

A mixed-methods study on the Espesyalista Para sa Bayan (Specialists for the Country) Program: Factors affecting retention, unintended consequences, and recommendations for improvement

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Abstract

Background

The Espesyalista Para sa Bayan (EPSB, literally Specialists for the Country) Program, has been implemented to address the inequitable distribution of specialist physicians in the Philippines. However, this program is only newly implemented and there is limited evidence on specialist physician deployment programs in low- and middle-income countries. This study aimed to identify determinants of retention in the program, its unintended consequences, and recommendations for improvement.

Methods

We administered an online survey to currently deployed EPSBs. We interviewed a subset of our survey respondents. We then supplemented it with interviews and focus group discussions with program implementers from the Department of Health at the local, regional, and national level. We analyzed the survey data descriptively. Meanwhile, we transcribed and analyzed the responses in the interviews and focus group discussions thematically.

Results

Our survey had 17 respondents, while we conducted a total of 17 interviews and focus group discussions with EPSBs and program implementers. We identified a total of four individual environment factors, five local environment factors, six work environment factors, and five national environment factors that influence retention. Some EPSBs consider relocating abroad temporarily for further training or studies, or permanently for better career opportunities. We also identified three unintended consequences of the EPSB Program, as well as five recommendations to improve the program.

Conclusion

The initial years of the EPSB program have not been without problems but is generally well regarded by its implementers and its deployed physicians. However, further improvements are needed to optimize it and to make sure it meets its goal of making specialist care accessible to all Filipinos.

Introduction

The shortage and inequitable distribution of specialist physicians has been identified as a barrier to the implementation of universal health coverage globally (1). Many programs have been developed globally to address the shortage and maldistribution of specialist physicians. In Japan, a new specialty training system has been implemented since 2018, although initial evaluation has shown that it has worsened inequities in specialty physician distribution (2). In Australia, the Specialist Training Program has been demonstrated to enhance rural and remote specialist workforce but does poorly in encouraging the practice of indigenous specialist physicians (3). However, as shown in this brief literature review of published and gray literature, most

of the specialist physician training programs that have been implemented and evaluated are in high-income countries, masking specialist physician needs in low- and middle-income countries where the need for specialist care is more acute.

In the Philippines, the shortage and maldistribution of specialist physicians have been established to be a barrier in the country's transition towards universal health coverage (4, 5). Cognizant of this problem, the Philippine Department of Health (DOH) implemented the *Espesyalista Para Sa Bayan* (EPSB, literally Specialists for the Country) Program. Implemented since 2023, the EPSB Program is a two-year voluntary program designed for board-certified surgeons, anesthesiologists, obstetricians and gynecologists, internists, pediatricians, psychiatrists, and family physicians. During this two-year deployment, these board-certified specialist physicians are deployed in an underserved Level 1 or Level 2 facility in a less-urbanized area of the Philippines with the hopes that they build up the capacity for specialist care in their facility of deployment whilst they set up their specialist practice there. In doing so, they receive a monthly salary for a medical specialist, government-mandated benefits for healthcare workers, share from Philippine Health Insurance Corporation (PhilHealth) reimbursements, and annual attendance on society conferences on official business (6, 7). However, due to the program's recency, there has been no previous systematic attempt to study its implementation, let alone identifying determinants of retention, unintended consequences, and recommendations for improvement.

This paper aimed to describe the determinants of retention, unintended consequences, and recommendations for improvement for the DOH's EPSB program. In doing so, we aim to improve the retention of specialist physicians in the Philippines and provide lessons that can be used in other countries as they address the persistent problem of specialist physician shortage and maldistribution.

Methodology

Study design

This paper describes a part of a larger study on measuring and understanding geographic inequities in physician distribution in the Philippines (insert citation on MUGI Protocol currently under review at *BMJ Open*). This study used a sequential explanatory mixed methods study design to understand the determinants of retention, unintended consequences and recommendations for improvement for the DOH's EPSB Program. We used this particular study design to give further context and nuance to initial quantitative findings from our survey and to identify issues that might be glossed over by our survey (8).

Study participants and data collection

For the quantitative part of the study, we administered an online survey to specialist physicians deployed under the EPSB program of the DOH from March to December 2025. The instrument we used for the survey is the Modified Stayer's Questionnaire (MSQ, Supplementary File 1). Briefly, it is a questionnaire used to study retention among rural health workers. It has nine sections covering personal information, individual environment factors, work-related environment factors, local environment factors, national environment factors, international factors, significance of factors that influence decision to remain in area of assignment, future plans, and open-ended questions on likes, dislikes, and suggestions to improve the program (5, 9). A link

to the online survey was disseminated through the Department of Health and posters through social media sites.

A subset of EPSB respondents from the survey who consented were invited into online key informant interviews (KIIs) to further substantiate their survey responses. These interviews were complemented with online interviews and/or focus group discussions (FGDs) with DOH EPSB Program Implementers from the facility or local government, regional, and national levels. Questions in these FGDs and KIIs revolved on their perceived determinants of retention, issues encountered during deployment, unintended consequences, and recommendations to improve the EPSB program (Supplementary File 2). The KIIs and/or FGDs were conducted between March 2025 and January 2026. The KIIs and/or FGDs lasted between thirty minutes to two hours and were conducted in both Filipino and English. The KII and FGD proceedings were audio-recorded and transcribed.

Data analysis and conceptual framework

We descriptively analyzed the data from the MSQ through compound bar graphs showing the distribution of respondents according to their responses for each question.

To identify the determinants of retention, transcripts from the KIIs/FGDs were coded deductively according to the modified socio-ecological framework for rural health workforce recruitment and retention proposed by Lehmann et al. where rural health workforce recruitment and retention are affected by individual factors, work environment factors, local environment factors, national environment factors, and international environment factors. Briefly, individual factors work at the level of the individual like age, gender, or marital status. Work environment factors include relationships with colleagues and management and opportunities for professional development. Local environment pertains to living conditions where the EPSB is deployed. National environment pertains to national policies that affect the EPSBs such as salaries, political climate, etc. Lastly, international environment factors pertain to pull factors from overseas such as higher salaries, better working conditions, and better opportunities for professional development (10).

On the other hand, the coding to examine the unintended consequences and recommendations for improvement of the EPSB program were done inductively for a lack of a clear theoretical framework for that purpose. Coding was led by the lead author (VCFP) and was reviewed by the author team. Disagreements in coding were elevated to the senior author (MMD) for consensus. Illustrative quotes were tabulated and were labelled EPSBx for quotes by EPSB respondents and lx for quotes by implementers.

Reflexivity

The author team is a mix of early career, mid-career, and senior researchers, and program implementers with varying experience in qualitative and mixed-methods study designs and implementation of health workforce deployment programs. VCFP, ARDP, HIMJ, and TPJZC are early career researchers who have conducted a few mixed methods studies on health workforce and the Philippine health system. JRM is a mid-career researcher with previously published work on health workforce. KU and WCT implement health workforce placement programs for the Philippine Department of Health. Lastly, MMD is a senior researcher with almost 50 years of experience in government, academe and international development, having served as a secretary of the

Philippine Department of Health and director for Human Resources for Health at the World Health Organization. All authors are based in the Philippines.

