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SECTORAL ACTIVITIES PROGRAMME

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Migration of health workers: Country case study Philippines

Institute of Health Policy and Development Studies*

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Executive summary

International migration has become an important feature of globalized labour markets in health care. A number of industrialized countries have opened their doors to highly skilled health professionals, a great number of which come from the Philippines.

This study, commissioned by the International Labour Organization (ILO), aims to provide in-depth information on the migration of Filipino health workers and the repercussions this has on individual migrants, their families, their professions and the nation as a whole. It specifically sets out to: (1) explore the reasons why health workers opt to migrate or stay in the country; (2) discuss the impact of health worker migration on the country's health system, in terms of the working conditions of the remaining health workforce and the health service provision; (3) analyse existing migration policies and practices and discuss the different viewpoints of the various key stakeholders, (4) identify lessons learned and best practices; and (5) recommend strategies and practices for socially acceptable management of health worker migration.

The study used a descriptive analytic case study design, employing qualitative methods of gathering information: literature review; records review; key informant interviews; and focused group discussions. Five cities – Manila, Cebu, Tagum, Valenzuela and Laoag – representing urban, "rurban" and rural areas, respectively, were included in the study. A total of 305 respondents from government and private hospitals, review and recruitment centres participated in the study. Information gathered from the interviews was transcribed, coded and then displayed in qualitative data matrices. Content analysis and pattern matching were used in the analysis of qualitative data. The triangulation of relevant trends/findings in literature, records and interviews was employed. Only empirical health worker migration patterns within the study areas are reported. Consequently, the results cannot be generalized to represent the migration patterns in all areas of the Philippines.

Filipino worker migration patterns

Filipino overseas migration reflects the socio-political and economic situation in the Philippines. Although worker migration is supposedly a temporary measure to alleviate inadequate employment generation, observations show that overseas migration has become a persistent trend in that country. The Department of Foreign Affairs reports that there are about 7.2 million Filipino migrants throughout the world. The deployment level of overseas workers increased from just 36,035 in 1975 to 841,438 in 2000. On account of the dearth of employment opportunities and inadequate wages, overseas migration results in the loss of millions of skilled and unskilled Filipino workers to first-world countries.

The "brain drain" – the phenomenon of well-educated professionals permanently migrating from developing to industrialized countries – has been observed among health professionals in the Philippines. This migration may be attributed to a number of factors: a colonial mentality; economic need; professional and career development; and the attraction of higher living standards. A common reason for migration given by health workers themselves is that the low and variable wage rates do not allow them to earn "decent living wages".

Filipino nurses represent the largest category of health workers migrating, followed by midwives and doctors. Records show that the top three countries of destination for Filipino nurses during the past decade have been Saudi Arabia, the United States and the United Kingdom – with Saudi Arabia consistently being the most favoured country. During that period, rates of total nurse deployment have fluctuated from a low of 38 per

cent to a high of 85 per cent. Other preferred destinations include: Brunei; Ireland; Kuwait, Libyan Arab Jamahiriya, Qatar; Singapore; and the United Arab Emirates. Saudi Arabia has consistently been the top destination for many nurses in the last decade accounting for a low of 38 per cent to a high of 85 per cent of all nurse deployment for certain years.

Due to external demand trends, there has been a boom in Philippine nursing education. As many as 200 applications for new nursing programmes were submitted for the 2004-05 school year alone. In 2005, 450 nursing schools offered Bachelor of Science in Nursing programmes.

Benefits and costs of Filipino health worker migration

Migration literature specifies that the social costs of migration are heavy as those who migrate are usually highly skilled. As a result, patient outcomes may be compromised. A shortage in nursing staff may lead to higher cross- infection rates, adverse events after surgery, increased accident rates and patient injuries, as well as increased violence against staff. An excessive loss of domestic labour may prompt a brain drain among young, highly skilled workers and bring about a severe reduction in the availability and quality of services. A decline in the workforce of a country causes a reduction in productivity, liable to restrict economic development. Furthermore, a diminishing supply of workers in the source country pushes wages up, putting added pressure on the economy.

Case study results support research review findings in terms of perceived profiles of health worker migrants; patterns of migration; the reasons why health workers migrate; and the perceived effects of migration on individuals and their families, health-care institutions and the country as a whole. Out of a total of 305 respondents who participated in the study, the numbers of those planning to migrate and those who had no plans of moving to another country were almost equal (45.8 and 44.6 per cent, respectively). However, of those who planned to leave, about half (50.8 per cent) of the respondents had plans of moving to another country within two years, while about a fourth (25.8 per cent) planned to move out of the Philippines in three years; the smallest group (23.4 per cent) intended to leave in five years.

Perceived health worker migrant profiles and preferred destinations

It was noted that nurses and midwives planning to migrate were young – between the ages of 20 to 30 years – female and middle class and most of them had a basic undergraduate education. Physical and occupational therapists and medical technologists shared the same characteristics, except that there were more male therapists intending to migrate than females. Physicians who migrate are usually older when they leave (between 31 and 40 years of age), male or female, middle class, and with residency or fellowship experience.

Nurses and doctors leaving the country tend to be well-trained, skilled and experienced because of their specializations. In the study, the respondents specified that a majority of those who had left during the period under review (93.6 per cent) had been in their positions from one to ten years.

Push factors were related to economics, working conditions and socio-political factors. Aside from the financial reasons given, emphasis was placed on the country's deteriorating condition.

Pull factors included the respondents' concern for the financial and physical security of their children. Indeed, this was a recurring theme in the discussion and reflected their anxiety about the prevailing social situation.

The United States is a preferred destination country for all categories of health workers who gave the following reasons for this choice: working conditions are better in terms of the professional development opportunities provided and the use of high technology facilities and equipment; availability of social support from relatives and friends; and a high opportunity for family migration and citizenship. The United Kingdom is also a preferred country, particularly by nurses and midwives, because of the shorter time involved in the processing of applications; qualification requirements are also less stringent. Canada is one of the favourite destination countries for midwives because it is fairly easy for them to apply for a job.

Those workers opting to stay in the country gave as their main reasons: satisfaction with the present situation; the desire to serve their country; and the wish to be with their families.

Perceived health worker migration gains and losses

Respondents in the case studies considered that migration was specifically beneficial as it improved the quality of life and secured the future of health-care migrants and their families.

It is widely recognized that the contributions of health workers – especially nurses – make up a substantial proportion of the PHP9 billion remittance contributions of land-based Filipino migrants. In the context of a weak economy, this is a substantial contribution.

If a substantial number of migrants returned – at least temporarily – to apply their acquired skills and experiences to Philippine health-care organizational settings, this would represent a great technical gain. The skills and knowledge transfer from the returning migrants to those who make up the current Philippine health-care workforce would be valuable in upgrading the technical framework of health-care services in the Philippines.

The study concluded that the societal losses incurred as a result of this situation were considerable. The health-care system was more fragile as a result of rapid turnover and a permanent loss of skilled and experienced health workers. More widely recognized consequences were the effects on the continuity of care and quality of services provided. Moreover, unmanaged migration mitigated the ability of health-care professions to renew their ranks as even the educators and trainers were lost through migration. The disruption of the family and its possible consequences such as drug abuse among poorly supervised children, as well as incest or extramarital relationships caused by the absence of the migrant spouse, were social repercussions that could not be discounted. Any economic gains are likely to be wiped out by social losses such as these.

National government losses might include inadequate funding for the development of health system infrastructure because many of the available health resources are spent on the training of staff replacements. Government income from taxation in the provinces and the country as a whole is also reduced because of the permanent migration of health professionals.

The consequences of health worker migration are highly variable. Experts note several areas that need attention: recruitment, retention, policy, education and the strain on current health workers.

Lessons learned from the Philippine health worker migration experience

A number of strategies have been adopted to address the issue of Philippine health worker migration; these might be considered best practices. The Migrant Workers and Overseas Filipinos Act or Republic Act 8042 of 1995 was instituted to oversee the welfare of overseas Filipino workers (OFWs). The legislation clearly specified procedures for recruitment, deployment, and welfare administration and established a higher standard of protection and promotion of the welfare of migrant workers, their families and overseas Filipinos in distress. Moreover, the creation of the Philippine Overseas Employment Agency (POEA) and the Overseas Workers Welfare Administration (OWWA) under the Act, both support institutions, stressed the importance of overseas workers and the country's recognition of the need to oversee their welfare.

Migration-related practices – particularly valued by departing health workers – include pre-departure seminars to prepare migrants both psychologically and physically for their big move. Orientation training on the new culture, practices and policies of destination countries is undertaken to ensure that migrant workers are well prepared to cope with the changes they will have to face.

Other strategies adopted by health facilities to cope with rapid staff turnover include more systematized staff training and development; changes in the workplace to improve working conditions; and other retention schemes such as the provision of generous annual bonuses for travel, cars and housing to reward loyalty and productivity.

In order to address the impact of the massive migration of nurses on other health workforce categories, the Philippines has embarked on a Human Resources for Health (HRH) Master Plan that will harmonize workforce planning and establish other human resources management strategies in the health sector covering such areas as: improved recruitment and retention; career planning; better compensation packages, etc. Part of the master plan is the development of key policies to ensure quality, equitable health human resources in the country.

Key issues

Present strategies to address migration have been largely government-led solutions. Sustainable solutions should involve the private and business sector so that policy and programme development are collaborative – given that health sector migration is market-driven.

There is also a need to harmonize measures taken by the private sector with national policies and action. The private sector tends to act separately and sometimes comes into conflict with government policies and programmes.

Another key issue refers to the lack of coherent government policies and programmes. National policies and programmes need to be synchronized with an overall national policy direction on health worker migration that is explicitly articulated.

Recommendations

The policy and programme framework recommended by this study incorporates the major categories of national policies that may impact migration patterns – namely rational production and utilization, public sector personnel compensation and management

strategies. In addition, bilateral and multilateral policies and negotiations involving social dialogue are recommended.

1. There is a need to ensure that government policies and programmes are brought together in a coherent health worker migration policy. The private sector should be encouraged to participate actively in translating national policies into action.

2. Within the framework of the HRH Master Plan coordinated by the Department of Health, the following may be accomplished through synchronized strategies of national government agencies in migration management:

   (a) the setting up of a national network on human resources for health development, which would be a multi-sectoral body involved in health human resources development through policy review and programme development. This body could ensure and oversee the rational production and utilization of health human resources – including the redistribution of the existing workforce;

   (b) the exploration of bilateral negotiations and policies with destination countries to bring about recruitment conditions that would benefit both sending and receiving countries. Existing multilateral policies could be reviewed to determine ways to ensure effective implementation for the mutual benefit of sending and destination countries. This could include, for instance, compensatory mechanisms for the health organizations from which the health workers were recruited;

   (c) national efforts should be exerted to attract migrants back to their home country and ensure that migration is predominantly temporary. Reintegration programmes should be developed so that health workers with enhanced skills could apply what they have learned to enhance the performance of the health system;

   (d) career-path development should be instituted, together with the requisite compensation mechanisms and conducive work environment. Domestic health careers should promote professionalism, minimize politicization and reward excellent performance.

3. Health-related organizations such as the Philippine Nurses Association (PNA), the Philippine Hospital Association (PHA), Philhealth and the Philippine Medical Association (PMA), together with professional and regulatory bodies such as the Board of Nursing, should yield authority to prevent domestic work-related exploitation since there are local hospitals that do not offer salaries to nurses in exchange for volunteerism and certification of experience in the hospital.

4. Orientation seminars could be expanded to include a short course in technical training and health-care system orientation to familiarize potential health-care migrants with the health-care systems in their destination countries.

5. The institution of the National Health Service Act (NHSA) would call upon graduates, especially from state-run health science schools, to serve in the Philippines for a number of years equivalent to their years of study before they leave. This would prevent a mass exodus that will ultimately undermine the health-care system.

6. It is vital to pursue the active participation of the Philippines in international debates moderated by international agencies such as the World Health Organization (WHO), the International Council of Nurses (ICN) and the International Labour Organization

(ILO), which have committed to address the global nursing shortage and health workforce exchange.

7. Managed migration should be integrated with other domestic and international labour policies and programmes that would ultimately be instrumental in enabling Philippine health human resources development address the country's needs and help the Philippine health workforce meet the requirements of other nations. With clear priorities, human resources for health could be developed strategically and bring about an effective global exchange of mutual benefit to all.

Abbreviations

AIDS	–	acquired immune deficiency syndrome
BHS	–	Barangay health stations
CHD	–	City Health Department
CHO	–	City Health Office
CHED	–	Commission on Higher Education
CFO	–	Commission on Filipinos Overseas
CSC	–	Civil Service Commission
DBM	–	Department of Budget and Management
DILG	–	Department of Interior and Local Government
DFA	–	Department of Foreign Affairs
DOH	–	Department of Health
DOLE	–	Department of Labor and Employment
EEOC	–	Equal Employment Opportunity Commission
EVP	–	Exchange Visitors Program
FGD	–	Focus Group Discussions
GATS	–	General Agreement on Trade and Services
GDP	–	gross domestic product
GGH	–	Gaoat General Hospital
GNP	–	gross national product
HHR	–	health human resource
HIV	–	human immunodeficiency virus
HRH	–	human resources for health
HRD	–	human resource development
HSRA	–	Health Sector Reform Agenda
HW	–	health workers
ICM	–	International Confederation of Midwives
ICNLE	–	International Council of Nurses Licensure Examination
ICT	–	information and communication technology
ICU	–	intensive care unit
ILAO	–	International Labour Attaché Office
ILAS	–	International Labour Attaché Service
ILO	–	International Labour Organization

IMAP	–	Integrated Midwives Association of the Philippines
IPAMS	–	Industrial, Personnel and Management Services, Inc.
JRRMMC	–	Jose R. Reyes Memorial Medical Center
KII	–	key informant interview
LCHO	–	Laoag City Health Office
LCP	–	Lung Center of the Philippine
LCN	–	licensed practical nurse
LGM	–	League of Government Midwives
LGU	–	local government unit
MCM	–	Medical Center Manila
MICU	–	medical intensive care unit
MD	–	medical doctor
MMGHHSCT	–	Medical Mission Group Hospital and Health Service Cooperative of Tagum
MMMHMC	–	Mariano Marcos Memorial Hospital and Medical Center
MW	–	midwife
NCLEX	–	Nursing Commission on Licensure Examination
NEDA	–	National Economic Development Agency
NHS	–	National Health Service
NHSA	–	National Health Service Act
NFFM	–	National Federation of Filipino Midwives
NGO	–	non–governmental organization
NHIP	–	National Health Insurance Program
NKFP	–	National Kidney Foundation of the Philippines
NKI	–	National Kidney Institutes
NKTI	–	National Kidney and Transplant Institute
NSCB	–	National Statistical Coordination Board
OFW	–	overseas Filipinos workers
OPD	–	outpatient department
OR	–	operating room
OT	–	occupational therapists
OTAP	–	Occupational Therapists Association of the Philippines
OUMWA	–	Office of the Under-Secretary for Migrant Workers Affairs
OWWA	–	Overseas Workers Welfare Administration
PART	–	Philippine Association of Radiologic Technologist

PASP	–	Philippine Association of Speech Pathologists
PD	–	Presidential Decree
PGH	–	Philippine General Hospital
PHC	–	Philippine Heart Center
PHIMIDAS	–	Philippine Midwifery Association
PMA	–	Philippine Medical Association
PNA	–	Philippine Nurses Association
POEA	–	Philippine Overseas Employment Agency
PRC	–	Professional Regulations Commission
PT	–	physical therapists
RA	–	Republic Act
RCN	–	Royal College of Nursing
RHU	–	rural health unit
RN	–	resident nurse
SARS	–	severe acute respiratory syndrome
SP	–	speech pathologist
TDH	–	Tagum Doctors Hospital
TESDA	–	Technical Education and Skills Development Authority
TOEFL	–	test
UK	–	United Kingdom
UKCC	–	United Kingdom Central Council for Nursing, Midwives and Health Visiting
UN	–	United Nations
UPM	–	University of the Philippines, Manila
US	–	United States of America
USMLE	–	United States Medical Licensing Examination
VGH	–	Valenzuela General Hospital
VSMMC	–	Vicente Sotto Memorial Medical Center
WFOT	–	World Federation of Occupational Therapists
WHO	–	World Health Organization
WTO-GATS	–	World Trade Organization – General Agreement on Trade in Services

1. Introduction

International migration has become an important feature of globalized labour markets in health care and its impact is very complex – both for health workers and for the countries involved. More particularly, the international migration of skilled persons has assumed increased importance in recent years, reflecting the effects of globalization, the revival of growth in the world economy and the explosive expansion in information and communications technology (ICT). A number of developed countries have liberalized their policies to admit highly skilled professionals and this has facilitated the movement of workers from one country to another.

There has been concern about international migration in health services for some years now, but recently the situation has become more acute for a number of reasons. The main problem is that the demand for highly skilled professionals such as health workers is largely met by the developing countries.

The Philippines is recognized as being one of the major source countries of health worker migration. For many decades, the country has consistently supplied skilled health workers to countries such as the United States and Saudi Arabia. In recent years, other markets have emerged and opened for Filipino health workers, such as the United Kingdom, Netherlands and Ireland. However, reliable and consistent data on health worker migration is lacking, as recent WHO research proves.

Significance of the study

Although the Philippines has a well-known track record in this area, there is still a dearth of information available to summarize the overall migration experience. By analysing existing data in the country, the study seeks to establish the magnitude and patterns of health worker migration. Such information will lend itself to relevant policy making and development at the national and international levels.

Research objectives

This study aims to provide in-depth information on the migration of Filipino health workers and the impact this has on individual migrants, their families, professions and the nation as a whole. Specifically, the study sets out to:

(1) explore the reasons why health workers opt to migrate or stay in the country;

(2) discuss the impact of health worker migration on the country's health system, in terms of the working conditions of the remaining health workforce and the health service provision;

(3) analyse existing migration policies and practices and discuss the different and sometimes controversial viewpoints of the various key stakeholders;

(4) identify lessons learned and best practices; and

(5) recommend strategies and practices for socially acceptable management of health worker migration.

Methodology

Study design

The study used a descriptive case study design to establish the magnitude and patterns of health worker migration, as well as to explore the reasons why health workers opted to migrate or stay in the country. Five cases based on the identified study areas were developed, from which patterns of migration practices were elicited. The study employed qualitative methods of gathering pertinent information to attain its objectives: literature review; records review; key informant interviews; and focus group discussions among health workers in various settings, representatives of recruitment and review centres and administrators of government agencies that affect health worker migration.

Health worker migration patterns were derived from an extensive review of available literature and empirical evidence from five areas to represent urban, rural and "rurban" trends. The urban areas included in the study were Cebu City and Manila; the rural areas were Tagum City in Davao and Loag in Ilocos Norte; and the "rurban" area – characterized as being in transition from a rural to an urban area – was represented by Valenzuela City.

Areas: City and province	**Region, island group and characteristics**
Loag City, Ilocos Norte	Region 1, Northern Luzon – rural
Cebu City, Cebu Province	Region 7, Central Visayas – urban
Tagum City, Davao del Norte	Region 11, Southern Mindanao - rural
Manila	National Capital Region –urban
Valenzuela City, Valenzuela	National Capital Region – rurban

Within each area, respondents were selected from one government hospital, one private hospital, one review centre and one recruitment centre. These institutions were selected to derive varying sources and patterns of migration practices. Although all the study areas were cities, their classification as rural, rurban or urban was based on income – as specified by the Department of Interior and Local Government.

Records reviewed

Previous studies on Filipino worker migration were reviewed to make the results of this study more robust in the light of previous findings. Specific studies on Filipino health worker migration were found to be very valuable since available data were incomplete.

Respondents

Focus group discussions were conducted with potential health worker emigrants, workers who had decided to stay in the country and returnees. Key informant interviews, on the other hand, were conducted to obtain expert opinions from government agencies' policy-makers, private institutions' decision-makers and hospital administrators on the health human resources migration issue. Representatives of recruitment agencies and review centres catering to potential migrants were likewise interviewed. The potential health worker migrant categories included in the study included doctors, nurses, physical therapists, occupational therapists, medical technologists and midwives. There was a total of 305 respondents from selected study areas and practice settings.

Table 1. Professional health worker respondent categories, 2003

Health workers category	Manila	Cebu	Ilocos	Davao	Valenzuela	Manila-based Hospitals	Review centres	Total
Medical doctor	8	18	10	13	11	21	0	81
Registered nurse	7	24	7	12	6	16	31	103
Physical therapist	3	2	1	2	2	6	0	16
Occupational therapist	0	1	0	0	0	0	0	1
Midwife	0	8	2	9	6	0	1	26
Medical technologist	2	6	1	6	4	6	0	25
Radiologic technologist	0	0	0	2	0	2	0	4
Speech pathologist	1	0	0	0	0	0	0	1
Reviewee	0	0	3	26	0	0	0	29
Returnee	0	9	3	3	0	4	0	19
Total	21	68	27	73	29	55	32	305

Table I represents the main professional health worker categories observed to be emigrating in large numbers. Fewer focus group discussions and key informant interviews were actually conducted than planned; out of the 55 focus group discussions planned, only 48 took place; out of the 56 key informant interviews planned, only 50 were conducted. A summary of the institutions included in the study and their characteristics follows below:

Study area-based hospitals

Laoag City, Ilocos Norte	■ Mariano Marcos Memorial Hospital and Medical Center (government hospital –tertiary) ■ Gaoat General Hospital (private hospital – secondary)
Cebu City, Cebu Province	■ Vicente Sotto Memorial Medical Center (government hospital – tertiary) ■ Cebu Doctors (private hospital – tertiary)
Tagum City, Davao Del Norte	■ Davao Regional Hospital (government hospital – tertiary) ■ Medical Mission Group Hospital And Health Service Cooperative Of Tagum
Manila	■ Ospital Ng Maynila (government hospital – tertiary)
Valenzuela City, Valenzuela	■ Valenzuela District Hospital (government hospital – secondary)

Out of the ten planned hospitals from different areas, only eight participated in the actual implementation of the study. Three hospitals from different areas declined to join the study. The Tagum Doctors Hospital in Tagum City was unable to set up a meeting with the research group due to their busy schedule and was replaced by the Medical Mission Group Hospital and Health Service Cooperative of Tagum. In Manila, the head of personnel of Medical Center Manila (MCM) was out of town and no other staff was in a position to decide on their participation in the research. The Manila Doctors Hospital was supposed to replace MCM but was unable to take part in the study because of difficulties in setting up appointments with the nursing director. When it finally agreed on a schedule,

the deadline set for gathering data had expired. In Valenzuela, the Fatima Medical Center also declined to participate in the study, so there were no private hospital representation in Manila and Valenzuela.

