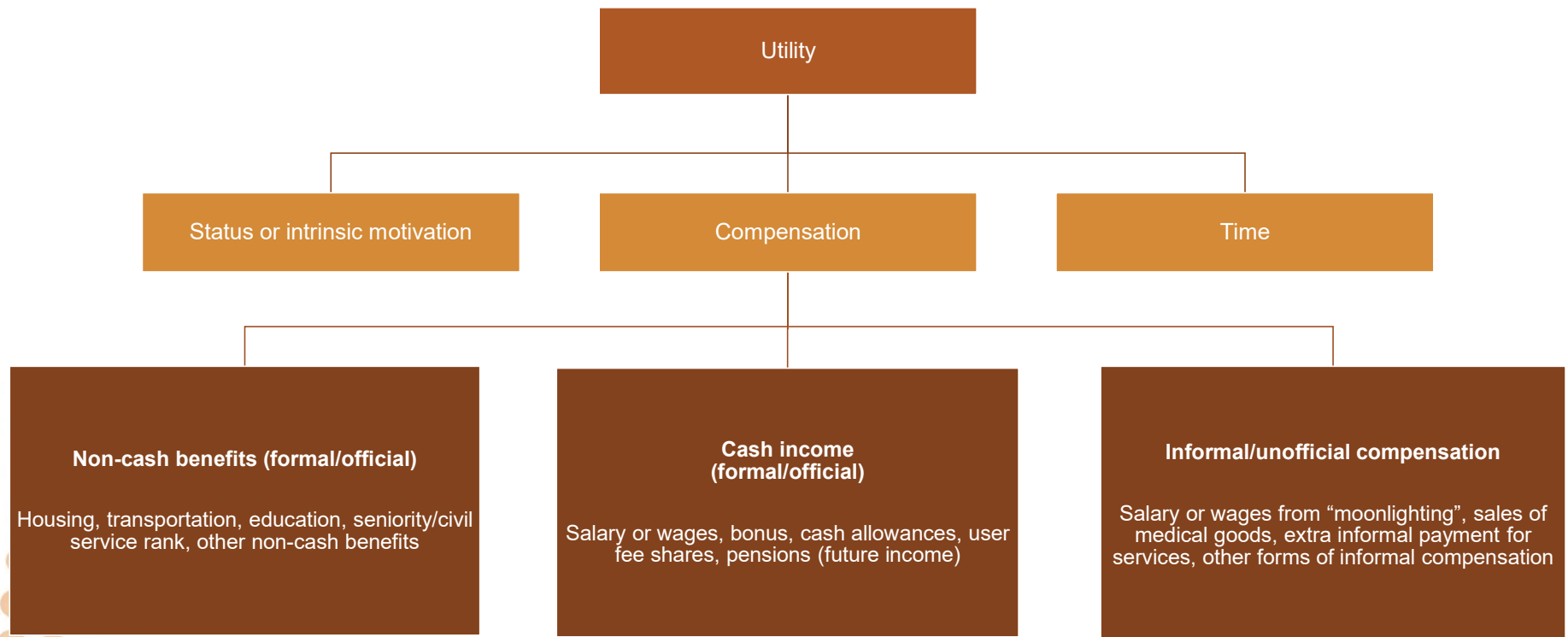
Department of Health

- Deployment/demand

Objectives

- 1.) Assess the level and adequacy of HRH emolument spending in reference to global benchmarks**
- 2.) Appraise existing local policies and programs related to HRH compensation and identify issues, challenges, and process deviations in the following key areas concerning HRH remuneration**
- 3.) Determine financial feasibility and impact of implementation of key proposed policy reforms (e.g. salary standardization and full implementation of MCPHW Benefits)**

This study uses Jakiewicz et al's (2016) definition of compensation, highlighting three (3) key components



Source: Jakiewicz et al's (2016)

We utilized mixed methods to provide a comprehensive assessment on HRH remuneration

Policy Scoping and Literature Review



- Legislation and National **Government policies and guidelines on HRH compensation**
- DOH National Human Resources for Health Master Plan
- International studies, white papers, and reports
- Other relevant documents

Key Informant Interviews



- **Semi-structured KIs** with 19 national and local offices and hospitals
- Spanned **across governance levels** – National Government (DOH, DOLE), LGUs, and LGU hospitals
- Included representatives from HRH unions and associations
- **Representativeness** – Luzon, Visayas, Mindanao, NCR

Secondary Data Analysis



- **Health Facility Statistical Reports** from **DOH**
- **Hospital Financial Statements**
- Occupational Wages Survey, Annual Survey of Philippine Business and Industry, Labor Force Survey from **PSA**
- Auxiliary datasets from **PSA** (poverty incidence, urban population, etc.)
- Socio-demographic variables and financial data from **DOF-BLGF**

Primary data collection



- **Survey targeted healthcare providers across all facility levels in 8 study sites. Employed a two-stage stratified random sampling approach**
- **Total respondents:**
 - 209 generalist medical doctors
 - 146 specialist medical doctors
 - 472 nurses
 - 204 midwives
- **Covered facilities from Rural Health Units (RHUs) to Level 1, 2, and 3 hospitals**

Rigorous analysis on qualitative and quantitative data

Qualitative analysis: 19 KIIs and a comprehensive policy scoping spanning multiple years

- 1. Policy scoping review** on national laws, policies, and circulars regarding HRH compensation
- 2. Thematic analysis on KIIs and FGD**
 - NGAs that had influence HRH remuneration were selected
 - HRH labor unions and professional societies
 - Selection criteria for LGUs are as follows:
 - Complete MCPHW compliance from '14-'22
 - Partial compliance – providing benefits in select years only
 - Non-provision of benefits from '14-'22

Quantitative analysis: 16 datasets utilized for analysis

1. Health Facility Statistical Reports 2017-2022
2. Hospital Financial Statements 2017-2020
3. National Health Facility Registry 2024
4. Occupational Wages Survey 2014, 2018, & 2020
5. Annual Survey of Philippine Business and Industry 2020
6. Labor Force Survey 2010-2023
7. Poverty Statistics and Small Area Estimates 2015, 2018, & 2021
8. Philippine Standard Geographic Code 2024
9. Census on Population and Housing 2020
10. LGU Scorecard on Health 2014-2022
11. LGU Annual Regular Income 2009-2022
12. LGU Capital Outlay and Personnel Services Expenditures 2017-2023
13. LGU Health, Nutrition, and Population Control Expenditures 2017-2023
14. LGU Statement of Receipts and Expenditures 2009-2022
15. Philippine National Health Accounts 2023
16. PIDS COBP-CATCH Healthcare Provider Survey (Conda, 2025)