Results

Description of Study Participants

Out of the 78 currently deployed EPSBs throughout the Philippines, 17 (21.79%) have accomplished the MSQ. Nine (52.94%) are internists, four (17.65%) are pediatricians, two (11.76%) are anesthesiologists, one (5.88%) is a family physician, and another one (5.88%) is an obstetrician gynecologist. All except one (94.12%) are women. Out of the 17 respondents, one (5.88%) wants to resign from being an EPSB as soon as he/she can, four (23.53%) no longer intend to renew after their current deployment, six (35.29%) want to renew as an EPSB but preferably in another area of deployment, and another six (35.29%) intend to renew as an EPSB and stay in their current area of deployment.

Out of the 17 EPSB MSQ respondents, seven (41.18%) agreed to be interviewed. One (14.29%) is a family physician, one (14.29%) is an anesthesiologist, three (42.86%) are internists, and two (28.58%) are pediatricians. These interviews were supplemented by ten other interviews and/or focus group discussions with local, regional, and national level EPSB implementers from all throughout the Philippines. Due to the recent implementation of the program, responding implementers have been on the job for less than three years at the time of the conduct of the KIIs/FGDs.

Determinants of Retention

Individual environment factors

Almost all EPSBs agree or strongly agree with all four statements on the individual environment factors, positively contributing to retention. However, few respondents chose neutral when asked whether their family supports their deployment as EPSB and when they were asked whether they enjoy their work (Fig. 1).

Sense of gratitude

An EPSB also found motivation in being a recipient of education and medical training from prestigious government institutions and sees their EPSB deployment as a way of initiating the 'giving back' phase of their life (Table 1, EPSB1).

Table 1
Illustrative quotes for individual environment factors.

Quote ID	Illustrative Quote
EPSB1	<i>I am a first-generation doctor in the family. I came from a rural area... studied in state universities for college and medical school... and had the opportunity to pursue residency in the Philippine General Hospital. It is not easy and I take that as a privilege and approach it as a once-in-a-lifetime opportunity. I had that goal to train from the best so that I would really go back to my roots to share the best (practices I have picked up from my training). My perception is that people in my province, the people where I would practice will not necessarily need to go to urban places to avail (themselves) of specialist services. That is why I want to earn that specialization because I want that, when I go home, I will be able to serve as a specialist so serving in Metro Manila is not really one of the options. I really want to have the training there, but the actual practice is really to go home here in Mindanao.</i>
EPSB2	<i>I really wanted to establish my practice here in our hometown. That is why it is perfect that there was an EPSB (position) opening here. The thing with being a DTTB (Doctors to the Barrios), its like, it's not really a long-term plan where I am assigned, I will end up staying. But I would have probably reconsidered if (my area of deployment is nearer to my hometown), but back then it was too far.</i>
EPSB3	<i>It is difficult to go straight to private practice. I also want to have regular income from government, and then it's good here because you have patients right away, we establish connections with the patients, you get to know new doctors, so it's a good system. You also get to know the consultants in the area.</i>
EPSB4	<i>I am a first generation doctor. I do not have backers. So actually, now, the DOH is planning to renew (the position) if the doctor is interested. I already submitted my intent to renew, but if I am given the chance, I really intend to continue here, I will continue here, because I will be starting from scratch again if I relocate to my hometown, and I am already okay here if they choose to renew my (contract).</i>
EPSB5	<i>Before, I was the only one in a long-distance relationship with my family. Now, I have influenced my mother (to join me), she is in a long-distance relationship with my father. My brother (who also relocated) is now in a long-distance relationship with his wife. One of my nephews who joined here is now in a long-distance relationship with his siblings. That's a little sad.</i>
EPSB6	<i>Sometimes, I fail to join the activities of my children or fail to attend the lectures that I wanted to join in because I am on duty.</i>
EPSB7	<i>Probably a challenge for me is the spiritual side. Before, I was active in youth programs in our Catholic Charismatic Community, so it has similar teachings as the Catholic Church. Thursdays are our praise and worship sessions, but I am a bit frustrated because Wednesdays and Thursdays are my duty days and I cannot join.</i>
EPSB8	<i>During my residency days, I kept on saying that I will just quit, it was very stressful and everything, but as a DOH deployed physician, I have better work life balance. We get to spend more time with our families and friends, and while the (work) load is more responsibilities heavy, but the load is partly lighter than we were still in residency. So as I said, work-life balance is better as a deployed physician (rather than a resident physician).</i>

The EPSB Program as a pathway to establish one's professional practice

A respondent who had worked on all three DOH physician deployment programs candidly admitted that they liked the EPSB program because it gave them an opportunity to set up their practice in their hometown (Table 1, EPSB2). Another respondent saw the EPSB as a perfect opportunity to establish their practice, noting the benefits of being an EPSB physician (Table 1, EPSB3). A respondent has mentioned that they want to stay

because they have already invested in building their practice in their area of deployment, and it will be difficult to set up everything again from scratch (Table 1, EPSB4).

Personal and family circumstances

While many of the EPSBs are supported by their friends and family, with some even relocating to the EPSB's place of deployment (Table 1, EPSB5), which contributes to retention, some EPSBs have admitted that they miss important personal and family milestones due to their tremendous workloads (Table 1, EPSB6 and EPSB7). On the other hand, another respondent said that being a DOH deployed physician is better than being a resident physician, as they had better work life balance and had more time for their friends and family (Table 1, EPSB8).

Local environment factors

While majority of the EPSB respondents agree or strongly agree with local environment factors statements, a few EPSBs disagree or strongly disagree with the statement that there are regular electricity, clean water, efficient transportation, clean toilet and shower, and options for leisure and entertainment. A few also reported that they do not feel safe in their areas of deployment. These deficiencies, while few, may adversely affect retention (Fig. 2).

Distance and remoteness

An implementer noted that one of the leading reasons for poor retention in the EPSB program is that their area of deployment is far from where he/she lives or is too remote.

Language and cultural barriers

Some EPSBs have been deployed in areas where the patients have different cultural practices and languages from what they speak (Table 2, EPSB9). A respondent who has experienced multiple physician deployment programs compared their exposure to cultures very different from their own as a DTTB, and very similar to their own as an EPSB (Table 2, EPSB10). This adversely affects quality of care provided to the patients as well as retention.

Table 2
Illustrative quotes for local environment factors.