Manila-based tertiary hospitals

A number of tertiary hospitals in Manila known to be popular sources of health worker recruitment were also included in the study to identify the issues facing health migrant workers and their environments. Among those included in the study were:

– Philippine Heart Center – government specialty hospital;

– Philippine General Hospital – government hospital;

– Mary Johnston Hospital – private general hospital;

– Jose Reyes Medical Center – government hospital;

– National Kidney Transplant Institute – government specialty hospital.

However, out of the six planned Manila-based tertiary hospitals, only five were able to participate in the actual research. Two hospitals, Makati Medical Center and St. Luke's Medical Center, declined due to scheduling difficulties. Mary Johnston replaced Makati Medical Center and Cardinal Santos Hospital was supposed to replace St. Luke's Medical Center; however, the former hospital's managers indicated that it was too busy to participate in the study.

Government agencies

Key government agencies that facilitated, regulated or were in some ways affected by Filipino worker migration were selected for focus group discussions and key informant interviews. These included the following: Civil Service Commission (CSC), Commission on Filipinos Overseas (CFO), Department of Budget and Management (DBM), Department of Foreign Affairs (DFA), Department of Labor and Employment (DOLE), Department of Local and Interior Government (DILG), National Economic and Development Agency (NEDA), Philippine Overseas Employment Agency (POEA), Professional Regulation Commission (PRC), Technical Education and Skills Development Authority (TESDA).

Among the government agencies, only the Department of Foreign Affairs (DFA) and the Department of Interior and Local Government (DILG) did not participate in the study owing to their schedules.

Private institutions

A small sample of three review centres and three recruitment centres were identified as valuable respondents to give the business perspective. These included:

– Review Centres: East West Review Center; Kaplan Review Center; International Review Network;

– Recruitment Agencies: Industrial, Personnel and Management Services, Inc. (IPAMS); Mabuhay Personnel and Management Services; ABBA Personnel Services.

Private institutions were chosen on the basis of the services they provided to potential health worker migrants and returnees.

Data analysis

All interviews were transcribed verbatim using a template specific to the form utilized during the interview, coded and displayed in qualitative data matrices using Microsoft Word. Textual investigation was carried out through content analysis – in which the forms/kinds of phenomena and variations within the phenomena and relationships among the codes were noted. Codes were predefined into sets of categories and further expanded during actual coding to qualify the theme or idea brought out in the paragraph. Coded entries of different respondents were organized into a matrix to make it easier to interpret data and arrive at tentative propositions. Data obtained were used for triangulation with other data. Tables that displayed relevant records reviewed were likewise crafted. All qualitative data gathered from the documents submitted with the questionnaire – as well as from all other sources – were closely examined; relevant portions were then entered into a database. The interview data were used to clarify and supplement the reviewed records but also to provide further detailed descriptions of the study variables.

Scope and limitations of the study

The field data results only report empirical health worker migration patterns within the selected study areas. The patterns and practices documented in the study are deemed to be a reflection of major health worker migration practices and trends; however, due to the limited sample and methods utilized, the results cannot be generalized to reflect the health worker migration patterns of all areas in the Philippines. With the purposive sampling and design used, it is hoped that the present research highlights significant patterns and practices of health worker migration that will be valuable in informing policy decisions and management strategies addressing this issue.

Major study constraints were posed by limited research resources and time allotted for the study. The study had to be completed in three months and within a tight budget. Many identified institutions took their time in replying to the invitation to participate in the study and therefore had to be excluded.

A common reason given for declining to take part in the study was scheduling. Contact persons were unavailable due to conventions, meetings, emergencies and other matters deemed of greater importance to their institutions. The study was also limited by the availability and quality of records gathered from the different hospitals, agencies and offices in the private and government sector. Due to a lack of records, a number of offices were supposed to provide variables of interest to the report. However, the reasons they gave for not being able to provide this data was that: (a) they had just started organizing data; or (b), they did not keep track of records and other statistics that were not mandated by the central authorities. For instance, the number of health workers who migrate is not monitored by most hospitals and city health offices as this is not required by the Department of Health (DOH). Another problem encountered by the research team in data gathering was the lack of cooperation from other offices.

2. Review of literature: The context of health worker migration in the Philippines

The movement of health workers away from the Philippines – either as migrant workers or merely as deployed overseas workers – was first observed in the 1950s when the exchange visitors' programmes with the United States started. At that time, the objective of moving to another country was to obtain more advanced training abroad and to disseminate the skills and learning upon return to improve the quality of health services. In the late 1960s and 70s active recruitment to the Middle East and North America picked up. All those who went to Saudi Arabia and other Middle Eastern countries eventually returned as specified by their work contracts. However, many of those who went to North America, especially Canada and the United States, stayed in their destination countries as migrant workers before being granted immigrant status.

In the late 1990s, in the face of widespread global nursing shortages, recruitment conditions changed, with destination countries such as the United States making more attractive and permanent recruitment offers. The Philippines is now experiencing a massive unmanaged migration of nurses and other health workers as a result of these changes.

In order to link the results of this study with previous knowledge of Philippine health worker migration patterns, an extensive review of literature was undertaken. This literature review aims to describe clearly the historical context of health worker migration. while highlighting key factors that influence its present character.

Demographic and socio-economic key indicators

As one of the developing countries in South-East Asia, the Philippines is in transition from an agricultural economy to a largely service-driven economy. The extent of Filipino overseas migration reflects the crisis of Philippine socio-political and economic life. Overseas migration means the loss of millions of skilled and unskilled Filipino workers due to the country's lack of employment opportunities and inadequate wages.

The population in the Philippines, estimated to be 84 million in 2004, is increasing at an annual rate of 2.3 per cent. About 38 per cent of the population is under 15 years old, making it a country with many young people. Those aged 65 years and over accounted for roughly 4.3 per cent of the population in 2004. The population is almost equally divided between genders, with males comprising 50.4 per cent of the total population. Women of reproductive age represent around 23 per cent of the population.

The Philippines is still predominantly rural, with about 52.4 per cent – or nearly 7.5 million families – living in rural areas. Urbanized areas are rapidly expanding and offer a wide range of economic, educational, recreational and other facilities that attract migrants from rural communities. Settlements in remote frontier areas are also increasing. As mentioned earlier in the text, there are now communities known as "rurban" communities.

Rural-to-urban and rural-to-rural migration has put considerable pressure on the provision of basic social services such as health care, shelter, water, sanitation and education. The congestion and pollution in urban areas are harmful to health. In frontier areas, people's health is affected by difficult access to health services and the presence of locally endemic diseases such as malaria, filariasis and schistosomiasis.

The country's labour force is estimated to be about 34.2 million – or about 42 per cent of the total number of Filipinos (estimated at 82 million in 2003) (figure 1). Those who are

part of the labour force comprise about 67 per cent of all Filipinos of productive age. Of all those in the service industry, 8.8 per cent work in health human resources (NSO, 1997). In October 2000, 3.4 million Filipinos were unemployed, indicating an unemployment rate of 11.2 per cent. This rate remained fairly stable from 2000 to 2002 but increased to 12.7 per cent in the first half of 2003. Every year about 800,000 young people begin looking for work in a contracting and job-scarce economy (Business World, 2001).

Even for many Filipinos who have jobs, the situation is not ideal. One out of every five employed workers is underemployed, i.e. underpaid, working part-time or employed below his or her full potential. Tables 2 and 3 show that, from 1987 to 2000, underemployment was fairly high at over 20 per cent,, rising again in 2003. It appears that job opportunities have not increased in line with the increase in the population. Similarly, labour productivity was stagnant from 1987 to 1999, growing by only 6 per cent per year on average (Villalba, 2002). Philippine labour has not been as competitive as its counterparts in neighbouring Malaysia and Thailand.

Filipino labour migration was originally intended to serve as a temporary measure to ease the tight domestic labour market. It was primarily intended to stabilize the country's balance-of-payments position and serve as an alternative employment strategy for Filipinos. However, observations show that there has been a growing dependence upon labour migration – or international service provision – to address the problems of the domestic labour market over the years. An international service provider is someone who:

(1) has been sent by his or her employer to a foreign country in order to undertake a specific assignment or duty for a restricted and definite period of time;

(2) engages in work that requires professional, commercial, technical or other highly specialized skills for a restricted and definite period of time;

(3) engages in work that is transitory or brief for a restricted and definite period of time, at the request of his or her employer in the country of employment.

The Department of Foreign Affairs reports that, in 1999, there were about 7.2 million Filipino migrants throughout the world. Of these about 40 per cent, or 2.96 million, were documented workers; 26 per cent, or 1.9 million, were reported as undocumented workers; while about 32 per cent, or 2.3 million, were permanent residents in their destination countries (DFA, 1999).

Deployment levels in the number of overseas workers increased from just 36,035 in 1975 to 841,438 in 2000. From 1995 to 2000, overseas deployment continued to increase by 5.32 per cent annually. Meanwhile, during the 1995-2000 period, the number of sea-based workers deployed (198,134) was equivalent to 25 per cent of the total land-based OFWs deployed. Overseas employment provides work to job-seeking Filipinos and it is a major generator of foreign exchange. Remittances of OFWs grew rapidly from nearly US$290.85 million in 1978 to an all-time high of US$6.8 billion in 1999 (Francisco).

The impact of high levels of training and expertise on the mobility of persons may be related to the expansion of world trade and increasing intra-firm linkages. This trend also reflects the growing international labour market within multinational firms, as well as the limited institutional frameworks for facilitating an exchange of skills. Likewise, the growth of specialized service providers or professionals like doctors, therapists and nurses, is a result of changing demographic patterns in certain developing countries.

Table 2. Selected labour force statistics, Philippines, 1995-July 2003 (in thousands except rates)

Indicator	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	July 2003
Household population 15 years old and over	32 889	33 469	34 462	35 478	36 520	37 636	38 599	39 831	41 004	42 213	43 156	44 599	45 770	44 995	46 321	47 640	48 929	50 344	51 596
Labour force (in 000)	20 743	21 362	22 563	23 449	24 120	24 244	25 631	26 290	26 879	27 654	28 380	29 733	30 354	29 674	30 758	30 911	32 809	33 936	34 206
Participation rate (%)	63.1	63.8	65.5	66.1	66	64.4	66.4	66	65.6	65.5	65.8	66.7	66.3	65.9	66.4	64.9	67.1	67.4	67.4
Employment (in 000)	18 136	18 836	20 040	21 205	21 908	22 212	22 914	23 696	24 382	25 032	25 676	27 186	27 715	26 631	27 742	27 452	29 156	30 062	29 858
Employment rate (%)	87.4	88.5	88.8	90.4	90.8	91.6	89.4	90.1	90.7	90.5	90.5	91.4	91.3	89.7	90.2	88.8	88.9	88.6	87.3
Unemployment (in 000)	2 608	2 526	2 523	2 244	2 212	2 032	2 716	2 594	2 497	2 622	2 704	2 546	2 640	3 043	3 017	3 459	3 653	3 874	4 348
Unemployment rate (%)	12.6	11.8	11.2	9.6	9.2	8.4	10.6	9.9	9.3	9.5	9.5	8.6	8.7	10.3	9.8	11.2	11.1	11.4	12.7
Underemployment (in 000)	nr	nr	5 312	4 985	5 091	4 964	5 161	4 866	5 282	5 353	5 137	5 719	6 121	5 758	6 127	5 955	5 006	5 109	6 211
Underemployment rate (%)	nr	nr	23.54	21.26	21.11	20.48	20.14	18.51	19.65	19.36	18.10	19.23	20.17	19.40	19.92	19.26	15.26	15.05	18.16

Note: nr = no record.

Source: *2000 Yearbook of Labor Statistics and Current Labor Statistics*, BLES, DOLE.

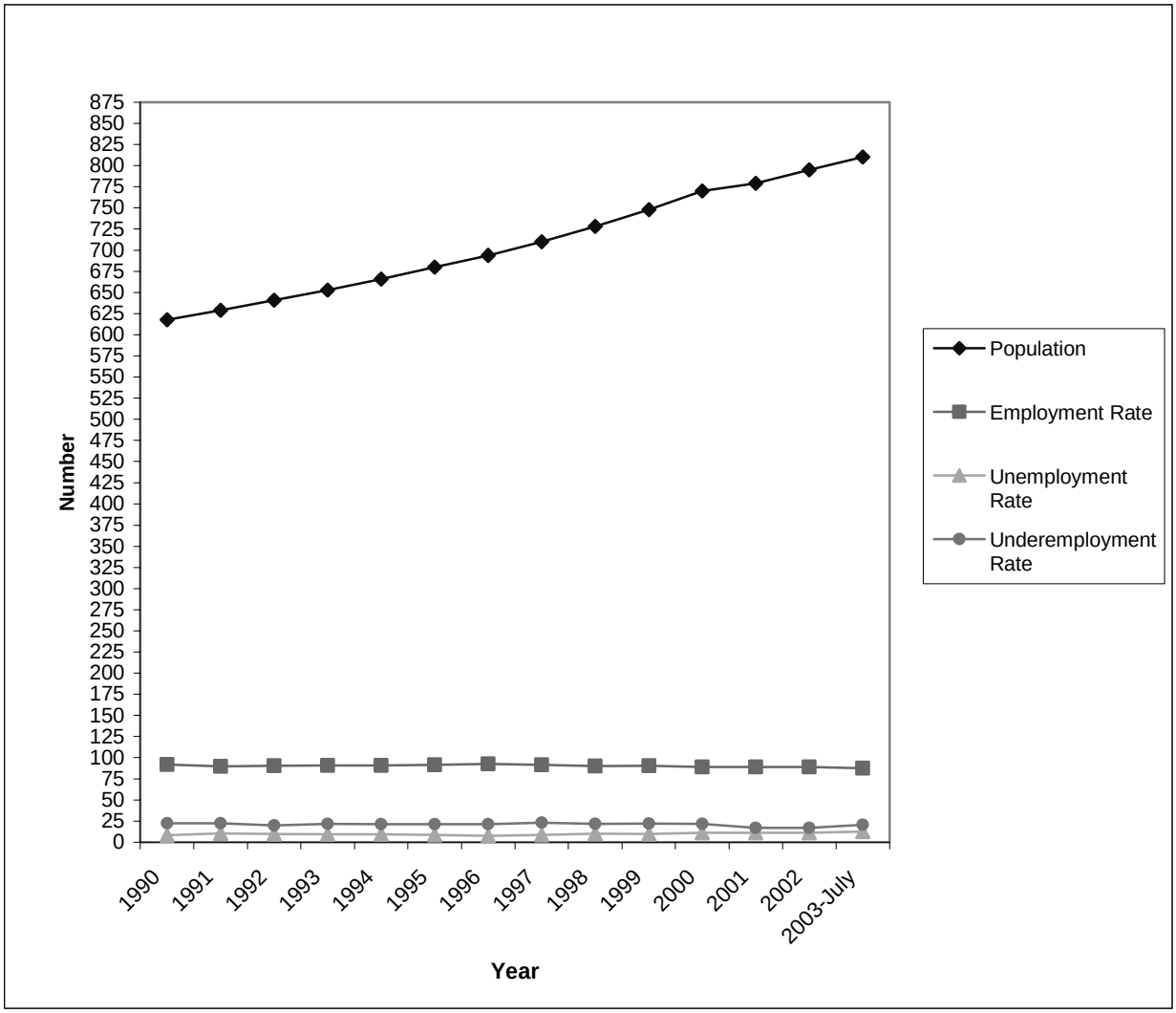
Table 3. Philippine population and labour force statistics, 1990-2003

Year	Population	Employment	Employment rate	Unemployment	Unemployment rate	Underemployment	Underemployment rate
1990	61 872 092	22 212	91.6	2 032	8.4	4 964	20.5
1991	62 957 154	22 914	89.4	2 716	10.6	5 161	20.1
1992	64 104 906	23 696	90.1	2 594	9.9	4 866	18.5
1993	65 321 320	24 382	90.7	2 497	9.3	5 282	19.7
1994	66 608 194	25 032	90.5	2 622	9.5	5 353	19.4
1995	68 009 744	25 676	90.5	2 704	9.5	5 137	18.1
1996	69 459 816	27 186	91.4	2 546	8.6	5 719	19.2
1997	71 096 055	27 715	91.3	2 640	8.7	6 121	20.1
1998	72 877 979	26 631	89.7	3 043	10.3	5 758	19.4
1999	74 834 407	27 742	90.2	3 102	9.8	6 127	19.9
2000	77 048 397	27 452	88.8	3 459	11.2	5 955	19.3
2001	77 925 894[a]	29 156	88.9	3 653	11.1	5 006	15.3
2002	79 503 675[a]	30 062	88.6	3 874	11.4	5 109	15.1
July 2003	81 081 457[a]	29 858	87.3	4 348	12.7	6 211	18.2

[a] Population projections by NSO.

Source: Philippine Population (National Statistics Office) and selected labour force statistics (*2000 Yearbook of Labor Statistics and Current Labor Statistics*, BLES, DOLE).

Figure 1. Philippine population and selected labour force statistics, 1990-2003



Note: Philippine population in millions expressed in three digit-values.

Source: Philippine Population (National Statistics Office) and selected labour force statistics (*2000 Yearbook of Labor Statistics and Current Labor Statistics*, BLES, DOLE).

Philippine health-care system structure and institutions

The nature of the Philippine health-care system and its institutions influences the current state of health worker migration. On account of the multifarious issues and problems involved, the system provides many push factors – and an understanding of the system will help towards analysing what future policy and programme implications might provide solutions to the present migration situation.

The Philippine Constitution recognizes health as a basic human right. It protects and promotes Filipinos' right to health and makes them aware of health matters. The Department of Health (DOH) is the lead agency in health promotion and protection. It maintains specialty hospitals, regional hospitals and medical centres. The DOH operates regional field offices, now known as Centers for Health Development, in every region. It has a provincial health team made up of representatives on the local health boards and personnel involved in controlling selected priority health problems.

With the devolution of health services to the local government units (LGUs) in 1990, the provincial and district hospital now come under the jurisdiction of the provincial government, while the municipal government manages the rural health units (RHUs) and barangay (village) health stations (BHSs). In every province, city or municipality, there is a local health board chaired by the local chief executive. Its function is mainly to serve as an advisory body to the local executive and sanggunian – or local legislative council – on health-related matters (Kalusugan Para sa Masa).

The private sector's involvement in maintaining people's health is enormous. It provides health services in clinics and hospitals, health and nutrition products, research and development, human resource development and other health-related services. Out of an estimated 1,600 hospitals in the country, about 60 per cent are private. However, private hospitals and clinics are much smaller than the government facilities and quality varies widely. Non-governmental organizations (NGOs) also provide limited health services, especially to marginalized, under-served groups.

Although the health-care system is extensive, access to it – especially by the poor – is mainly hampered because of high costs and physical and socio-cultural barriers. As a result, health-care outcomes have not improved drastically for Filipinos. Key health status indicators such as life expectancy and infant mortality rates show that Filipino health status improvement has lagged behind that of its South-East Asian neighbours.

Health sector reform

It has been reported that the health status of Filipinos improved significantly for 50 years after the Second World War. However, in more recent years, improvement rates have declined considerably. As an overall indicator of health status, the decline in infant mortality rates slowed down very much in the 1980s until 1995 – and beyond. Moreover, large variations in health status prevail among population groups across different regions. In both 1990 and 1995, the top five high-mortality provinces had infant mortality rates that were twice as high as the five lowest mortality provinces. The high-mortality provinces are rural and located in the poorest and most remote areas of the country: in the mountains of the Cordillera Administrative region or in the islands of the Visayas and Mindanao. Health reforms are needed to come to grips with the three major health problems facing the country: infectious diseases in remote areas and the country as a whole; major and increasing causes of death such as heart disease and cancer; and emerging diseases such as severe acute respiratory syndrome (SARS)and drug-resistant tuberculosis.

The ultimate goal of health sector reform is the improved health status of all Filipinos. The Department of Health (DOH) has taken the bold step of reforming the way health services are delivered, regulated and financed through its Health Sector Reform Agenda (HSRA). The HSRA focuses on the following goals: expand the effective coverage of national and local public health programmes; increase access, especially by the poor, to personal health services from both public and private health-care providers; and reduce the financial burden on individual families through universal coverage of the National Health Insurance Program (NHIP).

In pursuing the HSRA, the DOH proposes to improve health-care delivery, regulation and financing by introducing changes in five interrelated areas that affect the health sector, namely: hospital reforms; local health systems development; public health programme reforms; health regulation reforms; and social health insurance reforms (DOH, 1999, 2003).