Key Findings

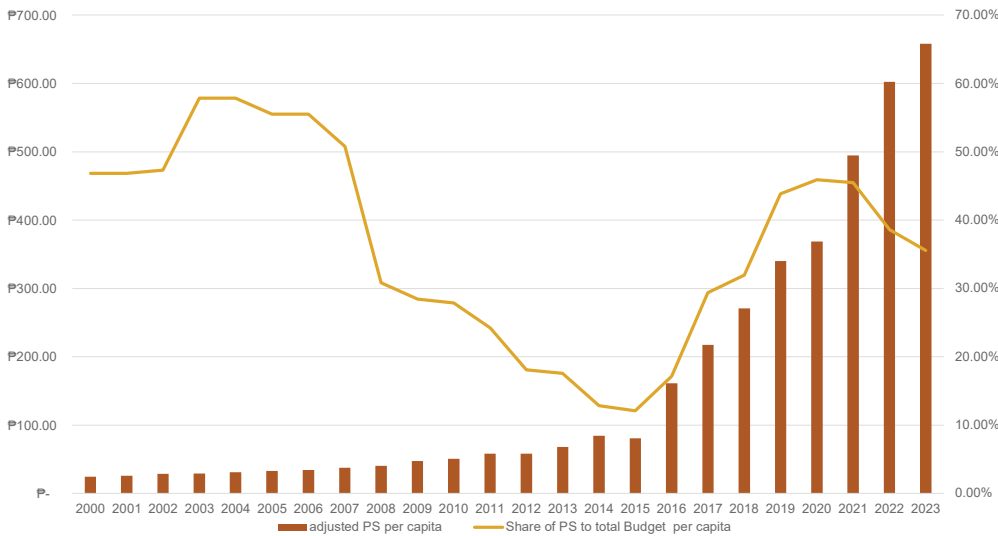
Governance: Multiple approaches are employed to compensate healthcare providers across public and private and by type of cadre

	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

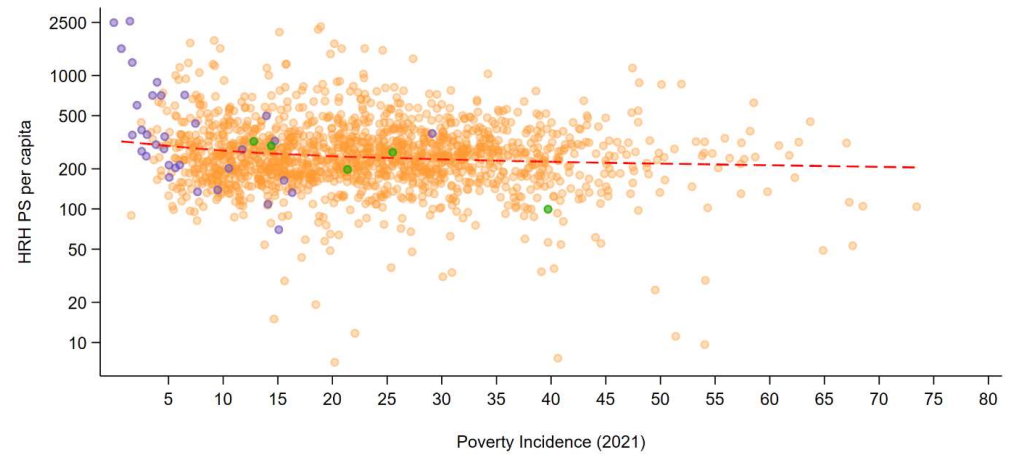
Financing: National government spending on HRH Personnel Services (PS) increased rapidly in real per capita terms; LGU spending accounts for only 42% of the total PS expenditure for the public health sector in 2023 (54.3 billion), making the national government the primary source of wage funding.

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



Note: Analysis of GAA (raw data)

Personnel services for HRH per capita of LGUs (2022) by poverty incidence (2021)