Quote ID	Illustrative Quote
EPSB9	<i>I am Ilongga... Then here, they are Bisaya. I know how to speak Bisaya because I studied in Bukidnon, I went to Bukidnon for college, so I was exposed to Bisaya, but I am really Ilongga. Then I spoke Tagalog during training. But (another language) they speak B'laan. Indigenous B'laan. It is an indigenous language native here. They have another tribe here and they have another language so it's extra challenging because sometimes, I do not know. I ask them if they can read Tagalog. Every time I talk to the watcher, the watcher interprets what I say, what the patient complains about, and the patient's responses. That's the community here, indigenous people.</i>
EPSB10	<i>The culture there is different. They have indigenous people there, Muslims, then Cebuano. But here, I am Ilocano. So yes, it is easier to connect.</i>
EPSB11	<i>In the first six months, I didn't have a problem. Recently after joining the annual convention, I went back to my hometown during election and left my gadgets (in the place where I rent) because I was confident. And then, when I came back, the place had been ransacked! My gadgets were stolen. Good thing I did not have money (left there)– only a little bit for tithes, but they stole my gadgets. The house I am renting is in a subdivision, it's gated, there are grills, but what happened was they sawed the grills to open the windows. The neighborhood was helpful; when they knew, we were able to recover the iPad, the laptop I am using now, but the MacBook, we weren't really able to recover it.</i>
EPSB12	<i>There were instances where they namedrop that they are some (VIP's) employee, 'I am a driver of...', they ask for medical certificates where they should not have. But we're strict because we must prioritize. We only have 200 beds; we reserve them for those who really need to be admitted.</i>
EPSB13	<i>That's the most difficult (part of the job). For example, VIP patients, you know them. For instance, they sent a private message to the chief of hospital that this patient, he/she is a friend of this VIP. That adds anxiety when it comes to treating the patient. Sometimes, I ask myself, should it be like this because there are so many questions but sometimes you need to be firm. Last month, I had a patient. He/she was a previous (hospital) chief, and he/she was running for councilor. I mean, he/she is already a doctor, then he/she is vying for a government position, and it's so difficult to move.</i>
EPSB14	<i>They are very appreciative. My patients are surprised that they do not have to pay for anything. Me, as a doctor, I really like giving patient education. My patients appreciate that. It's just difficult because we do not have a regular schedule – they say "Doc, I want you again. What is your schedule? But I cannot give my next schedule because our schedule gets changed regularly. But they are appreciative, we talk a lot, and they are happy about it.</i>
EPSB15	<i>There are times where, for example, we cannot please everyone despite doing our best. And now, they post about it to social media. Sometimes, it is very demoralizing, but there are real limitations to the hospital. Of course they cannot understand it.</i>

Peace and order

An EPSB recounted a traumatizing event where they were burglarized. Because of the traumatizing event, they invited their family members to join them, but they did their best to prevent that experience from affecting their practice (Table 2, EPSB11).

Politically sensitive patients and VIPs

Some EPSBs reported that a few patients namedrop their supposed connections with the hopes of getting priority or better treatment which makes the deployed EPSB uncomfortable (Table 2, EPSB12 and EPSB13).

Interactions with the community

Many EPSBs report that their community is happy with their services, and that the work that they do is appreciated. Some patients even like them so much that they would want the same physician to manage them later (Table 2, EPSB14). However, on the other hand, an EPSB reported that they cannot please everyone and it is somehow demoralizing (Table 2, EPSB15).

Work environment factors

All the EPSB respondents said that their community is appreciative of the work that they do, which positively contributes to retention. However, a few respondents have reported issues with their regional DOH program implementers, local government counterparts, and their work environment. Some respondents also reported shortages of medicines, supplies, and equipment which preclude them from providing optimal care to their patients. These issues contribute to poor retention (Fig. 3).

Shortages of medicines, supplies, and equipment

Respondents have corroborated and expanded on the shortages in medicines, supplies and equipment in the key informant interviews which prevent them from delivering optimal care, impacting morale and retention (Table 3, EPSB16). Another respondent mentioned that the EPSB program deployed a nephrologist to a hospital without a dialysis center, wasting their training, so he/she eventually left (Table 3, EPSB17).

Table 3
Illustrative quotes for work environment factors.

Quote ID	Illustrative Quote
EPSB16	<i>It is difficult for us doctors working in rural areas. If we have special cases, we're short on drugs. Example, we need a patient to have CT scan or MRI, we need to refer (the patient) to a farther hospital for that... And then you cannot give the ideal (treatment) for the patients because the drugs that we would have wanted to give to the patient is not available in the pharmacy. We only give what is available in the pharmacy. And then there's the financial reason. The medicines for heart failure are very expensive, so even if I know that it is the best for that patient, I cannot give that because at least with what I am prescribing, it is good for three months instead of 90 pesos per day for one drug... It is very difficult to give the ideal treatment for patients because there are shortages in medicines and funds. You must consider the patient's background.</i>
EPSB17	<i>For example, our previous nephron(logy) doctor here, you see, our hospital does not have a dialysis center. Why did they deploy a nephrologist here? Of course we can refer chronic kidney disease patients to them but the patient still needs to be referred in a level 3 hospital. I was thinking, it's such a waste that they were deployed here, it would have been better if he/she was deployed in a facility that has a dialysis center.</i>
EPSB18	<i>In our hospital, we have an ortho(pedic surgeon), but the problem is like, me now, there are no internists in our hospital now, because right now, there are only two of us left there. So, it's very difficult then for example, we have a referral, I accept the text referral because we are the only ones where they can refer to because there are no other internists in our area. That is why we just try our best to do with what we can do as physicians deployed there. It's very difficult.</i>
EPSB19	<i>Well, I just speak for the nursing service, but they're very, very few there.</i>
EPSB20	<i>So far, when I am (assigned) there in outpatient (department), I am more confident but here in the emergency room, I find the cases more difficult, like cardiac, renal, who needs specialists, so I first call a consultant on duty or if there are toxic pedia(tric) cases, there is a pedia(tric) consultant on duty which I consult in the ER on the management. So that, I need to study again or familiarize myself again because the last time (I was in ER training) was 2010, after that I was in the OPD setup most of the time.</i>
EPSB21	<i>I initially had a partner surgeon for one year. He was a PRDP (Post Residency Deployment Program) and then of course his program is only for a year, and so for my second year of deployment, I no longer had a partner surgeon or obstetrician in the hospital, so I found it lacking to practice my specialty, especially because I am an anesthesiologist and we're very surgeon dependent. If there are no surgeons, there are no cases. For a year, I didn't have a surgeon, there were no applicants, there were none who were deployed. I had to work around it, so when I am on duty, I ask from the chief of hospital if I could see COPD patients when I am on duty because I am not really doing anything unless there are referrals for pain management or intubation.</i>
EPSB22	<i>My stay here is more positive than negative because my colleagues are good, they are okay. Honestly, the nurses and my other co(lleague) doctors are also efficient.</i>
EPSB23	<i>You need to understand that the people in the district hospital are GPs (General Practitioners). So, I think about the lapses there, I am the one who addresses that. Then during monthly meetings, instead of correcting them, because they're already old, some of them are just waiting for retirement, like that. So, me, during meetings, I will just, I will just volunteer to discuss the latest clinical practice guidelines because some of them are really old (laughs) ... I am just newly deployed there, but they are the ones there for the longest time. But there are really lapses.</i>
EPSB24	<i>And then with our LGU (local government unit), I don't feel anything. I know it's bad, but I don't feel any support. I think our province does not prioritize healthcare. So, there is no support from their end and there are problems with patients complaining and the hospital gets blamed for having no materials. It is not the hospital's fault. It's the province who could have done better when it comes to procuring materials and then they throw it back at us (saying) 'Why are you not buying for the patient?' What kind of policy is that? Like what's that. That's not our responsibility. I mean we do</i>