Human resources for health (HRH) and the health sector labour market

Stock and distribution of health workers

As it is difficult to establish accurately the stock and distribution of health workers in the Philippines, reference is made to the findings of Lorenzo et al. in their Health Transitions Study (1998). Results of that study are interwoven with recent information on Philippine HRH production patterns to establish trends of production and distribution.

Historically, the Philippines produces nine major categories of professional health workers in varying quantities. The present stock of HRH is a result of production patterns that have changed over the years.

From the early 1900s to 1950, the production of HRH in the health sector corresponded to the demand for health workers, as shown in figure 2 and table 4. However, from 1950 to the present, the country has been producing more HRH than required. HRH production is defined as the number of licensed HRH produced per year, while demand refers to the number of available HRH positions in the country. It must be noted that these figures do not reflect the actual number of HRH graduates or the real need for health workers in the country.

Estimated production patterns in 2004 reveal that the health worker category producing the most HRH was that of nurses and the category producing the least was that of occupational therapists. The estimated annual figures are as follows:

– nurses (10,000) from 350 nursing colleges;

– doctors (2,000) from 30 medical schools;

– midwives (1,500) from 129 schools;

– dentists (2,000) from 31 dental schools;

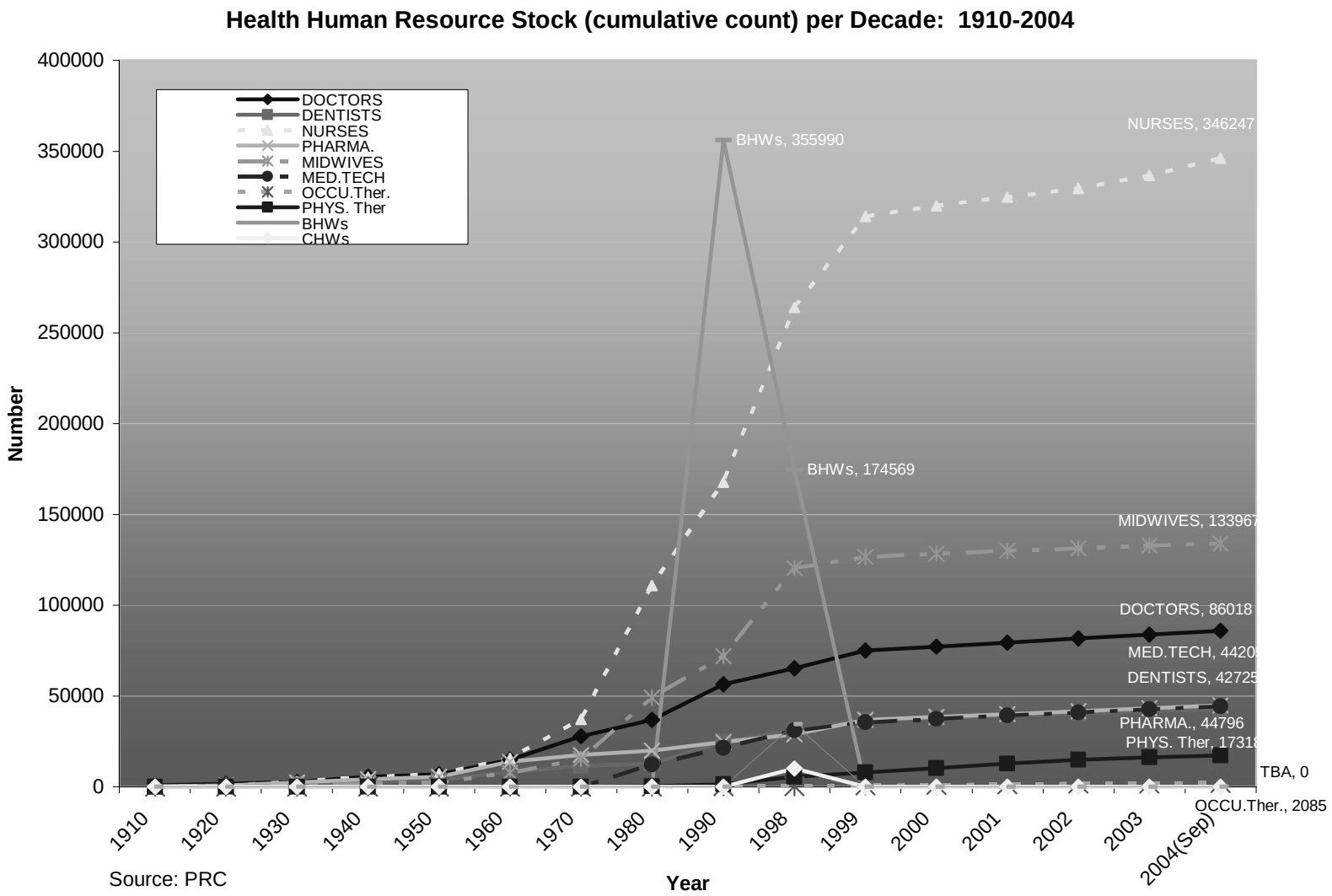
– pharmacists (1,500) from 35 pharmacy colleges;

– physical therapists (1,000) from 95 PT/OT colleges;

– occupational therapists (200) from 95 PT/OT colleges (NSCB, 1997; PRC, 2004, CHED, 2004).

The Health Transitions Study reported seven major categories of professional health worker, varying in number, in the Philippines. These are: nurses, midwives, doctors, pharmacists, dentists, and physical and occupational therapists. As mentioned above, Filipino nurses are the most numerous health worker category, followed by midwives and doctors. Pharmacists and physical and occupational therapists account for the smallest group of health workers trained in the Philippines. Other categories that have emerged since the 1980s include optometrists, caregivers, radiology and laboratory technicians. All in all, there are 11 categories of HRH produced in the Philippines.

Figure 2. Health human resource stock (cumulative count) per decade: 1910-2004



Source: PRC

Table 4. Distribution of health workers produced in the Philippines, 1998

	Government	Abroad	Private	Others	Total
Nurses	9 778	39 174	nd	21 4959	263 911
Dentists	1 963	242	10 513	18 320	31 038
Doctors	7 671	495	18 425	38 546	65 137
Pharmacists	229	302	nd	28 324	28 855
Midwives	15 893	1 196	nd	103 412	120 501
Medical technologists	1 560	2 090	nd	27 396	31 046
OT/PT	76	3 300	nd	2 602	5 978

Sources: Philippine Overseas Employment Administration; Department of Health-Personnel Office; National Statistical Coordinating Board-FHSIS; Philippine Nurses Association; Philippine Dental Association.

Table 5. Filipino health human resources working abroad, 1992-2003

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Doctors	86	91	57	69	47	82	63	59	27	61	129	112	883
Dentists	27	22	38	48	36	52	19	56	33	57	62	40	490
Nurses	5 788	6 739	6 853	7 597	4 698	4 282	3 217	5 413	7 683	13 536	11 867	8 968	86 641
Pharmacists	52	32	32	54	57	42	33	55	30	64	57	74	582
Medtechs	312	329	302	270	247	343	287	nd	nd	nd	nd	nd	2 090
Midwives	246	295	126	161	142	113	113	66	55	190	312	276	2 095
Ot/Pt	542	608	645	581	426	289	209	147	235	330	517	371	4 900
Year total	7 053	8 116	8 053	8 780	5 653	5 203	3 941	5 796	8 063	14 238	12 944	9 841	97 681

Source: POEA

Table 6. Regional distribution of health human resources employed in the government sector: Philippines 2002

Health human resources in Government				
Region	Doctors	Dentists	Nurses	Midwives
CAR	85	33	159	579
NCR	658	540	745	1 165
Reg. 1	158	96	203	1033
Reg. 2	175	58	267	801
Reg. 3	297	161	382	1 573
Reg. 4	350	256	648	2 282
Reg. 5	190	85	338	1026
Reg. 6	226	112	433	1 791
Reg. 7	229	115	379	1 473
Reg. 8	153	109	233	887
Reg. 9	90	55	196	675
Reg. 10	99	71	189	803
Reg. 11	79	71	161	791
Reg. 12	84	32	158	671
ARMM	69	23	99	371
CARAGA	79	54	130	613
Phil.	3 021	1 871	4 720	16 534

Source: *2004 Philippine Statistical Yearbook*, National Statistical Coordination Board.

Table 7. Urban-rural distribution of health human resources employed in the Government sector: Philippines, 1997

Health human resources in government								
	Doctors	Dentists	Nurses	Meditechs	Midwives	Pharmacists	PT/OT*	BHW**
Urban	3 536 (47%)	901 (45%)	4 067 (42%)	485	3762	126	60	28 942
NCR	2 759 (36%)	640 (33%)	3 094 (32%)	356 (23%)	1 552 (10%)	117 (51%)	54 (71%)	4 218 (2%)
Reg. 4	777 (11%)	261 (12%)	973 (10%)	129 (9%)	2 210 (14%)	9 (4%)	6 (6%)	24 724 (15%)
Rural	4 135 (53%)	1 062 (55%)	5 711 (58%)	1 075 (68%)	12 131 (76%)	103 (45%)	16 (23%)	140 558 (83%)
CAR	248 (3%)	50 (3%)	325 (3%)	48 (3%)	597 (4%)	6 (3%)	ND	5 283 (3%)
Reg. 1	324 (4%)	94 (5%)	430 (4%)	34 (2%)	1 026 (6%)	5 (2%)	1 (1%)	19 068 (11%)
Reg. 2	246 (3%)	69 (4%)	417 (4%)	61 (4%)	866 (5%)	9 (4%)	1 (1%)	7 870 (5%)
Reg. 3	497 (6%)	161 (7%)	626 (6%)	156 (11%)	1 342 (8%)	7 (3%)	ND	9 055 (5%)
Reg. 5	426 (6%)	81 (4%)	428 (4%)	132 (8%)	1 012 (6%)	6 (3%)	4 (5%)	11 222 (7%)
Reg. 6	454 (6%)	129 (7%)	696 (7%)	65 (4%)	1 586 (10%)	11 (5%)	3 (4%)	21 204 (13%)
Reg. 7	530 (7%)	115 (6%)	807 (8%)	161 (10%)	1 391 (9%)	13 (6%)	2 (3%)	14 910 (9%)
Reg. 8	291 (4%)	92 (5%)	371 (4%)	91 (6%)	821 (5%)	10 (4%)	2 (3%)	16 307 (10%)
Reg. 9	231 (3%)	59 (3%)	368 (4%)	97 (6%)	748 (5%)	7 (3%)	1 (1%)	7 132 (4%)
Reg. 10	216 (3%)	62 (3%)	362 (4%)	83 (5%)	759 (5%)	3 (1%)	1 (1%)	10 991 (6%)
Reg. 11	320 (4%)	34 (2%)	315 (3%)	39 (3%)	348 (2%)	17 (7%)	3 (4%)	3 707 (2%)
Reg. 12	187 (2%)	36 (2%)	270 (3%)	51 (3%)	625 (4%)	9 (4%)	ND	3 693 (2%)
ARMM	89 (1%)	28 (1%)	149 (2%)	22 (1%)	402 (3%)	ND	ND	2 244 (1%)
CARAGA	76 (1%)	52 (3%)	147 (2%)	35 (2%)	608 (4%)	ND	ND	7 872 (5%)
Phil.	7 671 (100%)	1 963 (100%)	9 778 (100%)	1 560	1 5893	229	76	169 500

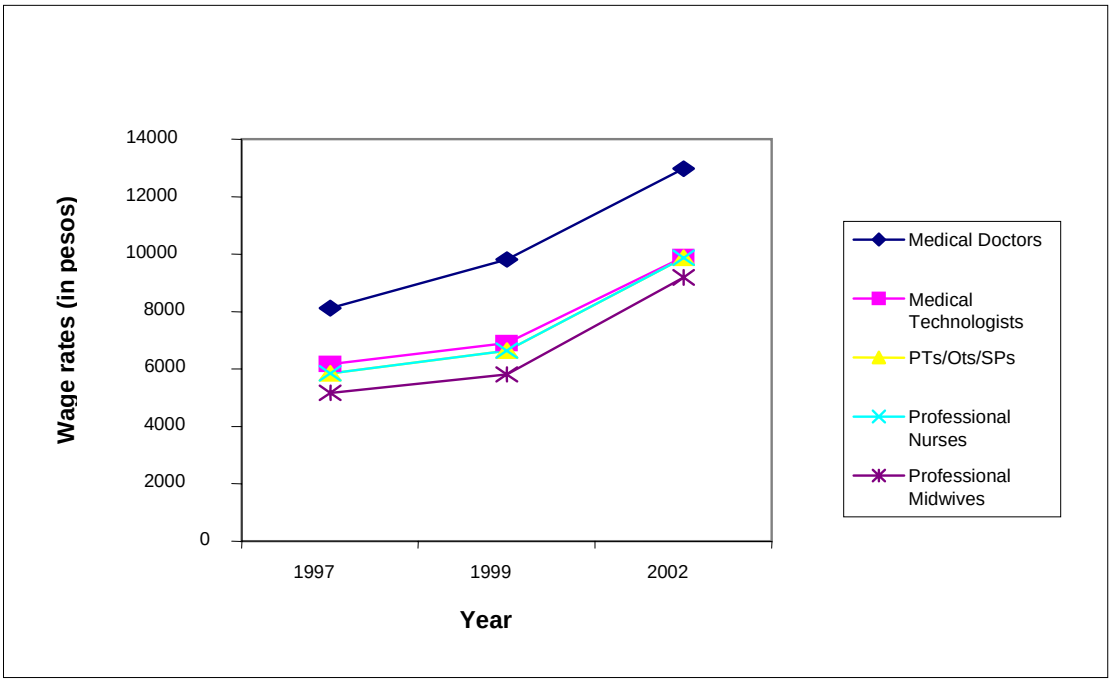
Source: National Statistics Coordinating Board – FHSIS; Department of Health – Personnel Office.

Table 8. Average monthly wage rates of private medical and other health services

	1997	1999	2002
Medical doctors	8 121	9 813	12 971
Medical technologists	6 168	6 899	9 898
PTs/OTs/SPs	5 849	6 633	9 869
Professional nurses	5 849	6 633	9 869
Professional midwives	5 162	5 817	9 194

Source: Bureau of Labor and Employment Statistics*: Occupational Wage Survey*.

Figure 3. Average monthly wage rates of private medical and other health services



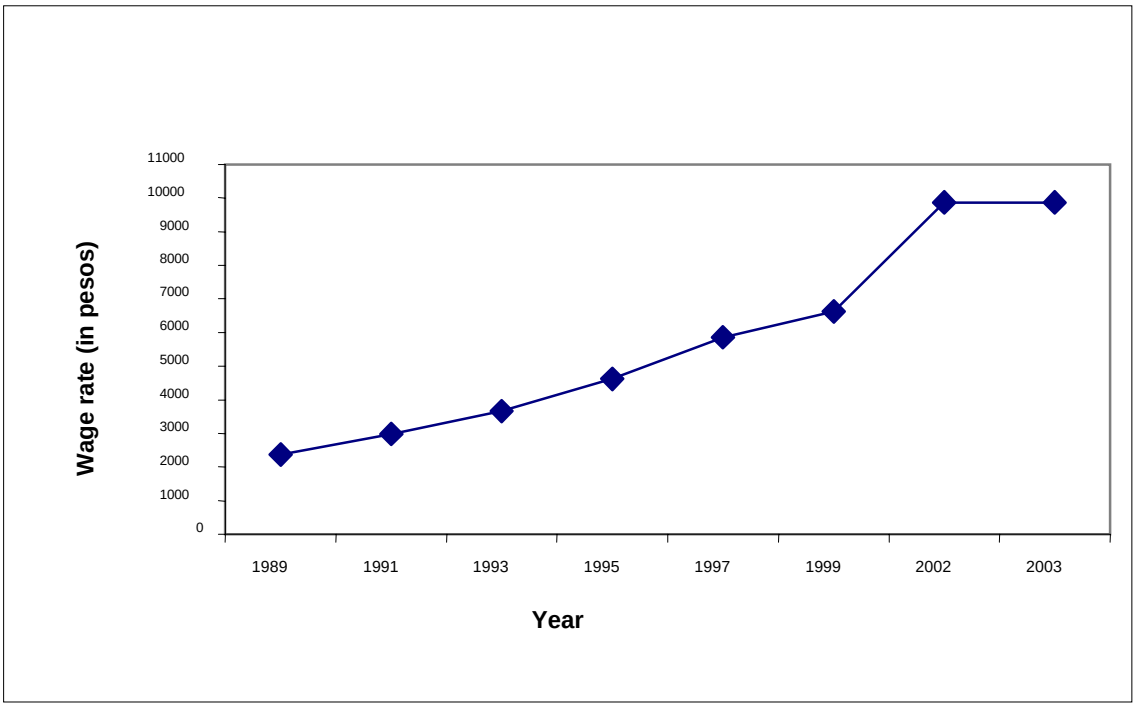
Source: Bureau of Labor and Employment Statistics, Occupational Wage Survey.

Table 9. Average monthly wage rates of nurses in the private sector (in pesos)

Year	Nominal wage
1989	2 363
1990	2 887
1991	2 985
1992	3 393
1993	3 661
1995	4 627
1996	nr
1997	5 849
1998	nr
1999	6 633
2000	nr
2001	nr
2002	9 869
2003	9 869

Note: nr = no records.
Source: Bureau of Labor and Employment Statistics: *Occupational Wage Salary 2003.*

Figure 4. Average monthly wage rates of nurses in the private sector



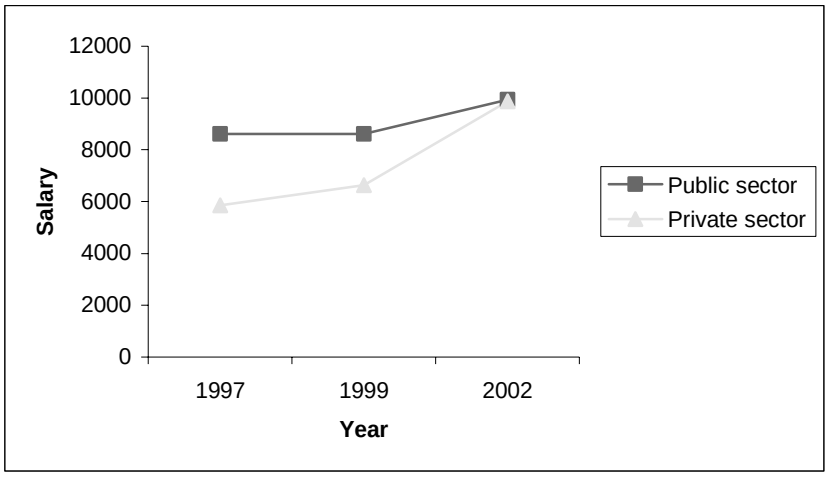
Source: Bureau of Labor and Employment Statistics: *Occupational Wage Salary 2003.*

Table 10. Comparison of mandated average monthly salaries of nurses in the public and private sectors (in pesos), 1997, 1999 and 2002

Year	Monthly salary	
	Public sector	Private sector
1997	8 605	5 849
1999	8 605	6 633
2002	9 939	9 869

Sources: Monthly Salary – 2002 Records, PGH[a]; Bureau of Labor and Employment Statistics: *Occupational Wage Salary 2003.*

Figure 5. Average monthly salaries of nurses in the public and private sectors



Sources: Monthly Salary – 2002 Records, PGH[a]; Bureau of Labor and Employment Statistics: *Occupational Wage Salary 2003.*

Assuming that urban areas in the Philippines are limited to the National Capital Region (NCR) and region 4, table 7 shows that medical technologists, midwives and barangay health workers mostly serve in the rural areas. Doctors, nurses and dentists are almost equally represented in urban and rural areas, while physical and occupational therapists are mostly located in urban areas. However, there are urban areas in many regions – such as in regions 7 and 10. It would seem from table 7 that health professionals in the Philippines usually gravitate around urban areas, i.e. cities of rural areas.

Table 7 also shows the clear inequities in the distribution of health human resources in the Philippines. Most of the professional workers practise in urban areas and only medical technologists, midwives and barangay health workers are predominantly located in the rural areas. Moreover, other regions aside from the NCR (Metro Manila) and region 4, which are rapidly encroaching upon the suburbs of Metro Manila, have very low percentages of professional health resources, ranging from one per cent to a high of 7-8 per cent.

It was impossible to measure systematically the demand for all categories of health professionals because of a lack of recent and accurate information. Hence, data on nursing that the researchers had previously compiled were used to depict the patterns of demand and distribution. According to the Department of Health (DOH), the Philippines produced 337,939 registered nurses from 1991 to 2000. This was about 400 times the number of nurses produced in the 1970s. The manning of nurses in domestic health facilities was broken down as follows in 2000:

– 17,547 in various government agencies;

– 7,535 in privately run health facilities;

– 2,078 in nursing educational institutions.

Corcega et al. (2000) estimated that demand for Filipino nurses consisted of 178,045 positions in local and international markets. Of these, 150,865 positions – or 84.75 per cent of the total demand – were in the international market, while only 27,160 – or 15.25 per cent – were in the domestic market. Total demand was estimated on the basis of known positions available in the domestic market and recorded deployment abroad.

Recent data from the Philippines Overseas Employment Agency (POEA) shows that from January to August 2002 alone, it deployed 7,855 nurses. This number is considered by POEA to represent an unusually high demand and may be explained by the fact that during 2000 and 2001, the demand for nurses in the United Kingdom increased considerably, along with deployment in the Netherlands and other European countries, as well as the United States. This is merely a fraction of the number involved, as most deployments are negotiated by the private sector.