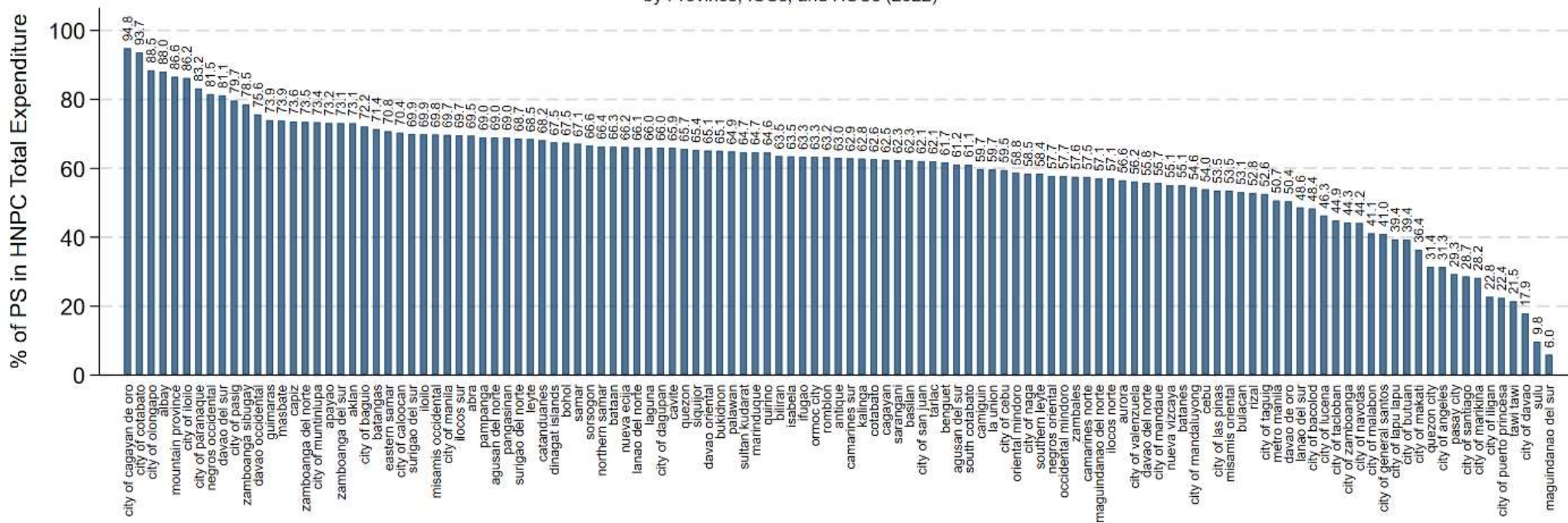


Note: Analysis of BLGF data (2022) and PSA data

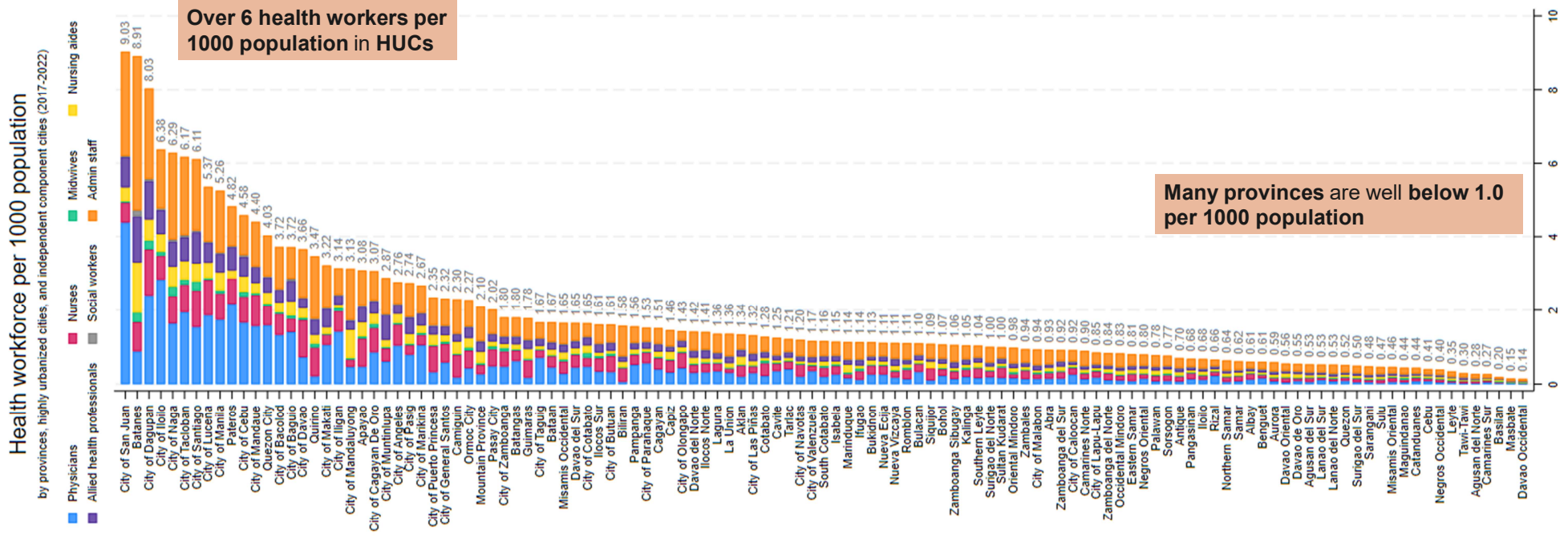
PhP 291 per capita
Average LGU spending on PS with considerable variation reflecting socio-economic disparities

Financing: 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.

% of Personnel Services (PS) to Total Health, Nutrition, and Population Control (HNPC) Expenditure
by Province, ICCs, and HUCs (2022)



Stock of health workers: The maldistribution of hospital HRH is stark. We examined the density of health workers in hospitals across provinces and highly urbanized cities.



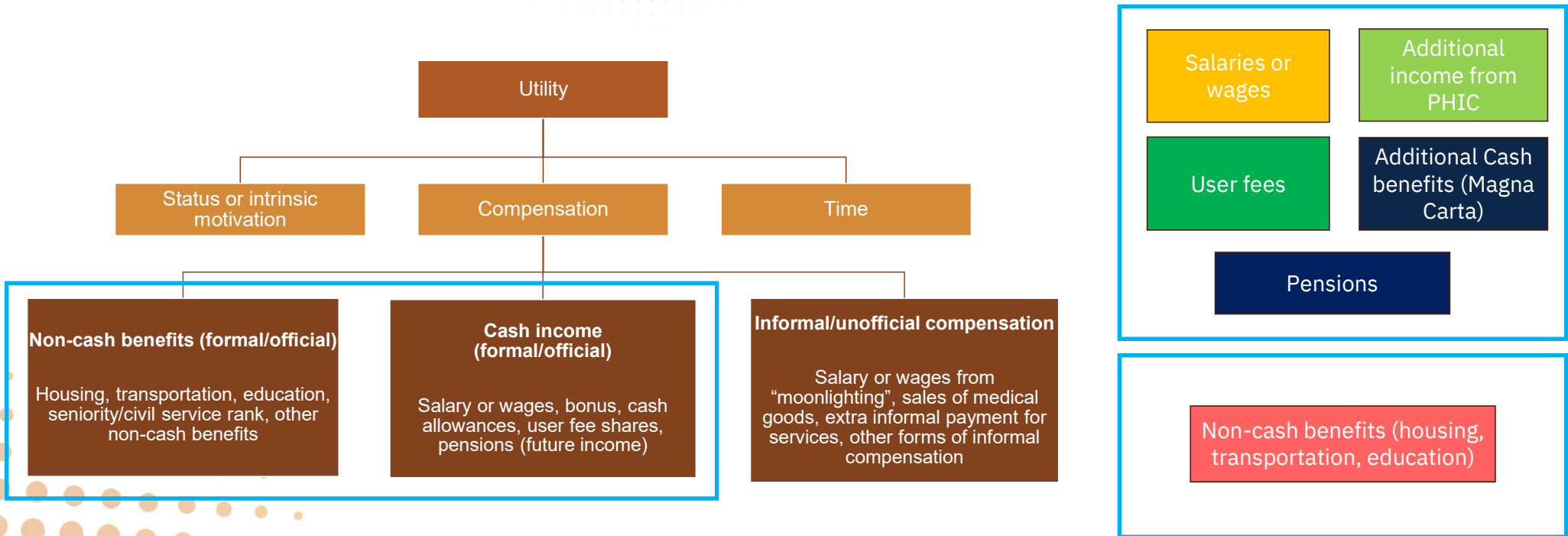
Source: Staff composition; Department of Health Health Facility Statistical Report

Stock of health workers: Public sector physicians typically experience higher workloads than their private sector counterparts, as seen in greater patient volumes and less nursing support, indicating a need for improved staffing levels in public healthcare facilities