Quote ID	Illustrative Quote
	<i>not have to buy everything for the patient. So that, I don't feel much support from the province so far, from 2023 up to now. The support from the province is not good.</i>
I1	<i>The (level of) empowerment in the provincial level is a little lacking.</i>
EPSB25	<i>I haven't met anybody personally from the LGU, but the feedback I received, you need to really review the memorandum of agreement. That is the bottleneck with the LGU because you want to check what is in the agreement before agreeing because they have counterpart PHP 7500 allowance a month and they take the time to review that contract. If I am in official business with the DOH, they pay that, but with the LGU, if you're not in the area, they will subtract from your allowance. They're like that. So, if I am attending conventions on official time, the DOH allows that because that is required, and there is even a DOH memorandum for that.</i>
EPSB26	<i>They are sometimes there, sometimes not. They're not consistent. For example now, we only have two internists left, then there are no incoming PRDP or incoming EPSB. So why is that? Last year there was me. For example, if I will be gone by October, there is only one internist left. It's so difficult to have no consistency. Then I hope that consistency extends to other specializations. There was a time where we did not have an OB(stetrician) at all.</i>
I2	<i>They were willing to serve there but they made enemies with somebody. So, the mayor blocked it (their appointment). Instead of letting these doctors serve, they resorted to politicking...</i>
I3	<i>I think there is some confusion about the role of the specialist. There are questions asking if their role is similar to that of a resident (physician)?</i>
I4	<i>We have five slots (for EPSB) but nobody is really applying.</i>

Shortages of other health workers contributing to deployment mismatch

In addition to shortages of medicines, supplies, and equipment, there are also shortages in other specialists and other health workforce cadres, which means that deployed EPSBs might have to work on cases outside their trained specializations lest their patients be left uncared for (Table 3, EPSB18 and EPSB19). This impacts their morale and retention.

Due to health workforce shortage, a respondent family physician lamented that they were deployed to the emergency room and are not very familiar with some of the cases there so they either had to call a specialist and/or re-learn how to manage emergency cases (Table 3, EPSB20). An anesthesiologist lamented that when their partner surgeon left, they had nothing left to do because there were no other surgical specialists in their area of deployment (Table 3, EPSB21). The latter fear that their skills will be dull from the lack of work and they are anxious if they will be fired due to this shortage, adversely affecting retention.

Relationship with colleagues

Many respondents said that their colleagues are good and efficient and it helps retention (Table 3, EPSB22). Some respondents also feel that they are unable to influence older colleagues to improve the quality of care they provide to the patient, resulting in frustration and lower morale, impacting retention (Table 3, EPSB23).

Relationships with local government

A respondent said that shortages in supplies, equipment, materials, and medicines are a result of procurement failures at the provincial government level. Because of these procurement failures, they get blamed by the

patients, but he/she clarified that it is the responsibility of the provincial government (Table 3, EPSB24). Another point of contention between the EPSB and the local government is deductions in the allowances of the EPSB from the local government if they are not in the area, even if the leave has been approved by the DOH (Table 3, EPSB25). These issues adversely affect retention, which were also corroborated by DOH implementers who said that their provincial counterparts are not 'empowered' (Table 3, I1). Another implementer mentioned that while they had a doctor who was willing to serve in a municipality, it was blocked by the mayor (Table 3, I2).

Confusion about the roles of the EPSB

An implementer noted that some stakeholders especially in the local government are confused about the role of a specialist physician (Table 3, I3). This could explain why EPSBs are not prioritized nor supported by their local governments.

Relationships with the DOH

While many of our interview respondents said that their DOH counterparts are mostly easy to deal with and the processing of their document requests are fast and easy, a particular respondent highlighted that their experience with DOH implementers in their area is inconsistent (Table 3, EPSB26). This inconsistency in the deployment of DOH physicians was also corroborated and acknowledged by DOH implementers (Table 3, I4), which they attribute to a lack of applicants.

National environment factors

None of the respondents disagreed or strongly disagreed with the statement that they are safe from terrorism and other forms of political violence. However, a few respondents said that their salaries and benefits from the national government may be too low, and that their representation and travel allowances, as well as extra benefits from their host local government and the Department of Health may be too low, adversely affecting retention (Fig. 4).

Changes on physician workhours guidelines

One respondent said that the new memorandum on shortened physician work hours caused some of their colleagues to lose pay and complain about the new policy, stressing them (Table 4, EPSB27).

Table 4
Illustrative quotes for national environment factors.

Quote ID	Illustrative Quote
EPSB27	<i>We had an issue with the DOH-CHD before because they suddenly disallowed the continuous 48 hours duty. They said that in a week, there should be rest. After 24 hours (of duty), there should be 24 hours of break, then that's the only time you can have another 24 hours (of duty). And then there were many (of my colleagues) who had their pay docked. And then they want us that for every eight hours of duty, there should be 1 hour break, so technically that's 9 hours. Just like in the office. Many complained about that. Many people also lost pay there because it's not like an office job where you need a one hour break.</i>
EPSB28	<i>(The salary grade for PRDP and EPSB) is Salary Grade 23. So the DTTB, it is a Rural Health Physician item. That's Salary Grade 24. The PRDP, it is Medical Officer IV, Salary Grade 23. Then the EPSB, it's Medical Specialist II, that is Salary Grade 23.</i>
I5	<i>We cannot fill our slots because it (the salary) is very low. Because as I have said, these are specialists. They can do so many things. They can have their own private practice, other hospitals, they can be consultants.</i>
I6	<i>Because the problem, Sir, to tell you honestly, we are still obeying the DBM (Department of Budget and Management) Standard Staffing Pattern. That was enacted 2012 – that's more than a decade ago. The DOH has not formulated anything new. The staffing pattern in the hospital is still from 2012.</i>
I7	<i>There is some delay in the release of their PhilHealth share. Some hospitals are halfway through the year, and they have not had their PhilHealth share yet. But we are worried for our doctors. They may no longer replenish their needs. The doctors need it.</i>
EPSB29	<i>There is no problem (with public-private practice). The issue with other doctors is that they work in government and use it as a platform to recruit patients to their private clinics. It should not be like that. The patient went to the government hospital and they bring it to their private clinic so that they can charge higher. Though some patients do that, asking the doctor if they have a private clinic so they can go there instead. Or they use government resources for their private practice.</i>
I8	<i>It is a band aid solution to a persistent problem. It is really a governance problem. We need guidelines. The PRD(P) is good, the DTTB program is good, the EPSB is also good, the problem is sustainability. Why do they not want job security? Why do they not want to absorb?</i>
I9	<i>Then they (local governments) are not offering plantilla positions. Mostly, just job order. So, the specialists are not taking it. Some specialists take it, but many of the doctors refuse because the salaries and benefits received from the LGU are very low.</i>

Uncompetitive salary not commensurate with experience and qualifications

While many respondents note that the salary is actually good especially with the lower cost of living in their areas of deployment, one respondent noted that the salary of an EPSB is lower than the salary of a Doctor to the Barrio, who is usually a general practitioner assigned in a geographically isolated and disadvantaged area, and is equal to the salary of a Post Residency Placement Program (PRPP) Physician, who are not board certified (Table 4, EPSB28). This has been corroborated by a DOH implementer who said that they find it difficult to find applicants nor retain current EPSBs because the pay of government specialists are much lower than what they can earn in their private practice (Table 4, I5). Another explained that this is partly due to outdated hospital staffing and salary guidelines (Table 4, I6).