It is widely perceived that the magnitude of deployment abroad is largely due to unavailable nursing positions in the Philippines. Many of the nurses currently working in the system are volunteers or casuals without any permanent plantilla positions. These positions do not provide benefits such as health insurance and security of tenure and are considered exploitative. Migrante International has pointed out that if public nurses were be given positions in local government units, and these were divided by the total population and number of barangays, a substantial number of additional nursing positions could be added to the present demand. This would result in a more favourable nurse to population ratio of one nurse for every 16,723 Filipinos and approximately one nurse for every nine barangays (Opiniano, 2003). There have been unsuccessful attempts to legislate on this matter in the past.

Another reason usually given by health workers for their decision to migrate is the low and variable wage rates in the country which do not allow health workers to earn "decent living wages". Table 8 and figure 3 show that professional wage rates levels were maintained from 1997 to 2002. Average wage rates mainly rose during this period because of governmental mandate. However, only government health facilities implement mandated average wages. Those who work in the private sector continue to receive salaries way below these levels.

The discrepancies between wages in the private and public sectors are seen in table 10 and figure 5. The Department of Labor and Employment (DOLE) has attempted to close the gap by mandating upgraded salaries for nurses. Nevertheless, implementation and monitoring have been poor and many private sector nurses still receive much lower salaries.

Philippine nurse migration environment and global nursing shortage

Of all the health workers in the country, nurses have been the most impacted by migration attrition on account of global nursing shortages. Widely publicized shortages in the industrialized countries and other nations up to 2020 have stimulated a very high interest in nursing education investments as well as in nursing recruitment.

The top three countries of destination of Filipino nurses from 1992 to 2003 included Saudi Arabia, the United States and the United Kingdom, as shown in table 11 and figure 6. Other preferred destinations included the Libyan Arab Jamahiriya, United Arab Emirates, Ireland, Singapore, Kuwait, Qatar and Brunei (POEA, 2003). Saudi Arabia was consistently the top destination of many nurses during this period, accounting for a low of 38 per cent to a high of 85 per cent of all nurse deployment. The United States was dominant from 199 to 1996, even surpassing Saudi Arabia deployment numbers in 1995. After 1995, nurse deployment in the United States declined significantly, dropping to a low of 0.1 per cent of all deployment for 1998. The United Kingdom, on the other hand, was a major destination from 2001 to 2003, second only to Saudi Arabia in those years; but it even overtook Saudi Arabia as top destination in 2001, when deployment to the United Kingdom accounted for a high of 40 per cent of all Filipino nurse deployment. From 1992 to 2003, Saudi Arabia accounted for 57 per cent of all Filipino nurse deployment, while the United States and the United Kingdom garnered almost 14 per cent and 12 per cent of the Filipino nurse deployment market, respectively (table 12). Table 13 and figure 8 show that Filipino nurse deployment started to peak again at the beginning of 2000.

Traditional markets such as the Middle East still continue to demand high numbers of skilled nurse professionals. However, new markets such as Europe and Japan have started to loom on the horizon. Indeed, there were as much as 200 applications for new nursing programmes for the 2004-05 school year alone. Only 24 were approved for regular permits. Many nurse recruiters and review centres have expanded and are beginning to open franchise agreements because of the demand for their services.

Overseas employment of nursing staff started in the 1950s but has increased markedly, impacting the expansion of nurse supply. In the 1970s there were almost 40,000 registered nurses in the Philippines, but by the end of 1998 this total had increased to approximately 306,000 (Corcega et al, 2000).

The nursing education market has grown tremendously over the years. In the 1970s, there were only about 80 nursing programmes in the country. As of 2004, there were 329 known nursing schools in the Philippines with government permits, serving an estimated 80,000 students and turning out about 20,000 graduates a year. Of this number,

anywhere from 5,000 to 10,000 graduates take and pass the board exam (ICNLE, CHED-TCNE). The average Filipino nurse is young, 31.8 years of age (the youngest age-group is 21-25, comprising 18.4 per cent of registered nurses), female (95 per cent) and paid as little as P3,000.00 per month in private health-care organizations. In 1998, Philippine nurses, working both inside and outside the Philippines, totalled more than 177,000; 85 per cent (150,085) were working overseas. The remaining 15 per cent were in different parts of the Philippines.

Migration and the Philippine labour market

Before the 1970s, the movement of highly skilled Filipino professionals, though significant, was primarily a private arrangement between HRH workers and their placement institutions abroad. It was only during the mid-seventies, after the surge of demand for contract workers in the Middle East, that the Philippine government commenced institutionalized management of temporary contract worker migration through the creation of the POEA and the Overseas Workers Welfare Administration (OWWA). With an increase of 36,035 workers leaving on contract work in 1975 to 214,590 workers in 1980, there was a clear need for a mechanism to guarantee an orderly movement of workers and a recruitment procedure. The annual number of contract workers deployed, including the new hires and those renewing their contracts, rose to more than 791,000 by 1998 – covering practically all skill levels (Alburo and Abella, 2002).

In the 1960s and 70s, the economic growth in Europe drew Filipino migrants to work in the service sector as hotel workers, hospital workers and domestic helpers. Women migrant workers dominated the migrant flow, proceeding primarily to Italy. In the mid-1970s and the early 1980s Middle Eastern countries became prime destinations. In the 1970s, the United States, the United Kingdom and Japan were the top receiving countries of land-based Filipino workers. However, the destination of Filipino nurses has become more diversified in recent years. Aside from the United States and the Middle East as major destination areas, Asia and Europe, particularly Singapore, Hong Kong (China), Japan, Taiwan (China) and the United Kingdom, respectively, have become attractive recent destinations of Filipino nurses (POEA, 2001).

However, recent POEA records show that permanent migrants still show a preference for the United States across three categories of health workers including doctors, nurses and midwives, as seen in table 14. Medical technologists were reported to state a preference for Canada over the United States (POEA, 2003).

Dimensions of health worker migration

The movement of health workers is characterized both by temporary and permanent migration. There is an almost equal share between those who migrate on a permanent or temporary basis. But there are significant differences in location. Permanent migration is dominant in North America (United States and Canada) and Oceania (Australia), while the predominant temporary migration destination is mainly the Middle East and Asia.

The brain drain is a phenomenon of well-educated professionals who permanently migrate from developing to industrialized countries. Permanent migrants consisting of higher-skilled professionals are unlikely to return to their home country during their productive years and therefore entail a greater social loss to that country (Alburo and Abella, 2002). Factors contributing to the migration of professionals include: a colonial mentality; economic need; professional and career development; and the attraction of a better quality of life and a higher standard of living.

The Philippines holds the record for the dramatic increase in migration since the 1980s (only 36,035 workers – mostly professionals migrated in 1975), far outstripping

other countries in Asia. In 1997, the Philippines deployed 747,696 workers, compared to 210,000 from Bangladesh, 162,000 from Sri Lanka and 172,000 from Indonesia. Since then, it has continued to increase its overseas deployment which stood at 866,590 in 2001, with remittances progressively rising up to US$7 Billion with high unofficial estimates of US$12 billion (Tujan, 2002). The large share of predominantly female nurses and other health workers, as well as the mainly female domestic helpers and retail workers, have contributed significantly to these figures.

The global shortage of nurses is a recurring phenomenon that has stimulated massive temporary and permanent migration. An inadequate number of nurses in all sectors of health care poses a potential threat to the quality of health-care delivery. According to Cassidy (2001), a lack of qualified nursing staff results in the cancellation of elective surgeries, the closure of some hospital beds and a lengthening time to wait for treatment – all of which lead to a disruption of hospital services. The prevention of these adverse outcomes has been a potent driver in the worldwide recruitment of nurses.

The United Kingdom is one of the many countries trying to address national nursing shortages. The managers are proactive in trying to fill vacant positions through intensive recruitment open days, advertising campaigns and family-friendly practices. The Government of the United Kingdom has spent £1.2 million on national recruitment campaigns aimed at dispelling old-fashioned perceptions of nurses. But, since there are not enough home-grown nurses to meet demand, UK employers look abroad for the nurses they need. International recruitment is viewed by many employers as a short-term solution to the problem.

The Philippines is the biggest health service provider of overseas nurses globally. According to figures from the United Kingdom Central Council for Nursing, Midwifery and Health Visitors (UKCC) for 2000-01, the Philippines was the major source of nurses and midwives in the United Kingdom, with 3,396 registered for the first time. This increase in the number of Filipino nurses complements the data obtained from POEA. From January to June 2001, 2,683 nurse professionals (613 males and 2,070 females) were deployed to the United Kingdom, overtaking Saudi Arabia as a favourite destination for nurses for many years with only 2,242 nurses (210 males and 2,032 females).

The United Kingdom has been careful not to engage in “unethical recruitment” or practices that can harm other countries’ health-care systems. This is expressed in the “Code of Practice for NHS Employers” involved in international recruitment of health-care professionals (DOH, 2001). This Code of Practice promotes high standards in the recruitment and employment of health professionals from abroad. It provides guidelines on obtaining value for money in dealing with recruitment agencies, as well as recommendations about ethical recruitment and fair treatment of overseas nurses during the recruitment process and their employment in the United Kingdom. The Code further stipulates fair and open treatment and support to nurses in their jobs by means of necessary adaptation courses.

In recent years, the number of overseas-trained nurses or internationally recruited nurses entering the United Kingdom has increased markedly. Final figures for 2000-01 show an increase of 41 per cent of nurses and midwives trained overseas, but outside the Europe Union, registered with the UKCC (8,403), as compared with 5,945 in 1999-2000 and 3,621 in 1998-99 (Tujan, 2002). The major source of nurses and midwives was the Philippines with 3,396. This compares with 1,052 and 52 in the two previous years.

Surveys, conducted by the Royal College of Nursing (RCN) and some human resources and personnel centres in the United Kingdom, found out that low pay, insufficient resources, poor job prospects, low morale, stress, increased workloads and poor staffing were the underlying reasons affecting nurse recruitment, retention and turnover (Buchan, 2002).

Table 11. Deployment of Filipino nurses by country of destination, Philippines 1992-July 2003

Year	Saudi Arabia		United States		United Kingdom		Libyan Arab Jamahiriya		United Arab Emirates		Ireland		Singapore		Kuwait		Qatar		Brunei		Total
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	
1992	3 279	55.52	1 767	29.92	0	0.00	269	4.55	271	4.59	0	0.00	0	0.00	320	5.42	0	0.00	0	0.00	5 906
1993	4 202	59.17	1 987	27.98	0	0.00	721	10.15	47	0.66	0	0.00	0	0.00	139	1.96	0	0.00	6	0.08	7 102
1994	3 332	48.04	2 853	41.13	0	0.00	15	0.22	270	3.89	0	0.00	0	0.00	455	6.56	6	0.09	5	0.07	6 936
1995	3 249	42.93	3 690	48.75	1	0.01	380	5.02	94	1.24	0	0.00	79	1.04	59	0.78	10	0.13	7	0.09	7 569
1996	3071	63.57	270	5.59	0	0.00	809	16.75	137	2.84	0	0.00	264	5.46	269	5.57	6	0.12	5	0.10	4 831
1997	3 794	84.54	11	0.25	0	0.00	175	3.90	209	4.66	0	0.00	228	5.08	25	0.56	14	0.31	32	0.71	4 488
1998	4 098	83.23	5	0.10	63	1.28	89	1.81	279	5.67	0	0.00	224	4.55	143	2.90	21	0.43	2	0.04	4 924
1999	4 031	79.55	53	1.05	367	7.24	18	0.36	378	7.46	0	0.00	154	3.04	53	1.05	12	0.24	1	0.02	5 067
2000	4 386	77.60	91	1.61	295	5.22	17	0.30	305	5.40	126	2.23	292	5.17	133	2.35	7	0.12	0	0.00	5 652
2001	5 045	38.07	304	2.29	5 383	40.62	9	0.07	243	1.83	1 529	11.54	413	3.12	182	1.37	143	1.08	1	0.01	13 252
2002	5 704	49.47	320	2.78	3105	26.93	414	3.59	405	3.51	915	7.94	337	2.92	108	0.94	213	1.85	9	0.08	11 530
2003-July	3 405	63.08	117	2.17	1051	19.47	39	0.72	122	2.26	179	3.32	237	4.39	15	0.28	232	4.30	1	0.02	5 398

Source: Philippine Overseas Employment Administration (POEA), 2003.

Figure 6. Deployment of nurses by destination countries: 1992-July 2003

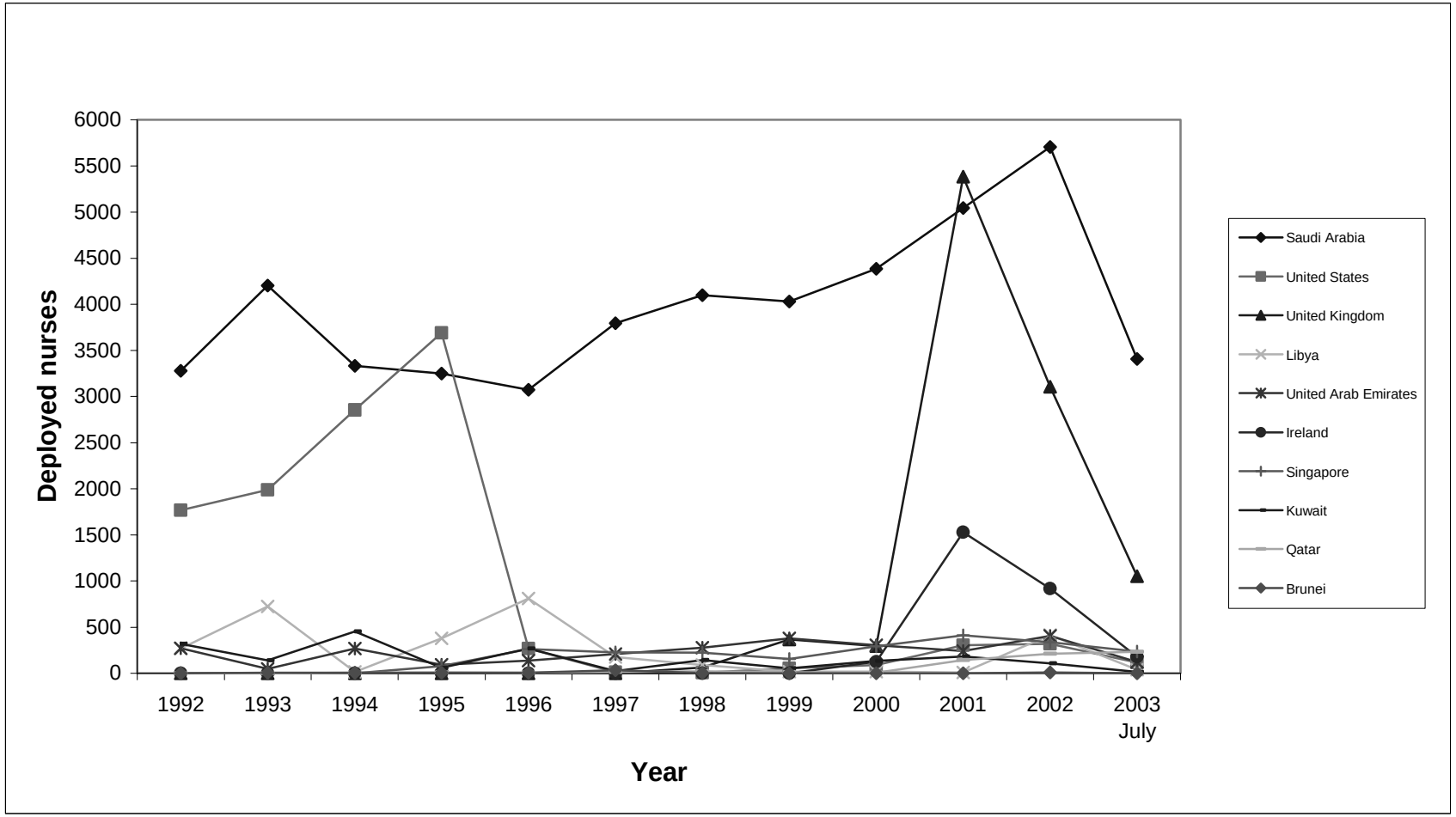


Table 12. Destination countries and percentage distribution of deployed Filipino nurses 1992-July 2003

Country of destination	Number	Percentage (%)
Saudi Arabia	47 596	57.58
United States	11 468	13.87
United Kingdom	10 265	12.42
Libyan Arab Jamaahiriya	2 955	3.58
United Arab Emirates	2 760	3.34
Ireland	2 749	3.33
Singapore	2 228	2.70
Kuwait	1 901	2.30
Qatar	664	0.80
Brunei	69	0.08
Total	**82 655**	**100.00**

Source: POEA, 2003

Figure 7. Destination countries and percentage distribution of deployed nurses: 1992-July 2003

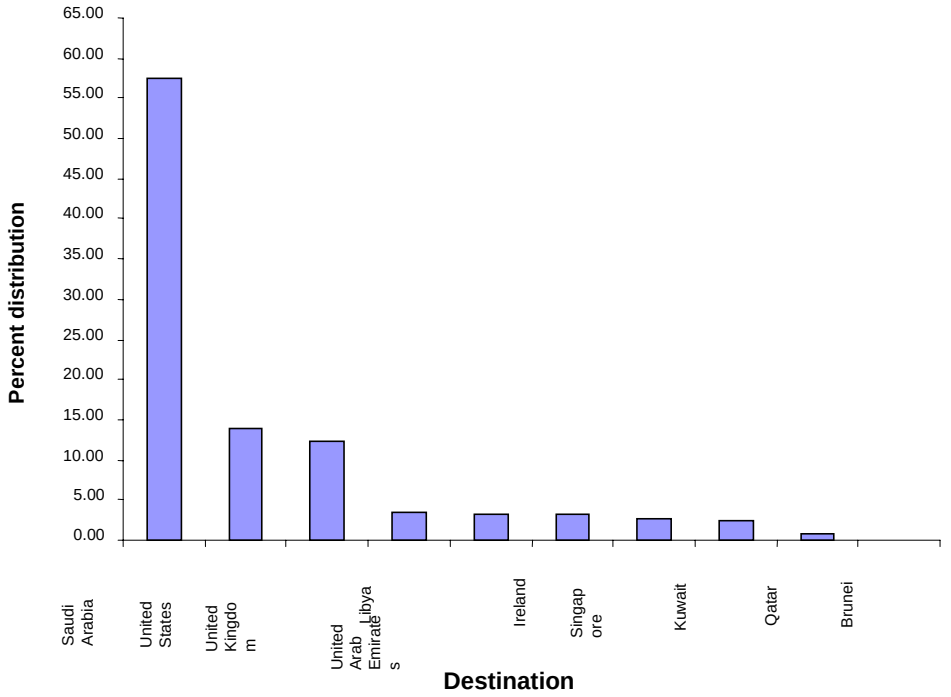
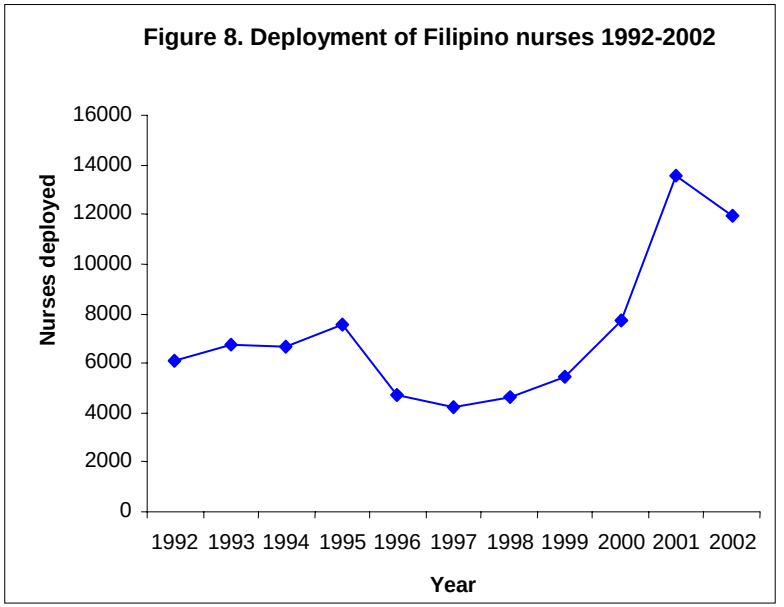


Table 13. Deployment of Filipino nurses 1992-July 2003

Year	No. of deployed nurses	
	Number	Percentage (%)
1992	6 078	7.67
1993	6 744	8.51
1994	6 699	8.46
1995	7 584	9.57
1996	4 734	5.98
1997	4 242	5.36
1998	4 591	5.80
1999	5 413	6.83
2000	7 683	9.70
2001	13 536	17.09
2002	11 911	15.04
Total	79 215	100

Source: POEA, 2003.



Massive health worker migration is due to a number of factors, among which the most important are: low salaries for health professionals in the Philippines, combined with a tremendous demand for health professionals abroad, especially for nurses and physical therapists.

This demand for labour in many developed countries has been exploited by labour recruitment agencies that charge fees for recruitment services to hospitals and other health institutions, as well as earn money from manning contracts.

The overall result is the rapid increase in the deployment of health professionals from developing countries that severely need health services, such as the Philippines and India, to man hospitals, nursing homes and similar institutions in the rich countries of the north – where they also sometimes work as domestic helpers or caregivers.

Health worker migration results in: a reduction of health manpower; a heavier workload for the remaining nurses; and a draining of skilled professionals from third world countries.

Health worker migration: Patterns, trends and policy implications

An international migrant is defined as a person who is to be engaged, is engaged or has been engaged in remunerated activity in a state of which he or she is not a national (Bach, 2003). The total number of international migrants is 175 million people (2.9 per cent of the world population), of which 48 per cent are women. Most of the world's migrants live in Europe (about 56 million), while Asia has 50 million and Northern America 41 million (Bach, 2003).