	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

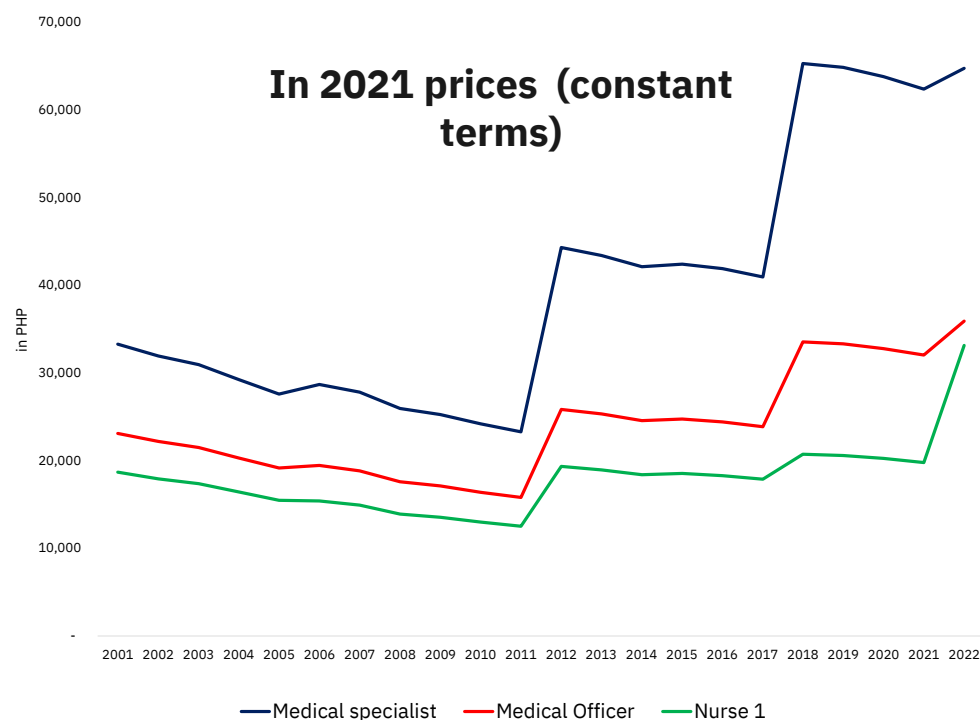
In terms of HRH utility in the Philippines, it's composed of the following components:



Source: Jakiewicz et al's (2016)

Public HRH earn more than their private counterparts across the board through the evolution of SSL and policy interventions that increase the salaries of specific cadres.

	Private		Government	
	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
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 cadre	₱23,220.72	1.03	₱37,820.38	1.68

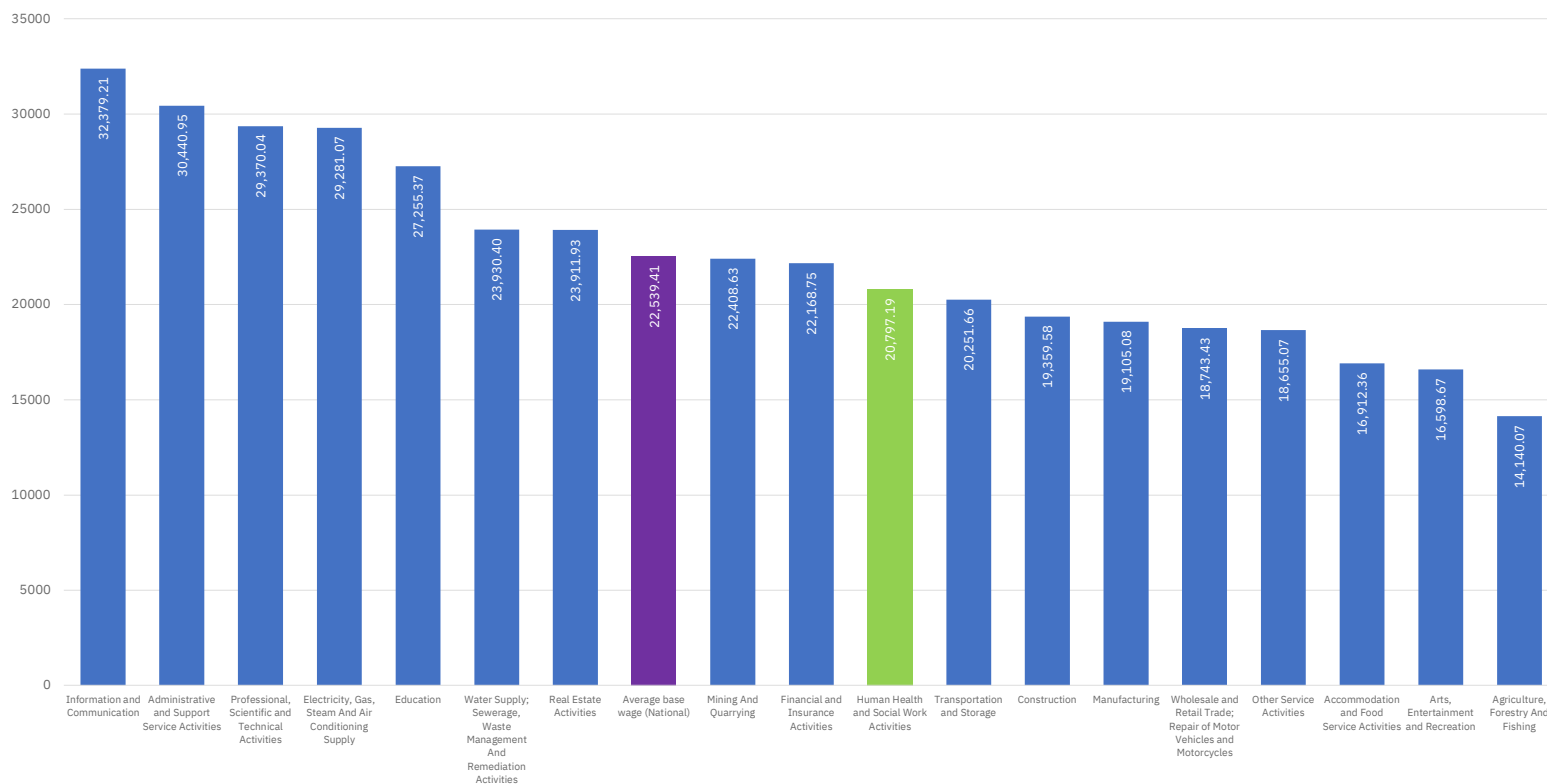


54%
Pay hike for Nurse I position from 2020 to 2021 (SG 11 to SG 15)

Salaries/Wages

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

In the private sector, remuneration is governed primarily by minimum wage rates; the average base salary for a private HRH is below the national average wage.