Delays in the processing of PhilHealth sharing

An implementer respondent noted that there are some EPSBs who experience very long delays in the reimbursement of their PhilHealth share, which may affect retention (Table 4, I7).

Public and private practice

The EPSB program allows specialists to maintain private practice if the required number of hours are met. One of the respondents, however, mentioned how it is an issue, which may dissuade recruitment and/or retention (Table 4, EPSB29).

Lack of job security for EPSBs after their initial deployment

Many implementers noted that the main barrier towards retention, not just in the EPSB program, but across all health workforce deployment programs, is the lack of mechanisms to absorb them after the end of their initial placements, with one implementer calling these programs ‘band aid solutions to a persistent problem’, in the absence of a mechanism to provide job security to EPSBs after their initial deployment (Table 4, I8). Another implementer placed the blame squarely on the local government as their offerings to these physicians are not competitive, if they even exist (Table 4, I9).

International environment factors

Most respondents are satisfied with their work here and are satisfied with their opportunities for career development in the Philippines; however, some are thinking about studying or practicing abroad after their tenure (Fig. 5). An EPSB further added *“I consider working abroad. Of course, I have batchmates who are already there. If you compare the quality of life and career development, it’s different overseas. So that – after being an EPSB, what’s next? That’s one of my considerations”*.

Unintended Consequences of the EPSB Program

Delays or foregoing subspecialty training

An EPSB noted that an unintended consequence of the EPSB program is that it could contribute to delays in subspecialty or fellowship training, especially if they enjoy their deployment. This could reduce the availability of sub-specialists needed in the country.

Fostering dependence of local governments from the national government

An implementer noted that an unintended consequence, not just of the EPSB Program, but health workforce deployment programs in general, is that it encourages local governments to depend on these programs instead of creating mechanisms for job security of deployed health workers contributing to the persistent problem of health workforce shortage and maldistribution.

Interaction between programs exacerbating physician maldistribution

An EPSB noted that DOH programs, especially the EPSB and the Bagong Urgent Care and Acute Service (BUCAS) Program has contributed to maldistribution of physicians in their province, calling on the DOH to harmonize physician deployment programs to prevent exacerbation of physician maldistribution: *“In our province, we have a current maldistribution because of the BUCAS Program. Because they are distributing it (extra physicians) in one hospital alone and leaving other hospitals with lacking physicians. So, what I said during our*

meeting last April was if there are programs in the DOH such as BUCAS program and then they know that there are already more physicians in a certain area, then there should have a limit so that they can know which hospitals need more doctors.”

Recommendations to improve the EPSB Program

Promote the program

All the interviewed EPSB respondents recommended better promotion of this program. Implementers note that they advertise these positions via social media. Despite this, they do not get many applications and many slots go unfilled. One of the recommendations was to reach out to other training hospitals to encourage recruitment or harmonize the training-to-EPSB transition (Table 5, I10). Another recommendation is to highlight the benefits and incentives of being an EPSB in job advertisements.

Table 5
Illustrative quotes on recommendations to improve the EPSB program.

Quote ID	Illustrative Quote
I10	<i>(They should) Add more training hospitals to whom we reach out. For example, we only have one teaching hospital here. Then we accept applicants from Bohol, then the others accept from Davao, so we reach out to other hospitals to increase our recruitment. Probably better as well if we can coordinate with the partner hospitals according to need. Let's say this region needs 18 slots for IM so we will be opening 18 slots for training. So we need to foresee future demand at the training stage.</i>
I11	<i>I think they should widen the specializations involved so that there can be more specialists who can join the program. Earlier during our consultative meeting, they were requesting other specialties. But the guidelines are quite strict. (They were requesting an) Emergency Medicine physician.</i>
I12	<i>In addition, they should have flexibility on the slots. In the interim guidelines, you must be certain about what slots to request. But when we conducted a consultative meeting with the hospitals, it ended up short. So, for example, we need three pediatricians, two obstetricians, but in the slots given, there are no slots for pediatricians and obstetricians. We will need to request change again to accommodate the needs of the hospitals.</i>
I13	<i>Maybe with EPSB, benefits received from the recipient facilities aside from the benefits received from the national level. Because national (government) already provides everything. Probably to entice, it will be better if they have added benefits from the LGU like transportation allowance because they do not have board and lodging. We do not have that for PRDP and EPSB (but we have that for the DTTB). And for three years, the salaries of PRDP and EPSB are the same. Medical Officer IV and Medical Specialist II. It would be better if the salary of the EPSB is higher because they are board certified. They passed both oral and written exams. We will have more applicants if the salary grade is increased.</i>
I14	<i>The DTTBs are incentivized to apply because there is a scholarship for them. For the PRDPs, (they are required). The EPSBs are a special case because they are already specialists. That thing...We should know that what drives doctors to apply to our programs are incentives like that.</i>
EPSB30	<i>For career development, if ever they offered you an internal medicine EPSB position, then you want to sub-specialize, then if you have a contract, retention will be much higher, of course. Isn't it the in-thing now, lateral entries, so if there are opportunities for EPSB, for example surgery, or pediatrics, they are allowed to do their fellowship training (with their salaries paid for by the DOH), then they return to the hospital, retention can be improved.</i>

Expand the included specializations and harmonization and flexibility in processing of EPSB slots

Implementers note that they need to expand the included specializations so that more specialists can be deployed to underserved areas (Table 5, I11). The same group of implementers recommended having some flexibility and harmonization in the requesting and processing of the slots because health workforce demands change rapidly, and that the bureaucratic rigidity is a cause for delays (Table 5, I12). An anesthesiologist EPSB who was assigned to a hospital with no other surgical specialists recommended that the DOH be more circumspect in assigning EPSBs so that her experience will not be repeated specially mentioning *“that they should see if deployed anesthesiologists have surgeons or obstetricians to assist and if the hospital has the equipment needed by the specialist”*.

Improve salaries and benefits

Many Implementers noted that the salary grade of the EPSB may be a little low specifically with respect to the salaries of other physician deployment programs. They also noted that the LGU can also provide greater benefits and allowances, like for example transportation allowance or communication allowance (Table 5, I13).

Foster opportunities for career development

An implementer noted the necessity of career development opportunities for EPSBs to promote recruitment and retention, much like for DTTBs (Table 5, I14). This has been corroborated by the EPSB respondents, who are advocating for lateral fellowships as a mechanism to encourage board certified specialists to apply for the program, stay, and simultaneously address the shortage of sub-specialists in the country (Table 5, EPSB30).

Have security of tenure

Both implementers and EPSB respondents unanimously highlighted the need for a mechanism to provide job security to EPSBs after the end of their initial deployment to encourage retention so that the initial investment and effort in recruiting and deploying the EPSB will not go to waste.