International migration should not divert attention from internal migration – i.e. migration from rural to urban areas. This form of migration and the impetus to recruit internationally are often interrelated because the authorities in many countries seek migrant labour to work in rural and remote geographic regions where shortages are most acute. There is also an increased awareness of the important role that gender plays in international migration, reflected in the increased proportion of women migrants. Women are more vulnerable to physical, sexual, and verbal abuse. Female migrants tend to be more reliable remitters, despite being deskilled in the positions they occupy.

In 1972, about 6 per cent of the world's physicians were located in countries other than those of which they were nationals. Significantly, approximately 86 per cent of all migrant physicians were found in five countries (Australia, Canada, Federal Republic of Germany, United Kingdom, and United States). This figure was estimated to be 5 per cent in the case of nurses, but the main recipient countries were the same as for physicians – with the exception of Australia (Mejia et al., 1979).

The Philippines as a source country

In the global exchange of health workers, the source countries have mostly been developing countries in Asia, Latin America or English-speaking Africa. However, the Philippines has a central role in the political economy of migration, with an estimated 7 million Filipinos working or living abroad; it has the largest source of registered nurses working overseas. The employment of nursing staff started slightly later than other categories of workers, but has increased markedly on account of the increase in the supply of nurses.

The benefits of health worker migration accruing to source countries include private advantages (enhanced quality of life and earning capacities of the health workers themselves) and substantial remittances that boost the country's GNP. Migration is also perceived as a safety net to provide alternatives to unemployment and underemployment in the source countries.

However, migration also has heavy social costs. Alburo and Abella (2002) pointed out that those who migrate are usually those with prior training, experience and qualifications. At the time of recruitment, they are usually gainfully employed and leave a skills void that may be difficult to replace right away. Recent studies show hard evidence that patient outcomes are compromised when there are nursing staffing shortages. Lowered nurse staffing can result in higher cross infection rates, adverse events after surgery, increased accident rates and patient injuries, and increased rates of violence against staff (Buchan, 2003). Observations in the Philippines show that the delay in and postponement of complex procedures such as heart transplants, dialysis and other surgeries are the result of a massive recruitment of trained and skilled nursing teams.

Destination countries

As previously mentioned, the Middle East continues to be the preferred destination of all temporary migrating Filipino health workers – although Asian countries like Singapore, Taiwan (China) and Japan are starting to match this demand. On the other hand, the dominant destination countries for permanent health worker migrants are the United States, Canada and Australia.

The United States, with its growing population, history of migration, and a health sector that has no parallel in terms of the scale of health expenditure, is expected to play a central role in the migration of health workers in the future. The country has a shortage of pharmacists and nursing staff, especially among registered nurses (RNs), and it has been estimated that a 6 per cent shortfall (110,000) out of a RN workforce of 1.89 million in 2000 could increase to a shortage of 800,000 RNs by 2020. At present only approximately 100,000 United States nurses have been trained abroad. Among physicians, graduates of foreign medical schools comprised 18 per cent of the workforce in the early 1970s, but this increased to 25 per cent by 2000 (Biviano and Makarehchi, 2002). Many Filipinos say that they prefer to work in the United States, and the United Kingdom is often their stepping stone to North America. Filipinos prefer to go to the United States because many have relatives there already.

The United Kingdom has historically been a major destination country for doctors and nurses. In 2002 over 200,000 doctors held provisional, full and limited registration. In terms of full registration, over half originated from doctors trained outside the United Kingdom. The data therefore indicate a high level of overseas trained doctors, especially from outside the European Economic Area. This situation is expected to continue as the DOH's global recruitment campaign for doctors gathers momentum.

Nevertheless, one aspect of this globalization of health labour markets is that historic ties are loosening as destination countries start to encourage migration primarily on the basis of economic requirements rather than historical or family connections. The reverse side of this process, as far as the source country is concerned, is the importance of countries like the Philippines that are encouraging overseas employment on a global basis – a strategy that is being emulated on a smaller scale by other Asian countries. A key question is whether migrants with few historical links to the destination country are more vulnerable to employment abuse and xenophobic attitudes.

Factors that affect the international migration of health workers

There are motivating factors – both from the destination and source countries – that stimulate health worker migration. Almost every first world country is scrambling to find and keep nurses because of the massive shortages they are experiencing. Consequently, nurses are being lured from poor countries to countries with relatively more money and better working conditions. The International Council of Nurses notes a shortage that spans the world, from Zambia to the Netherlands and beyond. Canada, for example, will need 10,000 nursing graduates by 2011. According to Matt Hamm, owner of Texas-owned Boles and Co., Canada is the quickest way to get to the United States – and nurses all seem to trickle through that trail. Hamm does not recruit from other countries because it takes too much time, money and red tape. But many recruiters eye Filipino nurses, who have their sights set on the United States (Coates, 2001).

Table 14. Number of registered Filipino health professionals prior to migration by major country of destination, 1988-2002

	1996	1997	1998	1999	2000	2001	2002	Total	%
Doctors									
United States	205	162	110	55	146	155	180	2956	80.83
Canada	20	24	12	8	11	17	15	393	10.75
Australia	4	3	4	2	1	4	8	197	5.39
Japan	0	1	0	0	0	1	0	7	0.19
Germany	1	0	0	0	0	0	0	3	0.08
United Kingdom	0	0	1	0	0	0	0	6	0.16
New Zealand	46	10	1	0	0	0	0	82	2.24
Others	0	1	0	0	0	2	1	13	0.36
								3 657	100.00
Nurses									
United States	365	318	226	306	1 075	1 381	2 057	13 567	84.14
Canada	88	65	49	41	98	141	127	1 566	9.71
Australia	16	24	26	15	34	39	37	612	3.80
Japan	4	5	1	1	5	2	6	46	0.29
Germany	2	11	9	3	3	3	3	73	0.45
United Kingdom	1	3	0	0	0	0	1	29	0.18
New Zealand	18	4	2	0	4	2	6	56	0.35
Others	11	8	7	4	11	7	12	175	1.09
								16 124	100.00
Professional midwife									
United States	49	43	64	25	13	35	29	682	62.28
Canada	4	11	5	5	2	3	3	109	9.95
Australia	3	7	4	4	1	2	3	98	8.95
Japan	2	2	7	3	2	6	0	46	4.20
Germany	2	4	11	2	5	7	1	61	5.57
United Kingdom	0	3	0	3	0	1	1	14	1.28
New Zealand	0	1	2	0	1	0	0	7	0.64

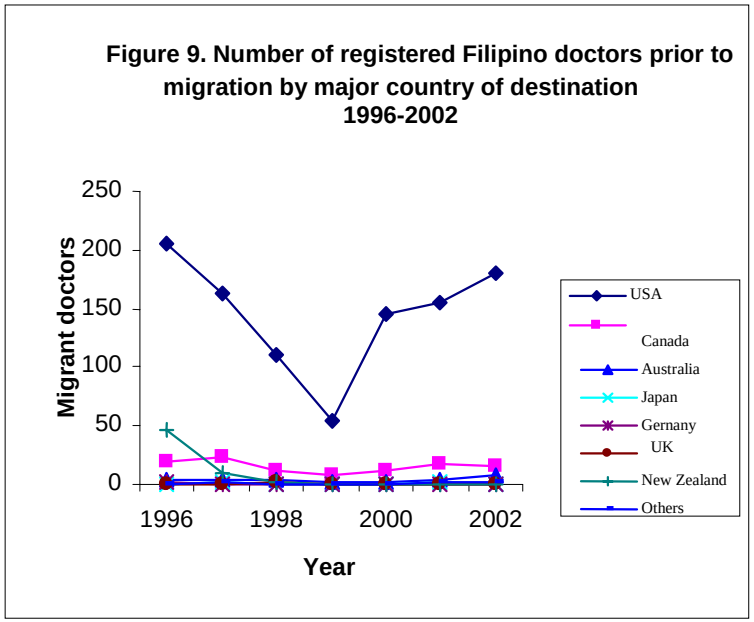
	1996	1997	1998	1999	2000	2001	2002	Total	%
Others	5	6	8	5	3	4	5	78	7.12
								1 095	100.00
Medical technologist									
United States	0	0	35	17	59	36	22	170	31.31
Canada	0	0	50	22	81	103	59	315	58.01
Australia	0	0	10	3	14	8	6	41	7.55
Japan	0	0	0	2	3	1	0	6	1.10
Germany	0	0	0	0	4	0	0	4	0.74
United Kingdom	0	0	0	0	0	0	0	0	0.00
New Zealand	0	0	1	1	0	0	1	3	0.55
Others	0	0	0	2	0	2	0	4	0.74
								543	100.00

Source: POEA, 2003.

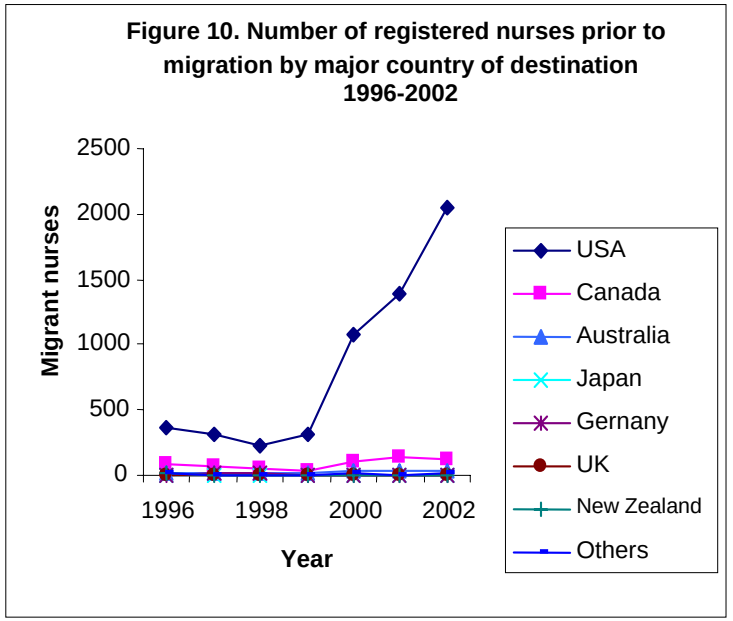
The Philippines educates more nurses than it needs. Many nurses work abroad and support families at home. Their economy is funded on money they send back which, in turn, raises some questions: Does it promote good health care in the Philippines? Is it ethical?

The Royal College of Nursing has stated that the reasons for shortages of nurses are remarkably similar wherever you look: poor wages, poor career prospects, no employer-friendly working conditions and a lack of respect for employees. In many poor countries, where there are few resources, nurses often leave the nursing profession and discourage others from joining because of the real risk of exposure, to hepatitis and HIV, without any protection (Buchan, 2002).

Experts note several areas that need attention: recruitment, retention, policy, education and the strain on current nurses. Solutions must be long-term, and salary is not the bottom line. Jeanna Bozell, RN, president of Professional Resource Group Inc., said her research shows that half of the top ten reasons why nurses leave their positions are related to supervision. “It’s not money.” she said. “Money was last on the list.” (Coates, 2002).

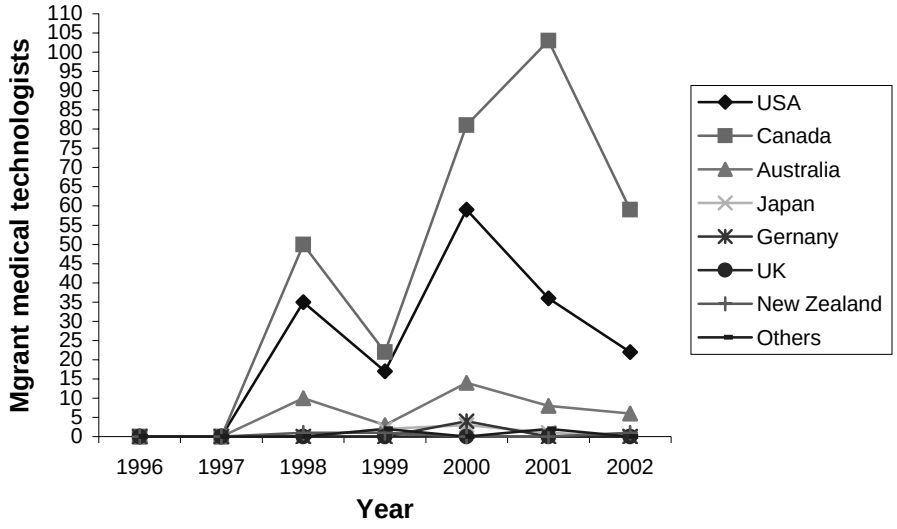


Source: POEA 2003.



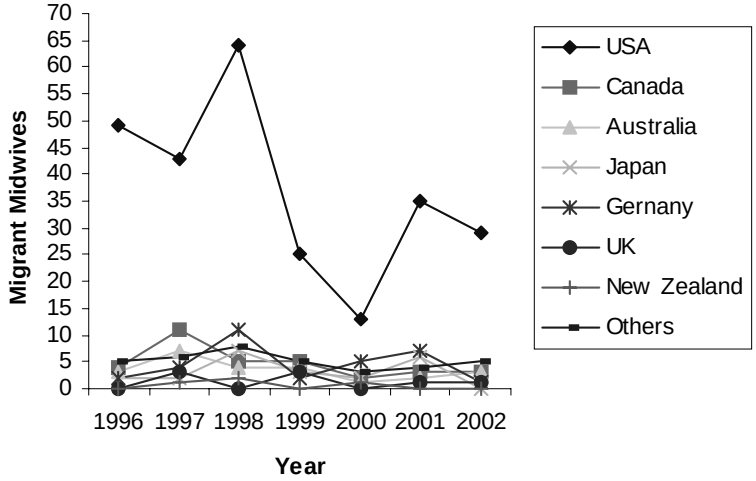
Source: POEA 2003.

Figure 11. Number of registered Filipino medical technologists prior to migration by major country of destination 1996-2002



Source: POEA 2003.

Figure 12. Number of Registered Filipino Midwives Prior to Migration by Major Country of Destination 1996-2002



Source: POEA 2003.

Socio-economic factors stimulating migration: Reasons for working abroad

Certain macro-level factors push Filipinos to find work abroad: high unemployment rates; low wages and per capita/GNP income; deteriorating economic conditions; scarcity of foreign exchange and institutional policies such as those stated in the overseas contract of the POEA. At the micro-level, factors might include personal and social factors such as a sense of adventure and family concerns – the family being the centre of a Filipino's life. However, not all motivations are financial in nature. It has been noted that women migrating do not always belong to the poorest of poor families in the respective labour exporting countries. They often wish to assert themselves and their freedom; escape from problems like strict parents, an uncaring husband or an unsuccessful marriage; and to enhance personal growth, experience adventure and face new challenges. The pull factors that encourage migration are the opportunity for professional and personal growth, the chance for better remuneration and the opportunity to travel. Push factors are the economy of the country which does not effectively absorb all nurses; income differential (the strongest factor influencing migration), as nurses' salaries of nurses are better abroad (like the United States); and the value of the salary increases when remitted to the Philippines (Dela Cuesta, 2002).

A position paper submitted to the Philippine Senate Committee on Health, the Alliance of Health Workers and the University of the Philippines College of Public Health, attributes the exodus of nurses to three structural reasons: the Government's labour exportation policy which includes skilled contract workers and health professionals; the aggressive recruitment strategies of local and international agencies; and the western orientation of nursing education which make Filipino graduates marketable to foreign countries (Ortin, 1994).

The working environment

In addition to the above-mentioned factors, a poor working environment may encourage individuals to seek employment abroad. An influence frequently cited in this context is the devastating toll reaped by the HIV/AIDS pandemic. Health professionals are also vulnerable to physical, verbal and other forms of abuse at work.

The migration decision is ultimately an individual one, but one that is influenced by the individual migrant's social and economic context. One of the clearest illustrations of these linkages occurs in the case of Filipino nurses as highlighted by the work of Rochelle Ball (1990). She demonstrates that the initial decision to become a nurse is often influenced by the knowledge that overseas opportunities exist, reinforced by encouragement from friends and family. This decision is shaped by the financial circumstances of the household with individuals attempting to maximize their attractiveness to overseas employers by careful selection of the hospitals and specialties in which they gain employment experience.

Impact and consequences of health worker migration

The receiving country benefits from migration as it provides much-needed labour when there is a scarcity of jobs. The country of origin of overseas workers relies on labour migration to ease employment and receives hard currency through remittances and benefits from new skills acquired by migrants abroad. Filipino overseas workers have been hailed the new heroes because of their huge contributions through remittances – in the millions each year – to make the economy stay afloat. However, the country of origin of the

migrants from the developing countries have become dependent on the national policies of the receiving country in the more developed countries and have not safeguarded the welfare of their own citizens/migrants.

The economic advantages derived from migration – new wealth, ideas, lifestyle, goods, attitudes and behaviour – have long been considered as the beneficial effects of migration. But the personal costs on the migrants themselves and their families have, at times, been unbearable (Dela Cuesta, 2002).

The negative impacts of migration on developing countries can be partially offset by the remittances of incomes earned abroad and the establishment of networks between migrants and their source country (OECD, 2002b). The new skills, knowledge and experience brought back by the migrants to their country of origin can also be imparted to others and help in developing and improving local services, thus potentially enhancing economic development.

Remittances are monies sent back home by the migrant workers, usually to family or friends, and constitute a potential advantage for source countries. This income can boost the local economy and accrue more value than the physical return of the individual to the labour force.

Migration can create international networks which can facilitate the exchange of information and expertise between migrant workers, their employers, and relevant organizations and professionals in the country of origin (Baptise-Meyer, 2001). These links can have a potential impact on economic growth in the source country.

However, migration can have multifarious negative effects on source countries. An excessive loss of domestic labour can lead to the "brain drain" of young, highly skilled labour, a depletion of the work force and a severe reduction in the availability and quality of services. If only less skilled workers remain in a country, this can lead to a reduction in productivity which might restrict economic development (Findalay and Lowel). Furthermore, a diminishing supply of workers in the source country may push wages up, putting added pressure on the economy (Baptise-Meyer, 2001).

It is recognized that in many health systems, health workers work in situations where they are underpaid, have inadequate resources to perform their functions, are struggling with heavy workloads and, in some cases, have to cope with the threat of violence. This may be the case in developing countries where health systems are under-resourced. In this situation, some workers will leave to go to other sectors, to other parts of the country or abroad, thus creating bigger challenges for those who remain.

In the Philippines focus group discussions (FGDs) with nurses, conducted by Lorenzo et al. in 2002, reported a number of economic, political, and professional factors that contributed to nurse supply/demand imbalances in the Philippines, and the subsequent decision to migrate. These included: a high general unemployment rate in the country; an overproduction of nurses that was not addressed adequately; decreased demand in the international market in the mid-1990s with no or very little increase in domestic demand; the non-enforcement of existing laws that controlled and monitored nursing supply and demand; the absence of comprehensive human resource planning in health; inadequate networking and collaboration among institutions and agencies responsible for the production and utilization of nursing human resources; a lack of emphasis on independent nursing practice; a perceived weakness of nursing leadership to advocate for nurses; an inability to influence decision-making and policy-making bodies; inadequate networking and collaboration between nurses; and a failure to shift from traditional roles to innovative and entrepreneurial roles.

Similar factors motivating nurses to work in Ireland, Norway and Australia were identified by Buchan, Parkin and Sochalski (2003). Respondents identified higher pay and opportunities for remittances, better working conditions, better resourced health systems, career opportunities, provision of post-basic education, political stability, travel opportunities and aid work.

But, while Filipino professionals who are taking chances to leave their families for employment abroad may have no other choice given the bleak economic conditions in the country, this phenomenon, according to the IBON Foundation, is likewise "deskilling" the country's human resources, even as many of them end up "deskilled" in their country of destination.

Impact on health systems in the source countries

In recent years, international migration, fuelled by many factors, has grown to such proportions that it is affecting the sustainability of health systems in some countries. While both developed and developing countries are experiencing the negative impact of loss of skills, such a loss is more keenly felt in developing countries, which are finding it increasingly difficult to compete for skilled human resources in the existing global market.

Concern is also rising about the shortage of skilled and experienced nurses in the Philippines. Most of the recent graduates who are still in the Philippines are relatively unskilled and inexperienced, and go overseas after a year or two of gaining experience. This poses serious implications for the quality of health care they provide.

Many of the difficulties confronting health workers in destination countries take the form of a heavy workload, staff shortages, stress and violence at work, gender and racial discrimination, as well as comparatively poor pay in relation to the workers' level of education. These factors apply to the local workforce as well as to migrant workers. It is not easy to distinguish between the influences of ethnicity, gender and the labour market and the fact that the worker is a migrant. The negative experiences identified by Buchan, Parkin and Sochalski (2003) included racism – from other staff or patients; an undervaluing of their qualifications (the RCN survey pointed out that one third of international nurses encountered this); and varying experiences with recruitment agencies.

Registration and licensing procedures in host countries are sources of potential problems. Before commencing employment, health professionals have to fulfil the appropriate registration and licensing requirements of the destination country. These licensing systems have a legitimate need to ensure that trained health workers meet the recipient countries' requirements so as not to jeopardize standards of patient care. At the same time they may act as a barrier to the employment of overseas trained health workers or hinder registration.

The Filipino Nurses Support Group in Canada has identified a range of barriers to licensing. A primary concern is the cost that can amount to 13,000 Canadian dollars. Many nurses coming to Canada are employed as licensed practical nurses (LPN) but are required to undertake further training to be fully registered. They are then caught in a difficult situation because Canada requires a student visa to access these programmes, which are costly.