An HRH worker earns almost **PhP 12,000** less monthly than a worker in Information and Communications Sector

Salaries/Wages

In the public sector, the policies that govern the salaries of healthcare workers have a progressive history.

No.	Allowance/Benefits for HRH	Public	Private	Comments
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

“We want to standardize the salary for public and private health workers but that’s difficult to do since we can’t just dictate the salary rates in the private sector, even DOLE can’t do that. All they can do is develop a reasonable salary per region.” – C2

Additional Cash benefits (Magna Carta)

Note: Author’s analysis on the compensation policies for HRH in the Philippines

PhilHealth, the country's national health insurer, uses case rates to cover total care costs—including professional fees—which serve as additional compensation on top of public health workers' government salaries; User fee remains one of the most important drivers of provider utility

- **30% of case rate** for medical cases allocated to professional fees.
- **40% or RVU-based** professional fees for surgical cases.
- In **government facilities**, PhilHealth PFs are pooled and distributed among accredited providers.
 - Since 2016, includes **non-physician health workers**, part-time workers receive half-share.
 - **Split: 50% for doctors, 50% for non-physician health workers.**
- **Private facilities:** No regulation on professional fee distribution—varies by institution.
- **Largely unregulated and unmonitored**, even in public facilities.
- Public facilities offer "private practice" arrangements (e.g., private wards), allowing physicians to charge fees beyond their salaries.
- Specialists may serve in public hospitals without regular salaries, especially in teaching hospitals.
- The system creates a **two-tiered structure** that may disadvantage low-income patients.
 - **No Balance Billing (NBB)** policy prohibits user fees in basic/ward accommodations.
 - "Pay" accommodations allow charging of hospital and professional fees.

Box 2. Computation of Distribution of Pooled Funds from PhilHealth

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

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

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.

User fees and PhilHealth payments



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 mandatory membership for both
- Government Social Insurance System (GSIS) covers public workers while Social Security System (SSS) covers private workers
- GSIS offers more flexibility with multiple pension packages

*“Health workers would want to practice in the public sector rather than practice in the private sector because of the pension benefits. Once you get a Plantilla position, you have a security of tenure and pension once you retire. In private facilities, if they lay you off, you only get a separation pay. Unlike in the government, **once you rendered 15 years of service or if you’ve reached the compulsory retirement age of 65, you’ve already secured your pension benefits.**”*

Pensions

Challenges and Issues on HRH remuneration

Wages differentials in public and private pose demoralization

- **Significant wage disparities exist between public and private health workers (HRH)**, pushing many to either stay in the public sector or seek better-paying opportunities abroad.
- Despite the vocational "calling," health workers emphasize the need for dignified wages that reflect the demands of their profession.
- Both qualitative interviews and sectoral feedback **affirm the need for better compensation**, especially for **private sector HRH**.
- **Quotes from Respondents:**
 - *“Even if a nurse is called to serve, they too have [financial] needs... Nurses are not dignified with the salaries they receive.” – D1*
 - *“They work their hardest but only receive minimum wage... the monetary investment in their education doesn’t reflect in their salaries.” – C4*
 - *“We call on government to legislate salary increases, not leave it to Wage Boards.” – D3*

Salaries/Wages

Across all levels, public health facilities allocate a higher percentage of total compensation to benefits than private facilities

- Public hospitals spend more on benefits and hazard pay while private facilities allocate more to professional fees
- This suggests that private facilities may attract more HRH through higher professional fees
- Distribution of PF is at the discretion of facility management leading to variation across facilities



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

Additional Cash benefits and non-cash benefits

User fees and PhilHealth payments

Pay disparity persists amongst public HRH due to salary rates dependent on LGU income class; PS cap is also a challenge, making LGUs hire through JO/COS arrangements

SSL salary rates per income classification

LGU Classification	Province/ Cities	SG 15 Example	Municipalities	SG 15 Example
1 st Class	100%	36,619	90%	32,957.1
2 nd Class	95%	34,788.05	85%	31,126.15
3 rd Class	90%	32,957.1	80%	29,295.2
4 th Class	85%	31,126.15	75%	27,464.25
5 th Class	80%	29,295.2	70%	25,633.3
6 th Class	75%	27,464.25	65%	23,787.35

Source: SSL & LGU Code of 1991



JO/COS employees are easier to hire because they no entitled benefits, and their salaries are sourced from the MOOE



The lack of Plantilla positions causes public health worker internal migration



LGUs need to strategize how they convert their JO/COS and/or contractual employees to Plantilla positions

“The challenge is on standardizing the salary. How come the national employees receive higher salaries than us? 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

“Well, the very first thing that we do during budget preparation is we really allocate funds first to Personnel Services (PS). 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

Salaries/Wages

Provision of Magna Carta benefits to public HRH vary across LGUs due to financial constraints, political priorities, and LCE discretion

Number of LGUs providing MCPHW benefits by income class 2014-2022

LGU Income Class	Magna Carta compliance (%)									
	2014	2015	2016	2017	2018	2019	2020	2021	2022	
1	58.40%	56.60%	58.80%	60.60%	65.80%	68.80%	75.90%	80.20%	79.40%	
2	49.50%	51.40%	53.00%	56.40%	60.00%	66.00%	74.10%	76.90%	81.00%	
3	46.10%	44.60%	45.70%	48.80%	52.00%	58.60%	63.60%	72.50%	76.30%	
4	42.20%	40.70%	42.90%	42.10%	46.60%	51.80%	63.20%	69.90%	72.60%	
5	29.10%	29.00%	28.30%	33.60%	35.30%	42.00%	52.00%	62.20%	64.70%	
6	44.00%	47.40%	38.10%	44.00%	50.00%	66.70%	52.00%	59.30%	63.00%	

70%
 LGUs that comply with Magna Carta benefits (hazard pay, laundry allowance, and subsistence allowance to permanent employees)

Note: Analysis of LGU Health Scorecard MCPHW compliance 2014-2022 (DOH, 2023)

“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

Additional Cash benefits (Magna Carta)

On average, medical doctors receive varied and inconsistent salary supplements across provinces, with only a minority receiving key benefits such as PhilHealth sharing or duty allowances.