Discussion

This paper identified the individual environment, local environment, work environment, national environment, and international environment determinants of retention in the EPSB Program, the EPSB program's unintended consequences, and recommendations to improve the EPSB program. The individual environment factors affecting retention include: (a) sense of gratitude; (b) the EPSB Program as a pathway to establish one's professional practice; (c) personal and family circumstances; and (d) sunk costs. The local environment factors affecting retention include: (a) distance and remoteness; (b) language and cultural barriers; (c) peace and order; (d) politically sensitive patients and VIPs; and (e) interactions with the community. The work environment factors affecting retention include: (a) shortages of medicines, supplies, and equipment; (b) shortages of other health workers contributing to a mismatch between training and job demands; (c) relationship with colleagues; (d) relationships with local government; (e) confusion about the roles of the EPSB; and (f) relationships with the DOH. The national environment factors affecting retention include: (a) changes on physician workhours guidelines; (b) uncompetitive salary not commensurate with experience and qualification; (c) delays in the processing of PhilHealth sharing; (d) public and private practice; and (e) lack of job security for EPSBs after

their initial deployment. Some EPSBs consider relocating abroad temporarily for further training or studies, or permanently for better career opportunities. The unintended consequences of the EPSB Program are: (a) delays in sub-specialty training; (b) fostering dependence of local governments on the national government; (c) and exacerbating physician maldistribution. Lastly, recommendations to improve the EPSB program include: (a) Promoting the program; (b) Expanding the included specializations and harmonization and flexibility in processing of EPSB slots; (c) Improve salaries and benefits; (d) Foster opportunities for career development; and (e) having security of tenure. Some of these factors identified in this study had been documented in other studies previous studies on retention of health workers in the Philippines (4, 5, 9). It also corroborated findings from Japan demonstrating that physician placement programs may unintendedly worsen inequities in physician distribution (2). However, due to the recency of this program and its specific focus on specialists, there are many factors affecting retention in this paper that were not in previous studies.

The pilot run of the EPSB program, despite some problems, had been well perceived by the implementers and by the EPSBs themselves. Learning from this experience, and from the recommendation of the respondents, the EPSB program should be expanded to other specialties – emergency medicine, otorhinolaryngology, ophthalmology, orthopedics, and even diagnostic specialties like radiology and pathology to build up the country's diagnostic and laboratory capacity; the shortage of which was demonstrated by the COVID-19 pandemic (11).

The salary of a physician under the DTTB Program, is Salary Grade 24 (12). The DTTBs are usually general practitioners, and with the advent of the Doktor Para sa Bayan Act, fresh graduates of government medical scholarship programs who are fulfilling their return service requirements (13). While DTTBs have a huge breadth of responsibilities – clinical, administrative, managerial, and epidemiological - their salaries are much higher than the salary of an EPSB (14), which is Salary Grade 23, despite the years of specialization training and board certification of the latter. This has been cited as an important barrier towards recruitment and retention in the EPSB Program. A higher salary grade, preferably Salary Grade 25 or higher, commensurate to the specialist training and board certification of the EPSB, will encourage specialists to join the program and will show to them that their extra years of training is valued. An even higher salary grade can be given to physicians who have finished sub-specialization or fellowship training by the time they joined the EPSB program as compared to those who are not done sub-specialization or fellowship training.

Shortages of health workforce, and supplies, medicines, and equipment had been demonstrated as a barrier to health workforce recruitment and retention (4, 5, 9). However, this is a more important factor for specialists who are more reliant on technologies, equipment, and other health workforce cadres as compared to general practitioners. The experiences of the respondents highlight the need for systems to ensure careful deployment of health workers to ensure that they have enough specialist colleagues that are vital for their practice (e.g., an anesthesiologist should be deployed in areas that have a surgical specialist and vice versa), and to ensure that they have the appropriate equipment for the specialist's practice (e.g., a dialysis machine for a nephrologist). Team deployments (e.g., the deployment of a surgeon and anesthesiologist together) instead of individual deployments (e.g., the deployment of an anesthesiologist alone), may help prevent this issue from happening. Health workforce deployments, especially specialist physician deployments, should be coupled with investments in infrastructure, equipment, medicines, and supplies necessary for their practice to ensure their retention (15–18).

The EPSB program can further be strengthened with the addition of a professional development component, similar to their DTTB counterpart (5). It can either be a master's degree for hospital administration, if the vision is for them to become future hospital administrators and to build up hospital capacity, or a fellowship program, if the vision is for the EPSB to have specific sub-specialty niches. Respondents mentioned a lateral fellowship program, where EPSB's deployment hospital is paying for their fellowship salary in another hospital, which traditionally pays very little or not at all. These lateral fellowships can be embedded in the EPSB program in return for extra years of return service to further encourage recruitment and prolong the years of service in the program.

The inability to provide job security to EPSBs and health workers in general after their initial deployment has been documented again in this study after being mentioned in a previous studies (4). At the heart of this problem is the devolution of healthcare services to local governments in the Philippines (19), who are supposed to develop local health systems, including the recruitment and retention of health workers. However, 30 years since healthcare was devolved to local governments in the Philippines, it has consistently been demonstrated that local governments rarely have the fiscal space and technical acumen needed to develop health systems or recruit and retain healthcare workers (4, 20, 21). One option is to re-nationalize the responsibility of health systems development, including recruitment and retention of healthcare workers. The other option is to go all in with devolution, re-allocate national government budget to local governments and let the latter develop their own health workforce recruitment and retention programs, especially with the Garcia-Mandanas ruling (22). Each option has its pros and cons, and there is no easy answer to this dilemma (23). Ultimately, however, this dilemma should be resolved by both the DOH and the Department of Interior and Local Government to address this problem optimally and ensure job security to health workers, including EPSBs, after their initial deployment.

Limitations

Our survey response rate has been very low (around 20%), which may mean that the responses may not be reflective of the reality of all deployed EPSBs. There is also a possibility that respondents may vary their responses from what they think or do in their everyday life because they are being studied, potentially affecting this study's internal validity.

Conclusion

The EPSB Program is a novel program aimed to address the inequitable distribution of specialists in the Philippines. Retention in the program is affected by factors working at the individual environment level, local environment level, work environment level, national environment level, and international environment level in interconnected ways. The program can be improved by promoting the program, improving administrative processes, aligning salaries and benefits commensurate to their level of training, fostering opportunities for career development, and having security of tenure after deployment. Despite initial issues in its implementation, the EPSB Program should be expanded to benefit other specialties. Doing so will finally make specialist care more accessible to Filipinos who are in most need of accessible and equitable specialist care.

Declarations

Ethics approval and consent to participate

We have received ethics clearance from the Ateneo de Manila University School of Medicine and Public Health Research Ethics Committee (Protocol ID: AdMUREC-ASMPH_24_003). Informed consent was collected from study participants before answering the survey forms or participating in key informant interviews according to the Declaration of Helsinki.

Consent for publication

Not applicable.

Availability of data and materials

The data underlying this article will be shared on reasonable request to Veincent Christian F Pepito healthgov.asmph@ateneo.edu, vcfpepito12345@gmail.com and the funder, St Luke's Medical Center Health Equity Research Foundation (herefoundation@stlukes.com.ph).