Many countries include a language test as part of the certification process because it is essential that health professionals are able to communicate with patients. A distinction is often drawn between technical language competencies and communication skills. Testing for technical language skills may be necessary but not sufficient to gauge whether an individual can communicate effectively with patients.

Compensation and working conditions in destination countries may also undermine the welfare of migrant health workers. Many countries that rely on overseas health workers have traditionally used them to undertake low-skilled low-paid work that is unattractive to their own nationals. Discrimination in terms of pay and conditions is often only revealed when cases are taken to national employment tribunals or labour courts. In 1999 the United States Equal Employment Opportunity Commission (EEOC) decreed that US$2.1 million should be paid to 65 Filipino nurses who had been discriminated against by a nursing home in Missouri (Bach, 2003). Contrary to its pledge to pay the Filipino nurses the same wages as it paid US-registered nurses, it had paid them about US$6.00 an hour less and they were generally assigned to nursing aides jobs. Even those nurses who had ultimately been provided with registered nurse jobs were paid at lower rates than their United States counterparts.

Various forms of deskilling and under-utilization of skills have been documented. For some overseas health workers, the type of visa they are issued serves to limit their job options. According to Pratt (1999), Filipino domestic workers in Vancouver who are admitted to Canada work as nannies despite being university educated. They are required to work as live-in caregivers for two years before they can apply for an open visa but this experience serves to narrow their occupational opportunities. A common experience amongst overseas nurses has been the lack of recognition of their skills, leading to a feeling that their competence as a nurse was being questioned.

Migrant health workers often feel constrained in making complaints about their employment conditions because of their sense of vulnerability. They fear that employers will retaliate by dismissing them. Without a job they will not be able to pursue their claim and will have forfeited their right to remain in the country. The vulnerability of migrant health workers to exploitation is reflected also in the degree to which internationally recruited nurses, particularly in the private sector, report working undesirable shifts (i.e. weekends and evenings), with financial obligations and their precarious employment status forcing them to comply.

The consequences of health worker migration are highly variable. The first issue to consider is whether the education and training of health workers is funded by the state or by private funds. For example, in the Philippines, the nursing colleges are predominantly private establishments. Nonetheless, the state still provides the resources to fund primary and secondary education and loses the tax revenue that would have accrued from these earning streams in the Philippines. In many countries, there is a requirement for doctors to work in rural areas before being allowed to work in other parts of the country. Variants of these bonding schemes require graduates to work for the Government for approximately three years or to buy back the bond before they can work overseas.

A second issue relates to the employment situation within the source country and the degree to which health professionals would have been gainfully employed in their home country. A third issue concerns the consequences for those workers that remain as their colleagues depart for employment abroad. A fourth issue relates to whether these movements reflect a temporary or permanent shift in location. In a politically sensitive area like health services, destination countries are less vulnerable to the charge that they are depleting the human capital of source countries if international migration is a temporary phenomenon. In general, temporary migration is viewed positively as an opportunity for workers to develop new skills and competencies and to widen their experiences that can benefit the source country upon their return.

Finally, the health systems of source countries benefit indirectly from remittances. There are few studies of remittances specifically related to the health sector. It has been suggested that the remittances of a Filipino physician practicing overseas are sufficient to compensate for the associated economic losses of emigration.

Role of recruitment agencies

The role of recruitment agencies is a further issue to examine when taking into account the push and pull factors. They can either function as stimulators – i.e. they actively encourage nurses to migrate – or they act as intermediaries in the process of international recruitment, fulfilling a facilitative or supporting role (Buchan, Parkin and Sochalski, 2003).

Some agencies have been criticized for disseminating misleading information about pay and the employment situation in the destination country, and for charging large fees to enable nurses to move from one country to another. Some importer countries have tried to regulate this by establishing "preferred providers" which are lists of agencies that comply with ethical criteria.

In the Philippines, government agencies also act as third party intermediaries – especially to explore new markets and mechanisms to promote labour migration. The labour and health departments even institute mechanisms to enhance the country's capability to send "globally-competitive" health professionals abroad.

To make sure that the country meets the standards of foreign employers, TESDA has forged partnerships with countries such as Canada that seek to raise the quality of education of Filipino health workers, particularly the caregivers.

The high demand for caregivers and nurses in developing countries is also being exploited by labour recruitment agencies that charge fees for recruitment services to hospitals and other health-care institutions, including private employers. "They tie up with job placement agencies that proliferate in many sending countries in Asia to exploit the demand for jobs by charging placement fees for the unemployed and underemployed in such job-starved countries as the Philippines. This partnership is a phenomenon of globalization, an internationalization of contractual hiring, exploiting even cheaper migrant labor" (Tujan, 2002).

Policy influences on health worker migration

The multiple factors that explain why health worker migration persists and thrives may be key issues in policy development. For individuals, the possibility of increased earnings remains a major consideration in their decision to migrate – and this is a context within which state policies can foster or inhibit migration. Differentials in salary levels between source and destination countries are an important stimulus to migration. Articles on Filipino nurses routinely cite earnings figures of US$75-200 per month in the Philippines, compared to US$3,000-4,000 per month in the United States. The attractiveness of migration may also be influenced by differential tax regimes, providing an access point for policy intervention. The availability of employment opportunities within the source country has been identified as playing an important role in a worker's decision to migrate or not.

For highly skilled workers, continuous professional development is an integral component of individual career planning and progression. A survey undertaken by the International Council of Nurses examined the incentives and disincentives that encouraged nurse migration. Although the results may only be seen as indicative as response rates were low, the strongest incentive cited by respondents was the scope for learning opportunities. The absence of opportunities for professional development and promotion, in contrast to perceived opportunities abroad, reinforces the attractiveness of overseas employment.

By focusing on one level of analysis – the individual, – the push-pull model is in danger of downgrading the role of other institutions, including state and supra-national institutions, to generate and sustain international migration. It excludes variations in state policy that countries develop, which actively insert themselves into the global economy to promote overseas employment; these countries include source countries such as the Philippines or ,alternatively, destination countries such as Canada, the United Kingdom and the United States that actively seek to recruit health workers from overseas. Similarly, there is a danger that this model overlooks the poorly understood – but growing – role of private sector intermediaries in generating and sustaining demand for international migrants.

3. Cross-case analysis: Patterns of health worker migration in the Philippines

The primary data collected for this study was crafted into five case studies that set out to establish the magnitude and patterns of health worker migration and to explore the reasons why health workers decided to migrate or stay in the Philippines. These were developed to explore urban, rural and "rurban" trends. The urban areas included Cebu City and Manila; the rural areas Tagum City in Davao and Laoag in Ilocos Norte; and the "rurban" area Valenzuela City. The primary data collection was intended to validate findings from the literature review. It drew upon records review, as well as information gleaned from key informant interviews and focus group discussions among health workers in various settings, representatives of recruitment and review centres and administrators of government agencies involved in health worker migration.

The full versions of each case study is given as appendices 1-5 in book 2 because of space limitations in the main report. Data collected from Manila-based hospitals, government agencies and professional organizations are presented as supportive case studies to portray differences across professional practice sites.

Within each area, respondents were selected from one government hospital, one private hospital, one review centre and one recruitment centre, in order to identify varying sources and patterns of migration practices.

The case studies describe the respondents' perceptions of health worker migration which will be examined together with the information obtained from the review of literature and records review, in an attempt to derive patterns.

Respondent profile

A total of 271 respondents participated in the focus group discussions conducted by the study. While the study was initially designed to have a similar number of participants from each area, a majority came from urban areas – mainly because these areas had fuller health worker complements than the rural or "rurban" areas. About half of all respondents (136) had lived longest in urban areas, whereas 135 had mostly practised in rural areas (see table 15).

Results showed that about half of the 271 respondents from Manila, Valenzuela, Cebu, Ilocos and Davao had served in their respective institutions for more than ten years. They therefore had reliable knowledge of the situation in their areas, as evidenced by their length of working experience.

Among the active health worker practitioners who participated in the study, there were almost equal numbers of those who planned to migrate (121) as those who wanted to stay (124). However, of those who planned to leave, about half of the respondents (63) had plans of moving to another country within two years, while about a quarter (32) wanted to move out of the Philippines in three years and the smallest group (29) in five years.

Table 15. Health workers migration respondents profile, 2004

	Manila	Valenzuela	Cebu	Ilocos	Davao	Total	
Number of respondents	73	28	85	63	22	271	
%	26.9	10.3	31.3	23.2	8.1		
Years of service						Number	%
< 5 yrs	14	3	25	26	5	73	26.94
5-10 yrs	10	7	17	9	8	43	15.87
> 10 yrs	49	18	43	28	9	138	50.92
Current residence							
Rural	0	2	22	31	1	56	20.66
Urban	73	26	63	32	21	215	79.34
Lived longest							
Rural	33	19	24	55	4	135	49.82
Urban	40	9	61	8	18	136	50.18
Plans of migration							
No	45	22	25	29	0	121	44.65
Yes	26	6	55	34	3	124	45.76
Within:							
Two years	14	3	21	23	2	63	50.81
Three years	7	1	18	6	0	32	25.81
Five years	5	2	16	5	1	29	23.39
NR	2		5			7	

Profile of health worker migrants

Potential health worker migrants were perceived to be young (between the ages of 20 and 30 years), female, middle class, mostly with basic undergraduate education (figures 13-16). This profile particularly seemed to describe potential nursing and midwife migrants. Migrant physical and occupational therapists and medical technologists tended to share the same characteristics, except that there were more male therapists perceived to migrate than females. Physicians who migrated on the other hand were older when they left, usually between 31 and 40 years of age, male or female, middle class, and with residency or fellowship experience.

As may be seen in table 16, those leaving, especially nurses and doctors, were usually well-trained, skilled and experienced. Most nurses had training and specialization in operating room (OR) and intensive care unit (ICU) work. Physicians tended to be either community doctors, in internal medicine or in pathology when they left.

The nurses and doctors who migrated were especially well trained and experienced because of the specialties in which they were proficient at the time they migrated. Nurses were specialized in emergency room or operating room work, or in critical care in various

units such as the ICU or CCU. Doctors, however, tended to have backgrounds in community medicine, internal medicine, haematology, and paediatrics. The other health-care provider categories, such as midwives and dentists, were not usually trained in particular specialties. Only ten (12 per cent) of identified migrants among the respondents had no specialty training or experience, compared to 70 (88 per cent) who were considered a greater loss because of their specialties.

Furthermore, most of the respondents who left were skilled and experienced as most of them (74 or 93.6 per cent) had been in their positions for between one and ten years, with most of them serving in their respective institutions for about two years before they migrated.

Figure 13. Perceived age of potential health worker migrants

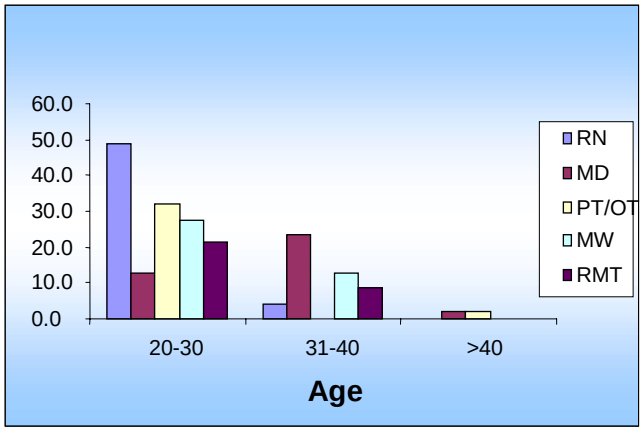


Figure 14. Perceived gender of potential health worker migrants

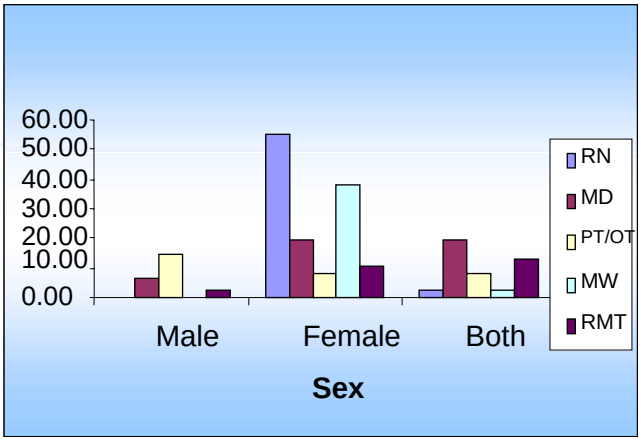


Figure 13. Perceived socio-economic status of potential health worker migrants

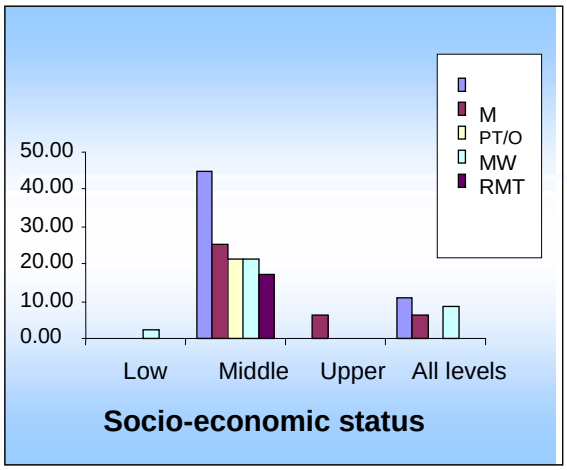


Figure 16. Perceived educational attainment of potential health worker migrants

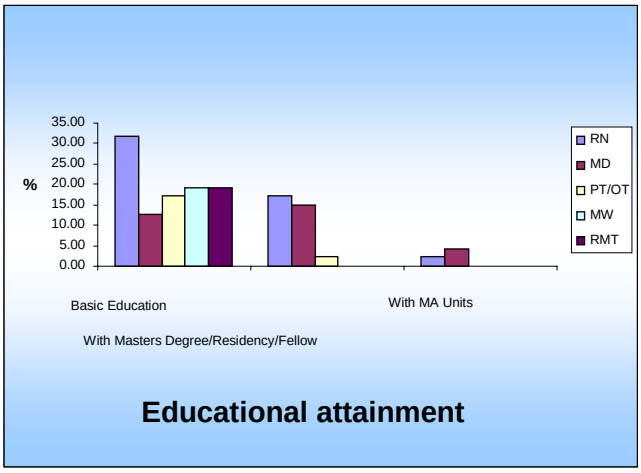


Table 16. Perceived specialty areas and years of service of health worker migrants across study areas

Specialty area	RN	MD	Total
Operating room	14	0	14
Emergency room	9	0	9
General practice	0	5	5
PDU	1	0	1
Internal medicine	1	3	4
Neonatal intensive care unit	2	0	2
Paediatrics	0	1	1
Obstetrics	0	1	1
EENT	0	1	1
Surgery	0	1	1
Intensive care unit	13	0	15*
Pathology	0	3	6**
Critical care unit	2	0	4***
Haematology	2	1	6****
No specialization	4	3	10*****

Years. of service in agency	RN	MD	PT/OT	MW	RMT	Total
1-10 years	22	13	12	15	12	74
11-20 years	2	2	0	1	0	5
21-30 years	0	0	0	0	0	0

* Total includes two midwives with specialization area in the ICU.

** Total includes three RMTs with specialization area in pathology.

*** Total includes two midwives with specialization area in CCU.

***** Total includes two midwives and one RMT.

Other professions were not included in table 16 because they were perceived to have limited or no specialty areas. Three medical technologists were specialized in pathology, while another had a specialization in microbiology. Two midwives specified that they were specialized in critical care (ICU). No particular specialization areas for physical and occupational therapists were identified.

Health worker positions: Manifestations of demand

This study attempts to establish the stock and distribution of health workers per study site and then document perceived patterns of internal and external migration in order to validate patterns discerned from the literature review. Data gathered show that government hospitals in the study areas provided more plantilla positions to health workers. Indeed, these positions accounted for at least 30-100 per cent of all health worker positions in those areas. As private hospitals are generally smaller, they have less positions for health workers. Many private hospitals do not provide for permanent positions for physical and occupational therapists.

There was a reported increase – although minimal – in government positions for doctors and nurses from 1998 to 2003. However positions for midwives, physical

therapists and medical technologists decreased during the same period. Formalized demand for nurses in the study areas topped available jobs for health worker groups with 12,168 positions, followed by positions for doctors that totalled 6,924. The smallest number of available positions was for physical therapists at 116, followed by medical technologists and midwives with only 910 and 1,044 positions, respectively.

Table 17, drawn from Department of Budget and Management (DBM) 2004 data, shows that a sizeable number of government health worker plantilla positions remained unfilled that year. The highest proportion of unfilled positions was observed among occupational therapists (42.3 per cent), physical therapists (8.6 per cent), doctors (8.2 per cent), and nurses (5.8 per cent). Although there were health worker shortfalls, this situation was brought about by rapid turnover and other administrative and political factors. In some other areas, casual or contractual personnel were employed instead of full-time career health workers, with local politicians acting as major decision-makers. The following year, 2005, the unfilled positions for doctors, nurses and medical technologists increased slightly, while the others remained the same or decreased slightly. The highest proportion of unfilled plantilla positions were precisely in those categories that are in great demand abroad. However, a further investigation needs to made into the very high number of unfilled positions for occupational therapists, as demand for this category of health worker abroad is not as high as that for nurses. This situation may be due to unattractive government compensation packages or to the fact that the positions available are in areas that do not entice health workers.

Table 17. Distribution of health worker positions in DOH-retained Government health facilities, 2004-05

Health worker categories	Subcategories	2004		2005	
		No. of positions	No. and % of unfilled positions	No. of positions	No. and % of unfilled positions
Dentists	Dentists	1 287	70 (5.4)	1 287	64 (5.0)
Doctors	Medical officers	3 983	373	3 984	366
	Medical specialists	1 663	89	1 664	157
	Medical specialists (part-time)	838	51	838	48
	Rural health physician	214	25	214	25
	Medico-legal officer	50	1	50	1
	Administrative health officer positions	174	28	174	26
	Total	6 922	567 (8.2)	6 924	623 (9.0)
Medical technologists	Medical technologists	970	25 (2.6)	970	26 (2.7)
Midwives	Midwives	1 044	47 (4.5)	1 044	46 (4.4)
Nurses	Public health nurses	3 687	62	3 687	72
	Nurse (hospital)	8 481	644	8 481	643
	Total	12 168	706 (5.8)	12 168	715 (5.9)
Occupational therapists	OT	58	16	58	16
	OT technicians	72	39	72	23
	Total	130	55 (42.3)	130	39 (30.0)
Physical therapists	PT	84	6	84	6
	PT technicians	32	4	32	4
	Total	116	10 (8.6)	116	10 (8.6)

Source: Department of Budget and Management, 2005.

Magnitude and patterns of health worker migration

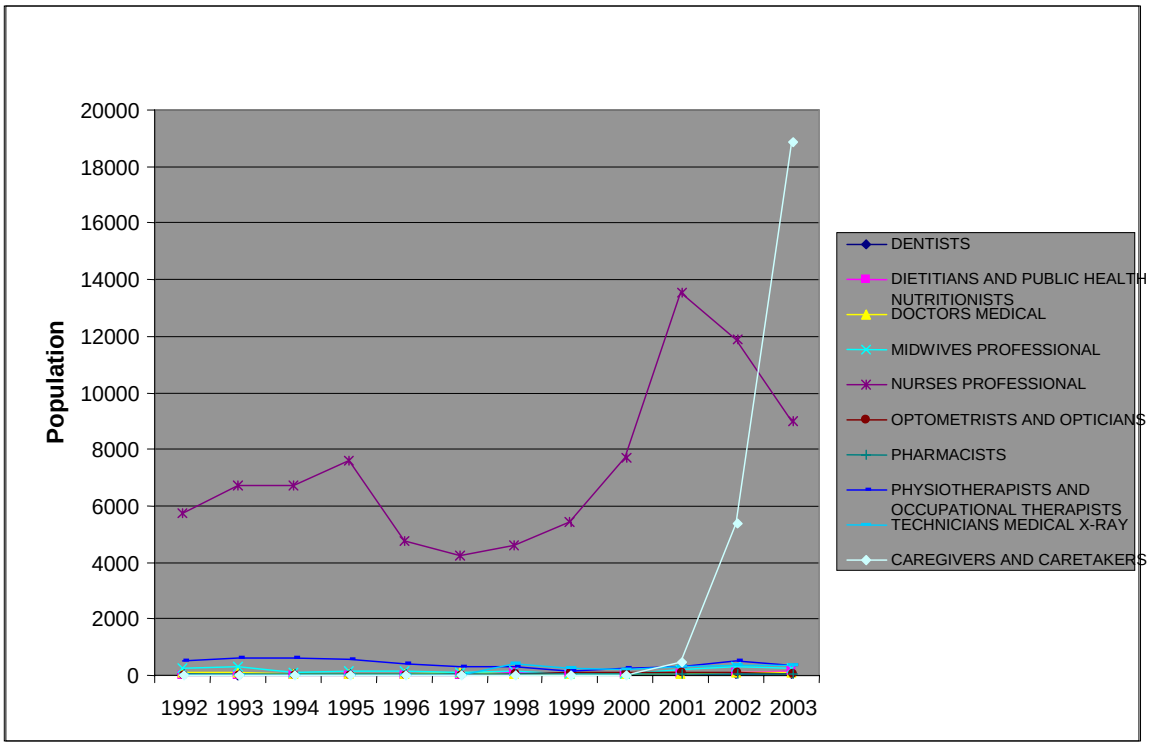
Since the late 1980s, there has been a steady increase in the number of health workers seeking employment abroad. Records from the Philippine Overseas Employment Administration (POEA) show that a growing number of nurses have been deployed overseas over the past few years. The outflow of Filipino nurses in the last decade started in 1993 and reached its peak in 2001.