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

Monetary Salary Supplements	North & Central Luzon				South Luzon				Visayas				Mindanao				Overall					
	La Union		Benguet		Batangas		Laguna		Iloilo		Aklan		Davao de Oro		Sarangani		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 = 127 (35.8%)	N = 21 (5.9%)			N = 50 (14.1%)	N = 30 (8.5%)	N = 64 (18.0%)	N = 28 (7.9%)
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)				

Additional Cash benefits
(Magna Carta)

User fees and PhilHealth
payments

Allied health professionals receive lower and more uneven salary supplements than doctors, with fewer receiving key benefits like duty allowance or PhilHealth sharing, and wide variation across regions.

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	
	La Union		Benguet		Batangas		Laguna		Iloilo		Aklan		Davao de Oro		Sarangani		N = 676 (100.0%)	
	N = 162 (24.0%)		N = 35 (5.2%)		N = 159 (23.5%)		N = 121 (17.9%)		N = 119 (17.6%)		N = 30 (4.4%)		N = 31 (4.6%)		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)

Additional Cash benefits
(Magna Carta)

User fees and PhilHealth
payments

Most public sector doctors receive non-monetary benefits like time off and training opportunities, but access to food, clothing, and especially subsidized housing remains limited and inconsistent across regions.

Non-monetary compensation of medical doctor 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%)

Non-cash benefits
(housing, transportation,
education)

Most allied health professionals in the public sector receive non-monetary benefits like training and vacation leave, but fewer receive clothing support or food rations, and subsidized housing remains virtually unavailable across all regions.

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%)

Non-cash benefits (housing, transportation, education)

Key Findings	Specific Findings
<p>Fragmentation and lack of predictability and transparency on wages and benefits</p>	<ul style="list-style-type: none"> • HRH compensation in the Philippines is fragmented and inconsistent, varying by sector (public vs. private), facility ownership, cadre, and local jurisdiction. Public HRHs follow national laws like the SSL and MCPHW, while market-driven, facility-based policies govern private HRHs. • Non-permanent HRH form a significant portion of public HRH as stated in the KIIs, and face greater unpredictability in compensation and benefits. • Implementation of laws like MCPHW is uneven across LGUs, often influenced by local fiscal capacity and political priorities rather than need or workload. • PhilHealth payments are opaque and inconsistently applied, especially professional fees, adding another layer of unpredictability that affects HRH retention and service delivery.
<p>Significant wage differentials between the public and private healthcare sectors</p>	<ul style="list-style-type: none"> • Public sector health workers earn significantly higher wages than their private sector counterparts, primarily due to multiple funding sources (i.e., line-item budgets, government subsidies, and PhilHealth reimbursements) that are not available to private providers. • Private facilities rely heavily on user fees and flat-rate PhilHealth payments, which have not been updated for inflation and are applied uniformly across provider types, disadvantaging the private sector. • Higher wages in the public sector often come with heavier workloads, highlighting the need to understand better how working conditions affect retention and satisfaction. • Key income sources like dual practice earnings and user-paid professional fees are poorly documented, particularly for specialists, making it difficult to assess total compensation and design effective policies fully. • Existing wage policies (i.e., 2003 DOH dual practice policy) may be outdated and need reassessment in light of rising public sector pay and persistent regulatory and transparency gaps.
<p>HRH policies affect broader health system goals, particularly financial risk protection and improvement to health outcomes</p>	<ul style="list-style-type: none"> • Fragmented and opaque HRH compensation systems create unpredictability for health workers and inefficiencies in provider payment. • Failure to capture the full cost of care in payment mechanisms pushes providers to charge user fees. • This leads to high OOP payments that can be financially catastrophic for patients, despite rising public health spending. • HRH compensation is inseparable from health financing reform: integrated, transparent provider payments are essential to protect both workers and patients.

Policy recommendations and ways moving forward

Explore creating a national health human resource support system for the public sector



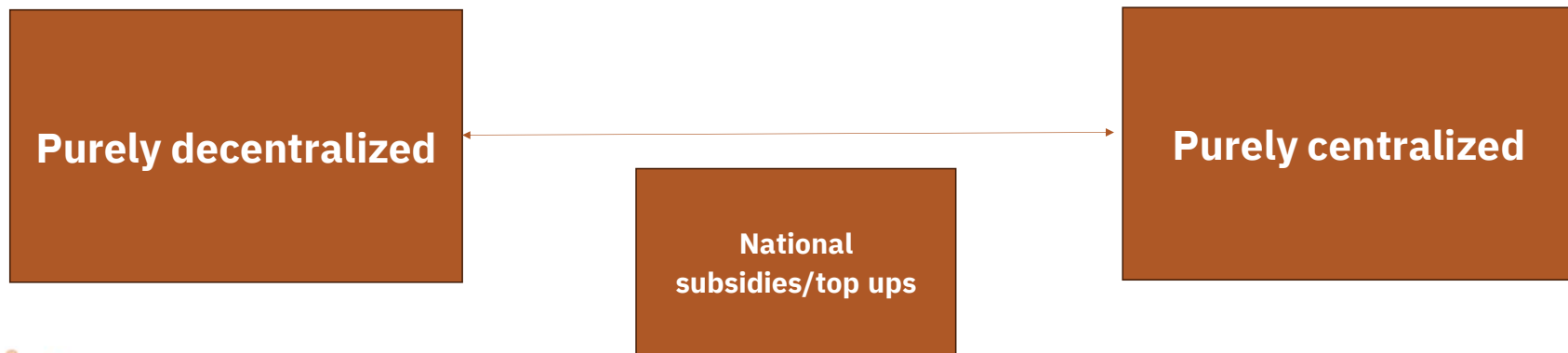
- **“Top-up” or counterpart financing system where the national government supplements LGUs that cannot fully cover HRH salaries and benefits**
- GIDA allowance to incentivize and support HRH in underserved areas
- “No private practice” allowance to incentivize HRH who commit full-time to public healthcare services
- PhilHealth pay-for-performance incentives for HRH that will tie provider payouts to specific inputs (e.g., full-staffing of facilities or performance-based incentives for HRH) and health outcomes

Fast-track implementation of a well-costed global budget system



- **Global Budget (GB) must be well-costed**, capturing total cost of care
- **Clear PhilHealth policies on how HRH receive compensation through the GB**
- Incorporate process of negotiation between PhilHealth and health facilities to ensure transparency in HRH compensation (monitoring of PF and user fee charging)
- Adjustment rates based on case mix and socio-demographic and economic characteristics of health facilities (i.e., higher pay outs for facilities in poorer provinces)
- Reconsider the non-differential payment structure of PhilHealth to account for the differences in financing streams between public and private facilities

Policy options we can explore in financing HRH remuneration in the Philippines:



Purely decentralized model

Strengthen National Monitoring of LGUs

- Empower DOH to track LGU compliance and performance in HRH hiring, retention, and wage standards.
- Implement a nationally run monitoring system to reduce information gaps in a principal-agent framework.
- Monitoring enables accountability, course correction, and benchmarking across LGUs.
- Most LGU HRH decisions are currently made with limited national oversight, weakening equity and consistency.