Competing interests

VCFP, TPJZC and MMD has receiving funding from the Zuellig Family Foundation to write papers on health systems strengthening. VCFP is implementing a community physician scholarship and placement program with the St Luke's Medical Center Foundation Inc. KU and WCT are employees of the Philippine Department of Health Health Human Resources Development Bureau and are involved in implementing the program being assessed in this paper. Other authors do not have conflicts of interest to disclose.

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Authors contributions

VCFP, TPJZC and MMD conceptualized and designed the study. VCFP, ARDP, HIMJ, and TPJZC collected the data. VCFP and ARDP analyzed the data. VCFP wrote the first draft of the manuscript. ARDP, HIMJ, TPJZC, JRM, KU, WCT, RGCM, and MMD gave feedback and revised the manuscript. All authors read and approved of the final manuscript.

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Figures

EPSB Responses on MSQ (n=17)

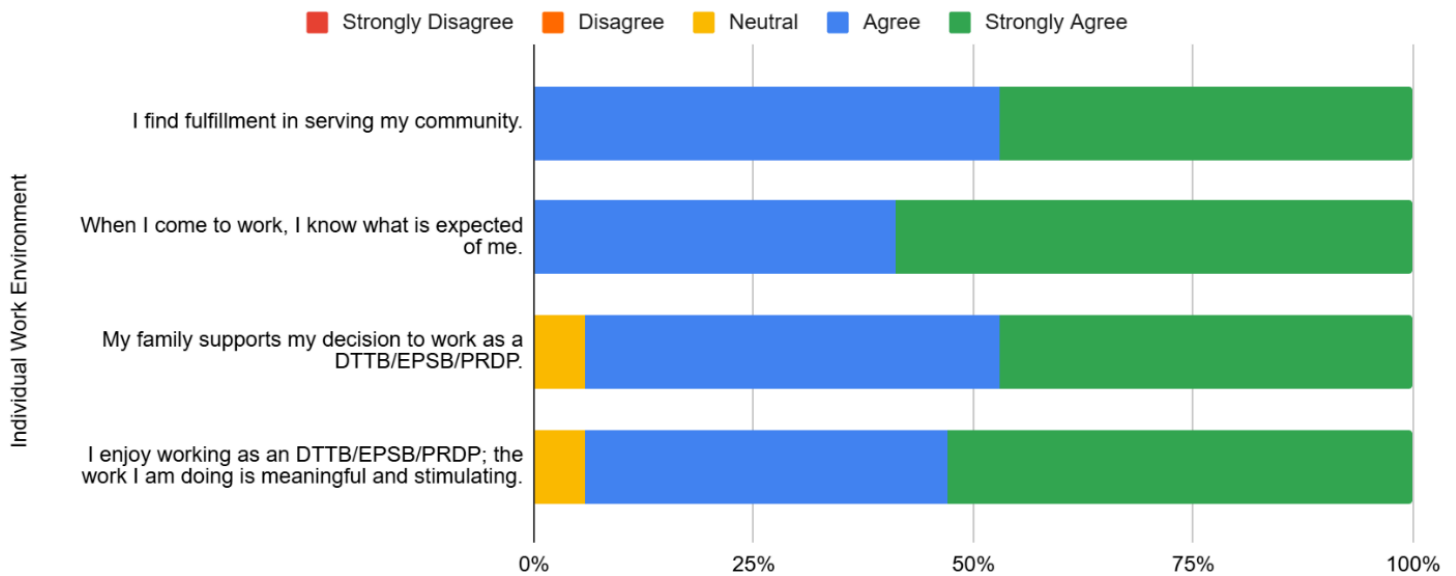


Figure 1

EPSB responses on individual work environment factors (n=17).

EPSB Responses on MSQ (n=17)

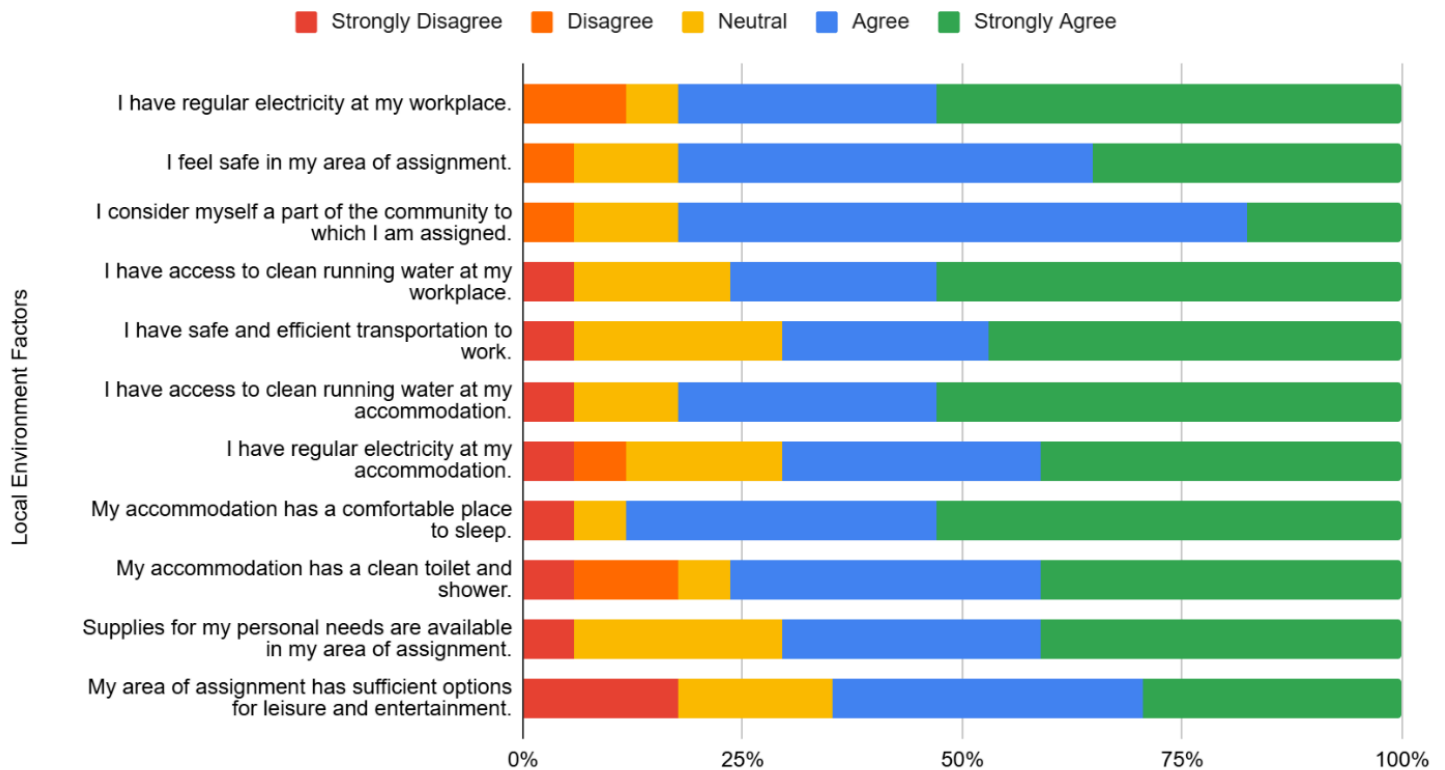


Figure 2

EPSB responses on local environment factors (n=17).