Table 18. Deployment of health workers abroad, 1992-2003

Health worker category	Year											
	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Dentists	27	22	38	48	36	52	32	56	33	57	62	40
Dieticians and public health nutritionists	nd	nd	nd	nd	nd	nd	98	66	45	64	98	134
Doctors medical	86	91	57	69	47	82	55	59	27	61	129	112
Midwives professional	246	295	126	161	142	113	149	66	55	190	312	276
Nurses professional	5 747	6 744	6 699	7 584	4 734	4 242	4 591	5 413	7 683	13 536	11 867	8 968
Optometrists and opticians	nd	nd	nd	nd	nd	nd	68	96	80	83	123	58
Pharmacists	52	32	32	54	57	42	47	55	30	64	57	74
Physiotherapists and occupational therapists	542	608	645	581	426	289	317	147	235	330	517	371
Technicians medical X-ray	nd	nd	nd	nd	nd	nd	409	249	223	285	359	384
Caregivers and caretakers	nd	nd	nd	nd	nd	nd	nd	nd	nd	465	5 383	18 878

Note: Figure derived from POEA,CFO records, 2005.

Figure 17. Deployment of health workers abroad, 1992-2003



Note: Figure derived from POEA , CFO records, 2005.

As of July 2003, 5,628 nurses were deployed abroad, showing similar deployment figures registered in 2001 and 2002. There was a similar increasing trend of overseas deployment among other types of health professionals between 2000 and 2003, but at a much lower rate. The number of doctors, therapists, and midwives seeking employment abroad in 2001 was almost twice that of those who left in 2000. Records from the Commission on Filipinos Overseas show, in table 19, the number of registered Filipino emigrants by medical profession from 1996-2000 and the countries for which they were bound (the United States, Canada, Australia, Japan, Germany, United Kingdom and New Zealand, etc.). It can be noted that most of these health workers were nurses. In one year alone, 2002, the CFO registered 2,249 emigrant nurses – 78.5 per cent of the number of emigrant nurses for the period 1996-2000.

In 2004, the Philippines' deployment to the United States under the H1B and EB3 visas numbered 11,349 – of which around 70 per cent, or 7,944, were issued to nurses (United States Embassy, Manila 2005).

Records also show that the Philippines is losing an increasing number of health professionals to other countries, thus impacting the country's health professional to patient ratio. In certain hospitals, it has been observed that the ratio can be as bad as one nurse to 60 patients, given the increasing rate of migration of Filipino health

In order to discern how migration trends are perceived domestically, focus group discussion respondents in the five case study sites (Manila, Cebu, Ilocos, Valenzuela and Davao) were questioned about their insights on domestic and international migration among health professionals. Respondents were asked what percentage of health workers left their institutions for domestic or international migration. Responses were categorized into 1-30 per cent; 31-60 per cent; and 61-100 per cent – as low, moderate or high rates of turnover. Efforts to validate these findings with records review proved futile as most hospitals did not track turnover rates by profession and by year.

Little information was obtained in answer to queries about domestic migration. Most of the respondents felt that only very few left their institutions to look for work elsewhere in the Philippines. Those in the urban and "rurban" areas, i.e. Manila, Cebu and Valenzuela, indicated that there were slight numbers of health workers who left their institutions for other domestic work, while those in rural areas of Davao and Ilocos did not notice any internal migration. These findings were contrary to expectations that the rural areas would experience more internal migration. Reasons given for the movement away from urban institutions to other areas (including rural areas) consisted of: getting away from peace and order disturbances, traffic and other urban problems such as pollution – in other words, to improve quality of life.

On the other hand, responses on the issue of international migration showed that most health worker respondents recognized the departure of health workers to foreign lands. They noted that physicians left at moderate turnover rates (31-60 per cent), while nurses left at high turnover rates (61-100 per cent). Health professionals from all study areas perceived that a small number of doctors left the country. While responses from Metro Manila did not indicate the departure of a large number of nurses, responses from the provinces indicated higher proportions leaving the country (31-60 per cent). Though the perceived proportions were small, it is apparent that the respondents recognized the rising trend of health worker migration to other countries.

It is interesting to note that these responses corresponded with observed nurse turnover patterns in some Manila hospitals: 2001 and early 2002 turnover rates were as high as 40-50 per cent – but stabilized to 20-30 per cent in 2003 and 2004 (interviews with selected chief nurses, 2004).

Table 19. Number of registered Filipino emigrants by medical profession prior to migration by major country of destination: 1996-2000

Medical profession	United States	Canada	Australia	Japan	Germany	United Kingdom	New Zealand	Others	Total
Anaesthesiologist	3	0	0	0	0	0	0	0	3
Dentist	394	100	18	4	6	1	34	7	564
Dietician and nutritionist	39	38	6	1	0	0	4	0	88
Medical doctor	678	75	14	1	1	1	57	1	828
Medical technologist	112	153	27	5	4		2	2	305
Medical X-ray technician	18	12	1		0	0	0	0	31
Ophthalmologist	2	0	0	0	0	0	0	0	2
Optometrist and optician	63	14	4	2	1	0	0	0	84
Paediatrician	17	17	2	1	0	0	1	0	38
Pharmacist	137	142	7	1	0	1	15	6	309
Physical and occupational therapist	36	28	3	4	0	0	0	0	71
Physiotherapist	24	20	2	1	0	0	1	1	49
Professional midwife	180	26	18	20	29	7	4	26	310
Professional nurse	2 290	341	115	16	28	4	28	41	2 863
Psychiatrist	125	225	24	1		1	17	1	394
Veterinarian	37	24	5	2	1	1	7		77
Other medical and related workers	73	72	5	1	3	2	1	2	159
Total	4 228	1 287	251	60	73	18	171	87	6 175

Source: Commission on Filipinos Overseas , 2002.

Table 20. Number of registered Filipino emigrants by medical profession prior to migration by major country of destination, 2002

Medical profession	United States	Canada	Australia	Japan	Germany	United Kingdom	New Zealand	Others	Total
Cardiologist	0	1	0	0	0	0	0	0	1
Dentist	102	45	7	1	1	0	1	2	159
Dietician and nutritionist	5	6	0	0	0	0	0	0	11
Medical doctor	180	15	8	0	0	0	0	1	204
Medical technologist	22	59	6	0	0	0	1	0	88
Medical X-ray technician	18	31		1	0	0	0	1	51
Optometrist and optician	16	3	1	0	1	0	0	1	22
Paediatrician	1	0	0	0	0	0	0	0	1
Pharmacist	31	56	3	0	1	0	0	0	91
Physical and occupational therapist	35	25	8	0	0	0	0	0	68
Professional midwife	29	3	3	0	1	1	0	5	42
Professional nurse	2 057	127	37	6	3	1	6	12	2 249
Veterinarian	6	7	1	0	0	0	0	0	14
Other medical and related workers	81	77	5	0	0	0	1	1	165
Total	2 583	455	79	8	7	2	9	23	166

Source: Commission on Filipinos Overseas , 2002.

Drivers and impact of migration

Drivers of migration

The push factors for internal migration given by respondents from rural areas varied widely – from career-related factors to socio-economic factors. Career-related factors included: limited or no job opportunities; casual status in government service; no security of tenure; and restricted opportunities for training. Doctors especially complained about the few hospitals and limited practice. Together with nurses, they thought that the rural areas provided them with poor career prospects. Socio-economic factors consisted of: low pay; no incentives and benefits; greater exploitation; insecurity (with threat of being kidnapped); lack of good schools and universities for their children.

Pull factors were merely complements of the push factor – with the exception of better opportunities for advancement and finding a spouse.

In the case of external migration, the push factors also varied widely. Some of the factors cited were security concerns; the fact that health was not a government priority, as evidenced by demoralizing working conditions; and the failure to implement the Magna Carta of Public Health Workers. Pull factors for the professionals included: availability of immigrant visas (for doctors and nurses) and better working conditions, such as lower nurse patient ratios – and consequently lighter workloads. Potential benefits for family members comprised jobs abroad. It was felt they would provide better opportunities for family security, improve the family's financial situation and provide more opportunities for the family to migrate (table 21).

Table 21. Reasons for moving out of present jobs: Push and pull factors, 2004

	Push factors	Pull factors
Economic	Local: Low salaries; neither commensurate with cost of living nor to years of service	Local : Family, higher salary in Manila
	International: High salary, economic stability	International: Higher salaries and better benefits, fair compensation at work
Individual// family-related	Local: Seek partner in life	Local: Quality of life, social benefits
	International: Promotion and salary	International: Independence from family, to get away from a difficult relationship, family migration/citizenship, security for the children, opportunity to see places and meet new people from other cultures
Job-related	Local: Inadequate salary	Local: For the family's benefit
	International: Slow rate of promotion, overworked staff, anxiety over malpractice government plantilla.	International: Additional knowledge, better working conditions, quality of life
Socio-political and economic environment	Local:	Local:
	International: Need for a political back up to get a job, unstable government/ political situation	International: Availability of jobs, higher standard of living, motivation and support from relatives in United States

Impact of health worker migration

In any policy related transaction, there will always be gainers and losers. In an attempt to discern clear losers and gainers in health worker migration, respondents in focus group discussions (FDGs) were asked to state who they perceived benefited from health worker migration.

Results from the FGDs showed that individual migrants and their families were perceived to derive the most benefits from emigration, since it was possible to identify more positive than negative impacts of emigration (table 22). Among the positive impacts cited were:

(1) for the health worker – personal and professional development, including independence, development of professional skills and meeting other nationalities;

(2) for the health worker's family – higher income, implying better quality of life;

(3) for the profession – professional growth, as well as development and application of skills and technologies learned abroad upon return to the country;

(4) for the health-care system – health-care system is enhanced by upgraded skills of those who return;

(5) for the economy – remittances bolster domestic economy and reduce unemployment levels.

Table 22. Perceived impact of migration

	Positive effects	Negative effects
Individual and family	■ Personal and professional development-independence, development of professional skills, and meeting other nationalities ■ Family-increased income, implying better quality of life	■ Personal-homesickness which may lead to depression ■ Family-disruption in family relationships
Profession	■ Growth and development of the professional ■ When the worker comes back and applies/shares what she/he has learned	■ Depletion of the pool of skilled health workers ■ Depletion of medical capability ■ Inexperienced health workers who replace those who leave have nothing substantial to contribute to the profession ■ Demoralization of the non-doctors who take up nursing
Health-care system and quality of health care	■ Health care is enhanced ■ Availability of more aggressive staff replacements who are eager to learn	■ Continuity of programme/services is adversely affected ■ Quality of care is compromised ■ People in the community are deprived of health services ■ Improvement of the hospital is delayed when resources are used to train staff replacement
Economy	■ Economy improves with the remittances ■ Unemployment is reduced	■ Loss of government resources used in education and training ■ Resources are spent on training of staff replacements ■ Reduced government income of the province and country from taxes of health professionals

On the other hand, it seems that the health system, profession and society in general are the big losers. The following negative impacts were cited by respondents:

(1) For the individual migrant and family – the pervasive homesickness of the migrant worker, which may lead to depression, was considered a high risk. For the family, the disruption of family relationships was the trade-off for health workers leaving home.

(2) For the profession – the negative impacts identified included the depletion of the pool of skilled and experienced health workers, as well as of medical skills, that could have dire consequences for patients. Inexperienced health workers replacing those who left had less to contribute to the care of patients and the profession. Additionally, non-doctors who took up nursing indicated that they experienced demoralization.

(3) For the health-care system and quality of health care – the continuity of programmes/services was adversely affected; quality of care was compromised; people in the community were deprived of health services; improvement of hospital facilities and services were delayed when resources were used to train staff replacements.

(4) For the economy and society – the negative impacts included loss of government resources used in education and training; resources that could be used for facility improvements were spent on the training of staff replacements. There was also reduced government income for the provinces and country from taxes of health professionals.

Health policies and practices that affect health worker migration

In general, formal policies (public, social and institutional) and informal policies (standards-operating procedures, norms that affect Philippine human resources for health) will ultimately impact health worker migration in terms of whether or not they adequately provide the necessary conditions for retaining domestic health services providers.

Different levels of policies – at the local (provincial), national and international levels – may affect patterns and practices of health worker migration. These are further analysed below, with results from case studies to provide potential solutions.

Many of the human resource for health (HRH) development policies govern the scope and limits of practice of health professionals in the Philippines. They provide for the regulation of practice, professional training, the registration of new professionals – and sometimes compensation and working conditions. They ensure quality, competency and proficiency of health professionals through regulation of professional practice. However, these laws do not stipulate the production, utilization and continuing development of health professionals (Rebullida and Lorenzo, 2002).

The legislation embodies the nature and scope of health professional practice in the Philippines. The relevant laws and their recent revisions include:

– The Philippine Nursing Law RA 877, first enacted in 1953 and amended by RA 7164, the Philippine Nursing Act of 1991, and its revision, RA 9173 of 2002;

– The Medical Practice Act, RA 2382, that was enacted in 1959 and amended by RAs 4224 of 1965 and 5946 of 1969;

– The Philippine Midwifery Act, RA 2644, enacted in 1960 and amended by RA 7392 of 1992;

– The Philippine Dental Act of 1965, RA 4419;

– Philippine Medical Technology Act of 1969, RA 5527 as amended by RA 6132, PD 498 and PD 1534;

– Philippine Physical and Occupational Therapy Law of 1969, RA 5680;

– Philippine Pharmacy Law of 1969, RA 5921;

– Radiologic Technology Act of 1992, RA 7431;

– Revised Optometry Law of 1995, RA 8050, Optometry Law of 1917, amended by RA 1998 of 1957.

It should be noted that these Acts were adopted without consideration of rationalizing frameworks such as the National Health Plan, the National Objectives for Health (NOH), the Health Sector Reform Agenda or a national health human resource development plan. Most of these policies merely considered specific professional trends and the state of professional practice at the time of enactment.

Some health professional Acts have not evolved over the years to redefine the scope and nature of practice in a changing health environment. Currently, there are raging debates over definitions and scopes of practice as some professional disciplines seeking to update their practice Acts discover that their interests collide with those of other professions. For instance, physical and occupational therapists seeking to expand their scope of practice find that they have to negotiate with physiotherapists (a medical specialty group), while optometrists are in discussions with ophthalmologists over their proposed expansion of their scope of practice. These negotiations occur because career paths and frontiers of many health-care disciplines have remained static and narrow, thus contributing to the dissatisfaction of professionals who are exposed to new and more dynamic and expanded scopes of practice abroad during their basic training.

Policies that affect equity, working conditions and career path development

The Magna Carta for Public Health Workers of 1992 (RA No. 7305) was a pioneering piece of legislation that attempted to comprehensively address policy issues on quality of life and service, as well as to motivate health-care workers in order to retain them – especially in remote and poor rural and urban under-served areas.

This quintessential problem of the inequitable distribution of health workers in the Philippines has been attributed to the lack of: qualifications that restrict recruitment; opportunities for capacity- building and development; and incentives that restrict entry and retention of those qualified.

The essential provisions of this law, that aimed to increase the number of health workers deployed in under-served areas, made provision for: salaries, a hazard allowance, subsistence allowance, longevity pay, laundry allowance, remote assignment allowance, housing allowances and privileges, free medical examination, compensation of injuries, leave benefits and opportunities for development.

Many public health workers pinned their hopes on this policy but were disappointed. Instead of bringing about greater job satisfaction and consequently facilitating the retention of public health workers, implementation problems gave rise to wider health worker dissatisfaction and fuelled the increase of both domestic and international migration.

The Magna Carta for Public Health Workers was inadequately and inequitably implemented as it coincided with the devolution of public health services to the local

governments in 1995. The burden of implementation of the law was therefore transferred from the national government to local governments, who were then mandated to grant the benefits for which the law provided. While a number of poor local governments simply could not afford to pay these benefits, many showed no political will to enforce the law as they feared it might trigger compensation inequities across different categories of local government workers who had no comparable benefits. Hence because some provinces implemented the law while others did not, this led to a general dissatisfaction among those who did not enjoy the Magna Carta benefits – and they were mostly in poor remote under-served areas. Transfers from the municipal and provincial health system to the national health department offices or to the private sector occurred and inevitably ended in migration abroad. As a result many devolved health services deteriorated.

The Magna Carta law set out to provide benefits for a wide range of health and health-related workers who were defined as follows:

> "Health workers" shall mean all persons who are engaged in health and health-related work, and all persons employed in all hospitals, sanitaria, health infirmaries, health centers, rural health units, barangay health stations, clinics, and other health-related establishments owned and operated by the Government or its political subdivisions with original charters and shall include medical, allied and professional, administrative and support personnel employed regardless of their employment status (section 3).

The Barangay Health Workers Benefit and Incentives Act of 1995 (RA No, 7883) was a similar policy but affected only the benefits granted to barangay health workers (BHWs) – or voluntary village health workers. For primary health care, barangay health workers (BHWs) emerged as a new category of health-care worker that linked the formal health-care system to the communities through voluntary work. This law acknowledged the BHW's vital role and encouraged their recruitment and retention. It also provided for the standardization of benefits and incentives accorded by local governments.

The law provided for the following incentives and benefits: a hazard allowance, subsistence allowance, educational programmes with stepladder curricula, continuing education, study and exposure tours, grants, field immersions, scholarship benefits, special training programs, and civil service eligibility after five years of service, free legal services and preferential access to loans (section 6).

Like the Magna Carta, inequities arose from its implementation. However, because the BHWs were used to their volunteer status, not much dissatisfaction among BHWs was observed. Minimum benefits that were negotiated for widespread implementation included educational scholarships for the BHWs or their children and free health benefits.

Policies that provide employment and deployment opportunities for health providers through a national insurance system

The National Health Insurance Act of 1995 (RA No. 7875) does not directly govern health human resources. However, it impacts the deployment and employment of all health workers as it states that:

> … the State shall adopt an integrated and comprehensive approach to health development which shall endeavour to make essential goods, health and other social services available to all the people at affordable cost. Priority for the needs of the underprivileged, sick, elderly, disabled, women and children shall be recognized … (Article 1, section 2).

When all Filipinos become members of the national health insurance system (which is expected to be achieved in 2010), the requirements for health workers should increase –

thus assuring universal coverage of social health insurance benefits. If these requirements were to be converted into budgeted positions, this would lead to the hiring of more health workers into the system and might bring about an improvement in working conditions. This, in turn, might have a positive influence on health worker satisfaction and facilitate their retention.

Public policies that affect health worker migration

Identified public policies that impact health worker migration revolve around the labour and employment and trade sectors. These policies provide for the promotion, regulation and protection of migrant workers.

The Philippine government first adopted an international labour migration policy in 1974 as a temporary, stop-gap measure to ease domestic unemployment, poverty and a struggling financial system. The system has gradually been transformed into the institutionalized management of overseas emigration, culminating in 1995 in the *Migrant Workers and Overseas Filipinos Act (RA No. 8042)* which put in place policies for overseas employment and established a higher standard of protection and promotion of the welfare of migrant workers, their families and overseas Filipinos in distress (Soriano in OECD, 2004).

Currently, the Government, through the Department of Labor and Employment and its attached agencies, the POEA and OWWA, is actively exploring better employment opportunities and modes of engagement in overseas labour markets, as well as promoting the reintegration of migrants upon their return. Instruments developed to this end include: pre-departure orientation seminars on the laws, customs and practices of destination countries; model employment contracts ensuring that the prevailing market conditions are respected and protecting the welfare of overseas workers; a system of accreditation of foreign employers; the establishment of overseas labour offices (POLOs) that provide legal, medical and psycho-social assistance to Filipino overseas workers; a network of resource centres for the protection and promotion of workers' welfare and interests; and reintegration programmes that provide skills training and assist returning migrants to invest their remittances and develop entrepreneurship.

Current policy debates hinges upon two issues. First, how deregulation and liberalization will change the migration services of recruitment entities. Liberalization, envisaged in the 1995 Act, foresees that the migration of workers will eventually be a matter between the worker and his/her foreign employer.

A second issue revolves around whether or not the Government should shift its policy from "managing" the flow of overseas migration, which is reactive, to "promoting" labour migration, which is proactive. Such a shift would require including overseas Filipino workers in the national development agenda and the professionalization of the deployment and even the qualification of these overseas workers. The entire system of training, deploying and securing Filipinos in overseas workplaces would have to be revised accordingly.

Dialogue and convergence of efforts at all levels among all stakeholders (government entities, private sector, destination countries, sending countries and migrants) are crucial to ensure adequate protection and welfare services to migrants and to optimize the gains from overseas employment (Soriano in OECD, 2004).

Typology of national policies that may impact migration patterns

Human resources for health (HRH) policies and strategies at the national level are important that may significantly impact migration patterns. There are three major categories proposed by Egger et al., namely:

Rational utilization: Policies in this category seek to make more efficient use of available personnel, through geographic redistribution, the use of multi-skilled personnel, and closer matching of skills to function.

To address the severe shortage of health professionals in rural, isolated or peripheral areas, four types of strategies have been pursued:

(1) an older strategy, reflecting human resources development (HRD) trends in the 1970s, involved training low-level health workers en masse to provide basic preventive and curative services in rural areas;

(2) more recently, several countries decided to set-up or expand training of certain health professionals to substitute for doctors in underserved areas;

(3) foreign health workers continue to be recruited in some countries to fill critical gaps and as an interim strategy until these countries can produce sufficient numbers of national professionals over the long term.

(4) finally, a fourth strategy provides monetary and other incentives to health professionals located in rural areas, or requires a period of mandatory service in underserved areas by new graduates.