Use Demand-side Financing to Address Inequities

- Leverage PhilHealth reimbursements via Special Health Funds (SHFs) to support equitable remuneration.
- Unbundle PS components from PhilHealth case rates to improve transparency and prevent double funding.
- Introduce adjustment factors in DRG/capitation rates to:
 - Incentivize service delivery in underserved or poorer areas
 - Recognize higher cost of HRH deployment in challenging settings
- Aligns with UHC Act mandates for provincial integration and performance-based payment systems.

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)

Hybrid model: National subsidies/Top ups

LGU	National government
LGU 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>

Hybrid model:

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

(Assuming all non-compliant municipalities will be subsidized with the 100% rate)

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

Province	100% rate (All non-compliant municipalities)	
	% of PS/Total Income (before)	% of PS/Total Income (after)
Abra	20.4%	21.6%
Agusan del Norte	29.0%	30.4%
Agusan del Sur	31.5%	32.0%
Aklan	35.8%	37.3%
Albay	29.6%	30.5%
Antique	30.9%	32.3%
Apayao	31.8%	33.4%
Aurora	-	-
Basilan	35.9%	37.5%
Bataan	24.9%	25.5%
Batanes	38.4%	41.9%
Batangas	33.3%	34.4%
Benguet	33.5%	34.9%
Biliran	75.1%	77.4%
Bohol	27.5%	29.2%
Bukidnon	-	-
Bulacan	25.2%	25.7%
Cagayan	29.4%	30.5%
Camarines Norte	30.9%	32.1%
Camarines Sur	37.1%	39.4%
Camiguin	34.4%	36.4%
Capiz	34.1%	35.5%
Catanduanes	36.9%	38.7%
Cavite	36.3%	37.6%
Cebu	25.6%	27.3%
Cotabato	20.1%	20.5%
Davao Occidental	-	-
Davao Oriental	-	-
Davao de Oro	25.6%	26.3%
Davao del Norte	-	-
Davao del Sur	-	-
Dinagat Islands	-	-
Eastern Samar	38.4%	40.8%
Guimaras	34.0%	35.8%
Iligan	36.3%	37.9%
Ilocos Norte	14.1%	14.8%
Ilocos Sur	15.7%	16.5%
Iloilo	31.2%	32.5%
Isabela	20.7%	21.6%
Kalinga	41.6%	43.3%
La Union	29.2%	30.9%
Laguna	35.0%	36.4%

Province (cont.)	100% rate (All non-compliant municipalities)	
	% of PS/Total Income (before)	% of PS/Total Income (after)
Lanao del Norte	33.0%	34.6%
Lanao del Sur	-	-
Leyte	32.1%	33.4%
Maguindanao	-	-
Marinduque	-	-
Masbate	38.6%	40.4%
Metro Manila	-	-
Misamis Occidental	34.2%	36.2%
Misamis Oriental	28.0%	29.4%
Mountain Province	46.0%	47.6%
Negros Occidental	33.7%	35.0%
Negros Oriental	31.7%	32.7%
Northern Samar	37.1%	38.6%
Nueva Ecija	30.0%	30.9%
Nueva Vizcaya	39.8%	40.9%
Occidental Mindoro	35.8%	37.9%
Oriental Mindoro	-	-
Palawan	16.0%	16.8%
Pampanga	-	-
Pangasinan	28.5%	29.5%
Quezon	30.0%	31.2%
Quirino	31.4%	32.5%
Rizal	-	-
Romblon	-	-
Samar	31.8%	33.3%
Sarangani	31.8%	32.9%
Siquijor	42.3%	44.2%
Sorsogon	31.1%	32.3%
South Cotabato	26.5%	27.8%
Southern Leyte	40.9%	42.8%
Sultan Kudarat	-	-
Sulu	-	-
Surigao del Norte	36.1%	38.3%
Surigao del Sur	-	-
Tarlac	29.1%	29.9%
Tawi-Tawi	-	-
Zambales	-	-
Zamboanga Sibugay	-	-
Zamboanga del Norte	28.3%	29.4%
Zamboanga del Sur	34.8%	36.3%

Centralized system model:

Profession	Policies	Institutions	PS Source
Public Health Workers	LGU Code (RA 7160); MCPHW (RA 7305)	DOH and LGUs	PS for public HRH in LGUs are sourced from their respective budgets while HRH in DOH-owned facilities are sourced from DOH
Public School Teachers	Governance of Basic Education Act (RA 9155) Magna Carta for Public School Teachers (RA 4760)	DepEd	PS of all public school teacher from primary to secondary education are sourced from DepEd's national budget
Philippine National Police (PNP)	Department of Interior and Local Government Act of 1990 (RA 6975)	DILG	Absorbed the PNP within DILG and sourced all PS of police personnel to DILG's national budget
Armed Forces of the Philippines (AFP)	The National Defense Act (Commonwealth Act No. 1, 1935)	DND	The DND provides all the salaries of its service members from its national budget.

- Under a purely centralized model, the national government would hire and compensate public HRH which is similar to the Thai health and Malaysian health system, and how the public-school teachers from DepEd and uniformed personnel from the AFP and PNP are financed.
- To operationalize this in the Philippines, **Expanding the National Health Workforce Support System (NHWSS) of the DOH to cover all HRH in the Philippines is essential.** A robust monitoring mechanism and equity allocation framework is also vital.

Centralized system: Estimated Costs in millions PHP

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	3,318,432.00	123,899.0	25,579.0	31,762.7	6,183.8

- 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**.
- Largest increases can be observed in regions with historically low wage rates
- Indicates the **magnitude of wage inequality in these areas**.

Maraming salamat po!