EPSB Responses on MSQ (n=17)



Figure 3

EPSB responses on work environment factors (n=17).

EPSB Responses on MSQ (n=17)

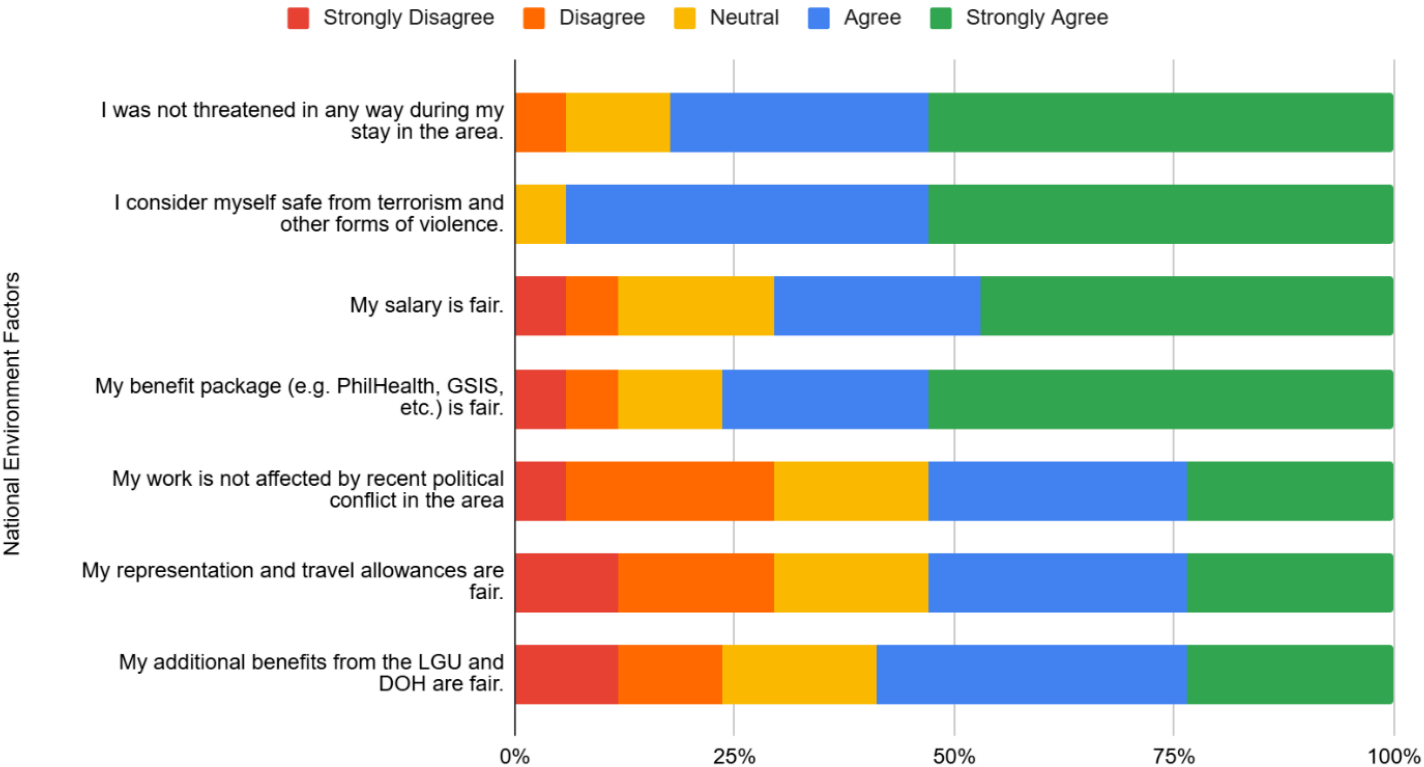


Figure 4
EPSB responses on national environment factors (n=17).

EPSB Responses on MSQ (n=17)

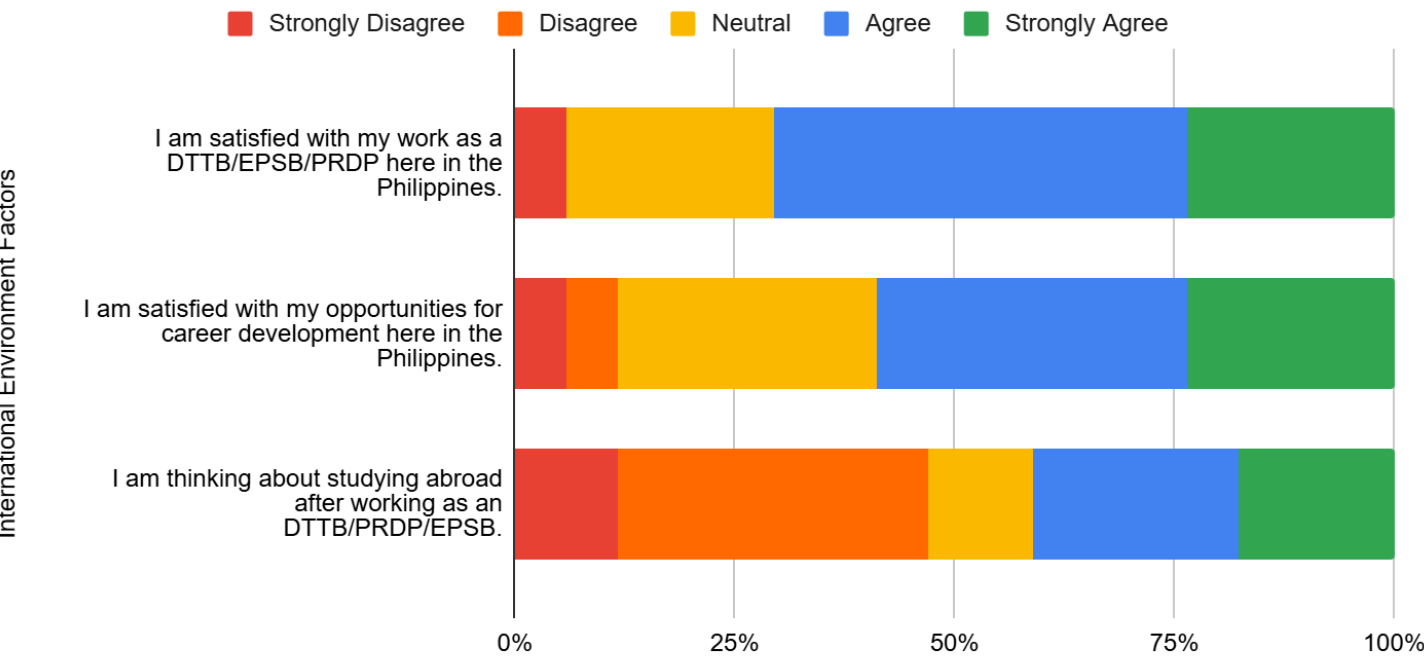


Figure 5

EPSB responses on international environment factors (n=17).

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