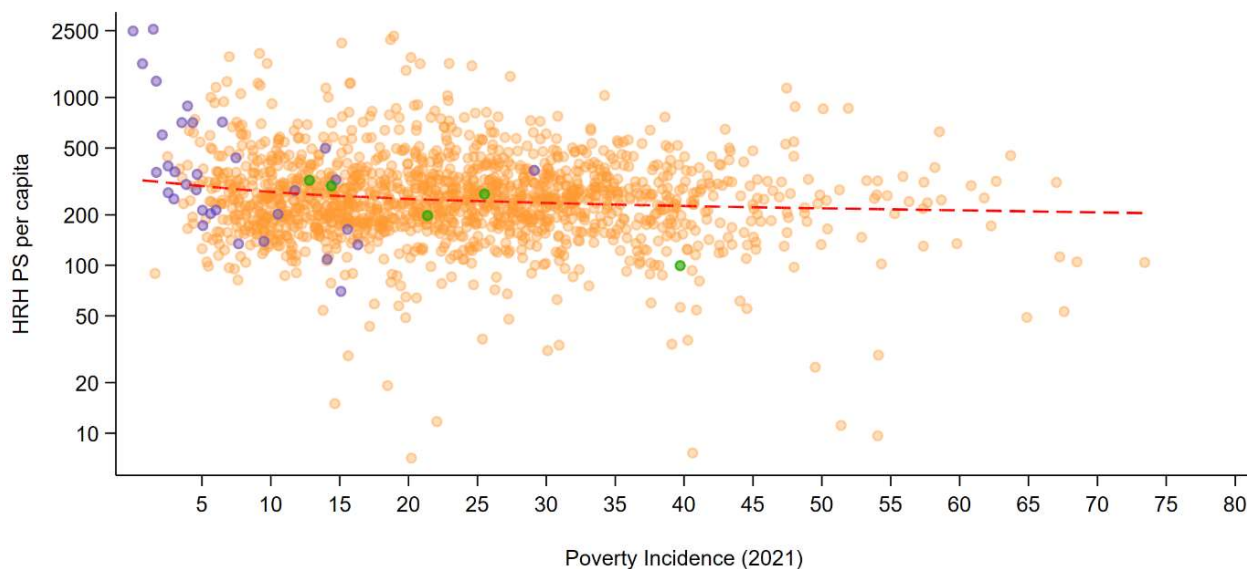
**HEALTH ECONOMICS
AND FINANCE PROGRAM**

Contact us at hefp@pids.gov.ph

Financing: 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.

PhP 291 per capita
Average LGU spending on PS with considerable variation reflecting socio-economic disparities

Personnel services for HRH per capita of LGUs (2022) by poverty incidence (2021)



Note: Analysis of BLGF data (2022) and PSA data

The salaries of public health workers have increased through the evolution of SSL and policy interventions that increase the salaries of specific cadres.



54%
Pay hike for Nurse I
position from 2020 to
2021 (SG 11 to SG 15)



Public health workers get paid 50%
more than private health workers

Salaries/Wages

Financing: National government spending on HRH Personnel Services (PS) increased rapidly in real per capita terms; share to total CHE fluctuates

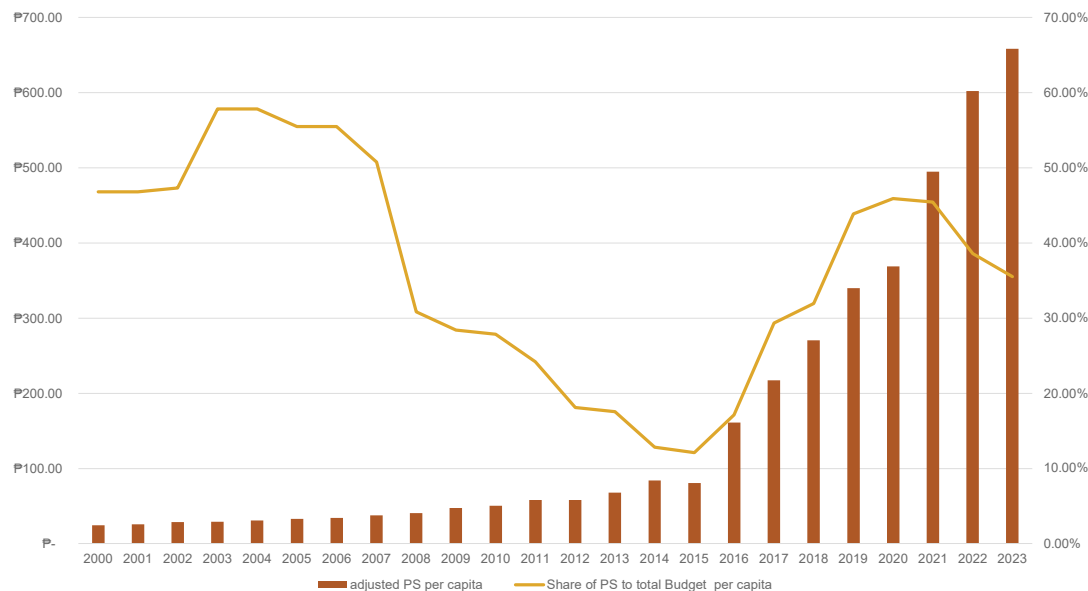
PhP 660

National government per capita PS expenditure (2023);
~30x increase compared to 2003

50%

Share of wages to national health spending (early 2000s);

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



Note: Analysis of GAA (raw data)

User fee remains one of the most important drivers of provider utility; largely market-driven.

- **Largely unregulated and unmonitored**, even in public facilities.
- Public facilities offer "private practice" arrangements (e.g., private wards), allowing physicians to charge fees beyond their salaries.
- Specialists may serve in public hospitals without regular salaries, especially in teaching hospitals.
- The system creates a **two-tiered structure** that may disadvantage low-income patients.
 - **No Balance Billing (NBB)** policy prohibits user fees in basic/ward accommodations.
 - "Pay" accommodations allow charging of hospital and professional fees.

User fees and PhilHealth payments

LGUs hire through Job Order (JO)/ Contract-of-Service (COS) to supplement their local HRH staff; the lacking benefits and job security effects HRH retention.



JO/COS employees are easier to hire because they no entitled benefits, and their salaries are sourced from the MOOE



LGUs need to strategize how they convert their JO/COS and/or contractual employees to Plantilla positions



The lack of Plantilla positions causes public health worker internal migration

“Well, the very first thing that we do during budget preparation is we really allocate funds first to Personnel Services (PS). 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

“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

Additional Cash
benefits (Magna Carta)

Salaries/Wages