Rational production: Policies in this category seek to ensure that the number and types of health personnel produced are consistent with the needs of the country. Most of the strategies involve education and training. In many countries, the focus is on medical schools.

Public sector personnel compensation and management strategies: Policies and strategies in this third category are designed to improve the productivity and motivation of public sector health-care personnel (Egger, Lipson and Adams, 2002).

International policies that affect Philippine health worker migration

The *General Agreement on Trade in Services (GATS)* is a multilaterally agreed framework agreement for trade in services which applies to all 148 WTO Members. It aims to: (1) progressively liberalize trade in services through successive rounds of negotiations which should aim at promoting the interests of all Members of the WTO and achieving an overall balance of rights and obligations; (2) encourage economic growth and development through liberalization of trade in services, as the *General Agreement on Tariffs and Trade (GATT)* does through the liberalization of trade in goods; and (3) increase the participation of developing countries in world trade in services and expand their services exports by developing their export capacity and securing export opportunities in sectors of export interest to them (OECD, 2004).

The agreement has a wide scope and applies to all services supplied on a commercial basis. The agreement includes both rules and a framework for countries to make commitments to open particular service sectors to foreign suppliers. As a further tool for making market-opening commitments, the GATS also sets out four possible modes or

ways, in which services can be traded between WTO Members. Mode 4 covers an individual service supplier who moves temporarily to another WTO Member for purposes of supplying a service.

The movement of labour from a country can vary in several ways: length of stay, level of skills and nature of the contract. A person can move for one day or permanently; be relatively unskilled or be a specialist in a particular field; move as an independent professional or be transferred from company headquarters in one country to a branch office in another country. Generally, GATS Mode 4 is seen as covering:

(1) persons providing services when a foreign service supplier obtains a contract to supply services to the host country company and sends its employees to provide the services;

(2) independent service providers abroad: an individual selling services to a host country company or to an individual;

(3) persons employed abroad by foreign companies established in the host country (but excluding nationals of the host country).

Mode 4 encompasses natural persons providing services in any of the service sectors on a "temporary" or non-permanent basis. There is no standard definition of "temporary" in the GATS. For the purposes of specific commitments, WTO Members are free to interpret the term as they wish and to set varying definitions for different categories of service providers. However, permanent migration is explicitly excluded. While Mode 4 technically includes service suppliers at all skill levels, in practice WTO Members' commitments have been generally limited to the higher skilled-managers, executives, specialists – although these terms are generally not further defined.

While there is no single, clear definition of Mode 4, a useful approach might be to consider both duration and purpose of stay. That is, Mode 4 service suppliers:

– gain entry for a specific purpose (to fulfil a service contract a self-employed or an employee of a foreign service supplier);

– migration or asylum programs who can move between sectors);

– are temporary (i.e. they are neither migrating on a permanent basis nor seeking entry to the labour market).

GATS commitments are the guaranteed minimum treatment offered to other WTO Members; countries are always free to offer better treatment if they wish, but they cannot offer worse. Commitments are binding, i.e. they cannot be changed without paying compensation to other members. Commitments are also in accordance to MFN (most-favoured nation), i.e. the access offered is open to suppliers from all other WTO Members (a country cannot offer access to suppliers from some WTO Members and not others except for some exceptions). Commitments can be made for each sector or sub-sector and, within this, for each mode of supply. Alternatively, commitments can be made "horizontally" covering a single mode of supply across all sectors listed in the schedule. Most commitments for movement of service suppliers under Mode 4 are horizontal rather than sectoral, reflecting existing migration regimes (OECD, 2004).

For each service sector or sub-sector, and for each mode of supply within that, countries make commitments as to the level of "market access" and "national treatment" they will offer. Together, market access and national treatment commitments inform a foreign supplier about the access they will have to the WTO Member's market and any special conditions that will apply to them as foreigners.

Recruitment practices and ethical codes of practice

The Philippines is struggling to move towards managed migration. The POEA has a number of key functions which mirror many of the processes involved in international recruitment. They include: the marketing of Philippine workers to potential employers; countering illegal migration; the negotiation of agreements; the regulation of private sector recruitment agencies and the protection of Philippine workers by a variety of mechanisms including assessment of employers, inspection of employment contracts prior to departure, pre-departure orientation seminars and the gathering of information about working conditions overseas.

Among the destination countries, the United Kingdom has set an example by adopting a code of recruitment practice that promulgates the ethical recruitment of health workers from abroad. The international recruitment guiding principles include:

(1) international recruitment is a sound and legitimate contribution to the development of the NHS workforce;

(2) extensive opportunities exist within the NHS for individuals in terms of training and education and the enhancement of clinical skills;

(3) developing countries should not be targeted for recruitment;

(4) candidates will only be appointed who demonstrate a level of knowledge and effectiveness comparable to that expected of an individual in the United Kingdom;

(5) candidates will only be appointed who demonstrate a level of English-proficiency consistent with safe and skilled communication with patients, clients, careers and colleagues;

(6) staff legally recruited from abroad to work in the United Kingdom is protected by UK employment law in exactly the same way as all other employees;

(7) staff recruited from abroad will have the same support and access to further education, training and continuing professional development as all other employees.

The development of codes of practice serve a useful function in publicizing good practice for employers on issues such as induction and training. They also ensure a level of transparency about the requirements placed on employers. Voluntary codes of practice, however, are relatively weak regulatory mechanisms because they have no legal basis. The difficulty with codes of practice, which have similarities to the labour codes that some multinational companies have signed, is that of enforcement and monitoring.

The role of international standards and trade agreements

Interventions to manage migration can also occur at international level. There are a number of overlapping constituencies that have become more active in their consideration of health worker migration. Amongst the United Nations institutions, the ILO has a commitment to implementing basic labour standards and is promoting opportunities for decent and productive work.

Policy options

Five core elements for national policy on labour migration and related support measures:

(1) an informed and transparent labour migration admissions system designed to respond to measured, legitimate labour needs, taking into account domestic concerns as well;

(2) a standards-based approach to "migration management" protecting basic rights of all migrants and combating exploitation and trafficking;

(3) enforcement of minimum national employment conditions standards in all sectors of activity;

(4) a plan of action against discrimination and xenophobia to sustain social cohesion;

(5) iInstitutional mechanisms for consultation and coordination with social partners in policy elaboration and practical implementation.

Alternative policies that may be crafted include: policies for labour mobility – freedom to move – in regional integration areas; changing terms of aid, trade and international relations to facilitate development in more equal terms; creating specialized institutions for policy coordination, enforcement and monitoring; encouraging voluntary return and reintegration into countries of origin; combating trafficking and exploitation of migrants by organized crime; and gender-sensitive policies focusing on equal treatment and equal outcomes.

Regulation mechanisms and representation of social partners

A prerequisite for effective social dialogue is strong, independent and responsible social partners who recognize the legitimate roles and interests of each other, commit themselves to constructive engagement in agreed process of dialogue and deliver their side of negotiated outcomes (ILO, 2002).

Concerning the migration of health services workers

At the ILO Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness, held in October 2002, the following conclusions concerning the migration of health services workers were adopted (ILO, 2002)

The ILO should take action to:

(a) promote for health service workers respect for the principles and rights contained in the ILO Declaration on Fundamental Principles and Rights at Work;

(b) undertake a study on social and labour issues relating to the migration of health workers with input from the WHO and with a view to its possible contribution to the report to be prepared by the ILO on migrant workers for the 92nd Session (2004) of the International Labour Conference;

(c) call on the governments of all countries which host migrant health workers to ensure that they are entitled to the principles and rights contained in the ILO Declaration on Fundamental Principles and Rights at Work as well as access to education and health care;

(d) call on all governments and recruitment agencies which recruit workers from other countries, especially essential workers such as nurses, doctors and other health professionals, to commit themselves to ethical recruitment codes and principles, preferably bound in regulation or legislation;

(e) urge governments and social partners to establish information programs for intending emigrant health workers;

(f) bring to governments' attention the fact that health workers moving to another country on a temporary basis, as other migrant workers, have the right of freedom to emigrate and the right to return to their home country.

Current Philippine developments, future policy and programme directions

At present, health sciences programmes – especially nursing – are the most popular courses in the country. Many professionals, notably doctors, physical therapists, teachers and lawyers, make career shifts to nursing. However, they use nursing as a stepping stone to obtain other jobs or migrate abroad. As a result, many of the underserved areas in the Philippines have become more fragile as they lose not only nurses but other members of the health team as well. In the past, when doctors became scarce, nurses assumed the post of managers of rural health units and primary hospitals until new physicians were recruited. With the loss of both the nurses and physicians, many government district hospitals are undermanned and are in danger of closing, together with some private hospitals.

The trade and investment sector of the country is also showing interest in developing health services as a magnet for new revenues in their hospital tourism and medical zones initiatives. This is viewed as double-edged as it might provide acceptable mechanisms for retention but might also exacerbate the shortfalls if health human resources are considered to make up for balance-of-payments inequities.

The DOH has embarked upon an ambitious Human Resources for Health (HRH) Development Master Plan for 2005-30 that lays out long-term policy and programme strategies to manage migration, improve retention and establish career tracks and other management systems to ensure quality HRH for the Philippines in the long run. Moreover, a presidential executive order is being prepared to ensure integrated and unified government and private sector policy in HRH development.

At the national level, the Philippines has various executive departments that may implement significant measures to ensure that health worker migration is well managed. It is proposed that their functions be incorporated into a presidential executive order that will mandate their active roles in managing health worker migration:

Department of Foreign Affairs: The Department, through its home office or foreign posts, shall take priority action or make representation with the foreign authority concerned to protect the rights of migrant workers and other overseas Filipinos and to extend immediate assistance – including the repatriation of distressed or beleaguered migrant workers and other overseas Filipinos. It shall assist in the accurate documentation and tracking of all Filipino migrant workers wherever they might be.

Department of Labor and Employment: The Department shall see to it that labour and social welfare laws in the foreign countries are fairly applied to migrant workers and, whenever applicable, to other overseas Filipinos including the grant of legal assistance and the referral to proper medical centres or hospitals. It shall also coordinate the maintenance of an accurate database on Filipino migrant workers as a subset of the database of Philippine health workers.

Philippine Overseas Employment Administration (POEA): The POEA shall regulate private sector participation in the recruitment and overseas placement of workers by setting up a licensing and registration system. It shall also formulate and implement, in coordination with appropriate entities concerned, when necessary, a system for promoting and monitoring the overseas employment of Filipino workers taking into consideration their welfare and the domestic manpower requirements. It shall be responsible for organizing and creating data sets on health worker migration trends.

Overseas Workers Welfare Administration (OWWA): The welfare officer – or in his/her absence the coordinating officer – shall provide the Filipino migrant worker and his or her family with all the assistance they may need in the enforcement of contractual obligations by agencies or entities and/or by their principals. In the performance of this function, he/she shall make representation and may call on the agencies or entities concerned to conferences or conciliation meetings for the purpose of settling the complaints or problems raised.

The Government has special responsibilities with regards to professionals and highly skilled Filipinos abroad. In addition to encouraging them – especially those in the fields of science and technology – to participate in and contribute to national development, the Government should provide proper and adequate incentives and programmes to secure their services in priority development areas of the public and private sectors. A reintegration programme is needed for this purpose.

POEA programmes

The POEA has a number of key functions. It adopts policies and procedures, prepares and implements programmes to eradicate illegal recruitment activities such as, but not limited to the following:

(1) providing legal assistance to victims of illegal recruitment and related cases which are administrative or criminal in nature;

(2) prosecuting illegal recruiters;

(3) conducting special operations, such as the surveillance of persons and entities suspected to be engaged in illegal recruitment;

(4) carrying out information and education campaigns (Bach, 2003).

Philippine nursing sector initiatives

In an attempt to address the crisis of massive runaway nurse migration and its deleterious effects on the Philippine health services, the nursing sector formulated a strategic plan in 2001 that proposed initial strategies. These later became components of a still-evolving Philippine nursing development plan. A number of these strategies have been echoed by other health professionals in an attempt to address the issue of nurse migration. Finally, they have been incorporated into the DOH Human Resources for Health Development Plan contained in the 25-year HRH Master Plan covering 2005-30.

These strategies include:

(1) the institution of a national network on HRH, which would be a multi-sectoral body involved in health human resources development through policy review and programme development;

(2) the exploration of bilateral negotiations with destination countries for recruitment conditions that would benefit both sending and receiving countries. Through the bilateral negotiations the Philippines might devise compensatory mechanisms that

would be used to improve domestic postgraduate nursing training, upgrade nursing education and increase nurses' compensation and nursing scholarships. Alternatively, multilateral negotiations might be forged with the guidance of international agencies such as the ILO and WHO;

(3) the forging of north-south hospital-to-hospital partnerships so that local hospitals benefit from compensatory mechanisms for every nurse recruited from them. It is proposed that for each nurse recruited, the cost of post-graduate hospital training (estimated at US$1,000 for two years at 2002 prices) would be remitted to the hospital where the nurse had been recruited so that the hospital could use this amount to train the next tier of nurses who to staff the hospital;

(4) the introduction of a six-month leave period for hospital nurses hired by their foreign counterparts, during which they could return and train local hospital nurses. Health-care organizations should have returnee integration programmes developed in order to maximize the potentials of skills and knowledge transfer;

(5) the institution of the National Health Service Act (NHSA) that calls on graduates, especially from state-run nursing schools, to serve locally for a number of years equivalent to their years of study;

(6) the delegation of authority to health-related organizations, including the Philippine Hospital Association, Philhealth and nursing bodies such as the Board of Nursing and the Philippine Nurses' Association (PNA), to exercise police power to prevent domestic work-related exploitation; indeed, there are local hospitals that do not offer salaries to nurses in exchange for volunteerism and residency requirements;

(7) the pursuance of the active participation of the Philippines in international debates moderated by international agencies such as the WHO, ICN and ILO that have committed to address the global nursing shortage.

These strategies are also incorporated in a proposed executive order intended to facilitate their urgent implementation in order to ensure the competitiveness of the nursing sector and the health human resources sector in general.

Managed migration, an undertaking that will require inter-country collaboration, is a goal worth pursuing to ensure that both sending and receiving countries derive mutual benefit from the exchange. Ultimately this will benefit global health human resources and ensure quality of health-care services for all.

4. Conclusions and recommendations: Policy implications and future directions

The Philippines' health worker migration experience based on the results of this study, seems to be characterized by long-term or permanent migration rather than temporary migration. While the determination of net social benefits migration trends is imperative, it was not possible to accomplish a full benefit-cost analysis because of the lack of information. Hence a qualitative benefit-cost analysis is attempted in this report to provide the conclusions of the study.

This section summarizes health worker gains and losses, describes lessons learned from the Philippine experience thus far, and finally identifies policy and programme recommendations to ensure that health worker migration is mutually beneficial to both the Philippines and the destination countries.

Health worker migration gains and losses

Respondents in the case studies considered that migration was specifically beneficial as it improved the quality of life and secured the future of health-care migrants and their families. In the light of a weak economy that is unable provide sustainable employment to those in the productive age group, this is an important benefit. This is supported by the recent findings of a World Bank-commissioned paper:

> Overseas Filipinos work in dozens of foreign countries which experienced sudden (and heterogeneous) changes in exchange rates due to the 1997 Asian financial crisis. Appreciation of a migrant's currency against the Philippine peso leads to increases in household remittances received from overseas. The estimated elasticity of Philippine peso remittances with respect to the Philippine/foreign exchange rate is 0.60. In addition, these positive income shocks lead to enhanced human capital accumulation and entrepreneurship in origin households. Favorable migrant shocks lead to greater child schooling, reduced child labor, and increased educational expenditure in origin households. More favorable exchange rate shocks also raise hours worked in self-employment and lead to greater entry into relatively capital-intensive enterprises by migrants' origin households (Yang, 2005).

At the time of writing this report, the lack of data makes it impossible to estimate accurately the economic contribution of Philippine health worker migrants. However, it is widely recognized that health workers' contributions, especially those of nurses, make up a substantial proportion of the remittances of land-based Filipino migrants. It has also been acknowledged that health worker migrants' remittances do much to shore up a weak Philippine economy. More research needs to be conducted on the benefit-cost analysis of migration with a focus on the value of remittances. This research should break these remittances down by category to be able to determine the net social benefit of health worker migration.

Given that trade globalization has encouraged migration, it would be wise to determine potential gains. If a substantial number of migrants returned – at least temporarily – to apply their acquired skills and experiences to Philippine health-care organizational settings, this would represent a great technical gain. But this would require two major approaches: (i) temporary migration policies should be encouraged over permanent migration arrangements; and (ii) health worker migrants' reintegration and retention programmes should be established and sustained. The skills and knowledge transfer from the returning migrants to those who make up the current Philippine health-care workforce would also be valuable in upgrading the technical framework of health-care practice in the Philippines. The example of what has happened in India in information technology (IT) is a case in point. The Indian migrants in the United States were enticed to

return to their country and they went on to form the backbone of the blossoming IT sector that now allows them to compete globally.

The issue of losses from migration is being hotly debated at present. As a result of this study, the authors concluded that the societal losses seemed to be greater, especially in consideration of the greater good and the number of Filipinos who were adversely affected by the losses vis-à-vis the gains of the migrants and their families. For instance, the health-care system was more fragile as a result of rapid turnover and a permanent loss of skilled and experienced health workers; and while the value of remittances might seem to have been substantial enough to rescue a beleaguered economy in the last couple of years, the loss of national productivity due to illness that was not prevented and treated in a timely manner might have been greater. More widely recognized consequences were effects on the continuity of care and quality of services provided.

Moreover, unmanaged migration mitigated the ability of health-care professions to renew their ranks as even the educators and trainers were lost through migration. This was perceived by the researchers as the biggest threat of all as the inability to renew their ranks might eventually lead to a massive deterioration of the quality of health workers produced – and consequently health care throughout the country.

The disruption of the family and its possible consequences such as drug abuse among poorly supervised children, as well as incest or extramarital relationships caused by the absence of the migrant spouse, were social repercussions that could not be discounted. Any economic gains are likely be wiped out by social losses such as these.

National government losses might include inadequate funding for the development of the health system infrastructure because many of the available health resources are spent on the training of staff replacements. Government income from taxation in the provinces and country as a whole is also reduced because of the permanent migration of health professionals.

Lessons learned from the Philippine health worker migration experience

The Philippines is currently regarded as a model for health worker migration. This may be due to its current position as the leading source of nurses in the world; it supplies about 25 per cent of all overseas nurses to OECD countries. Moreover, it is perceived that the Philippines has deliberately embarked on a systematic national overseas deployment of nurses to gain competitive advantage and ensure government fiscal support. Some of these perceptions need to be clarified or corrected.

A number of best practices have been adopted with respect to support institutions and their policies. The *Migrant Workers and Overseas Filipinos Act (Republic Act 8042)* of 1995 was instituted to oversee the welfare of overseas Filipino workers (OFWs). While the country has no explicit policy to promote migration of Filipino workers, RA 8042 clearly specified procedures for recruitment, deployment, and welfare administration and established a higher standard of protection and promotion of the welfare of migrant workers, their families and overseas Filipinos in distress. Moreover, the creation of the POEA and the OWWA under the Act, both support institutions, stressed the importance of overseas workers and the country's recognition of the need to oversee their welfare.

Migration-related practices – particularly valued by departing health workers – include pre-departure seminars to prepare migrants both psychologically and physically for their big move. Orientation training on the new culture, practices and policies of destination countries is undertaken to ensure that migrant workers are well prepared to

cope with the changes they will have to face. Compliance in attending these seminars has waned over the years as coordination between government agencies requiring attendance and the agencies that provide the seminars has been weak. Many of the potential migrants are not informed about the holding of these seminars.

Other strategies adopted by health facilities to cope with rapid turnover include more systematized staff training and development to attract young graduate nurses into their institutions. They have also crafted career tracks to ensure higher satisfaction among those who are considering developing nursing careers in the Philippines. Some institutions have introduced changes into the workplace to improve working conditions – such as greater staff participation in decision-making and enhanced staff autonomy. They have further provided for "family friendly" arrangements such as family loans for children's tuition, flexi-hours that conform to children's school hours, etc. Other employers have also experimented with retention schemes such as the provision of generous annual bonuses for travel, cars, and housing to reward loyalty and productivity. Some of these innovations have shown promising results but needs to be institutionalized and sustained if they are to become effective in the long term.

It is recognized that a massive migration of one category of health workers, such as nurses, will affect other health workforce categories. In order to address this situation, the Philippines has embarked on a HRH Master Plan that will harmonize workforce planning and establish other health human resources management strategies covering such areas as: improved recruitment and retention; career planning; better compensation packages, etc.

Key issues

Health worker migration is – it is generally agreed – market-driven. In discussions with the business sector, this is considered a natural exchange of resources. The industrialized world has an excess of money but not enough human resources; the reverse is true in the developing countries. Sustainable solutions should therefore involve the business sector so that policy and programme development can be collaborative.

Another key issue refers to the lack of coherent government policies and programmes. There are some government offices, i.e. DOLE or POEA, that encourage and facilitate migration. On the other hand, other agencies such as the DOH exert efforts to curb migration due to its deleterious effects on the health system. National policies and programmes need to be synchronized with an overall national policy direction on health worker migration that is explicitly articulated.

Private sector players act separately and sometimes come into conflict with government policies and programmes. There are private stakeholders – such as schools, recruiters, review centres – that are "rent-seeking" and take advantage of the push factors to facilitate migration processes without regard for national goals or need. Given its size, measures by the private sector also need to be harmonized with national policies and action.

Recommendations

The policy and programme framework recommended by this study incorporates the major categories of national policies that may impact migration patterns – namely rational production and utilization, and public sector personnel compensation and management strategies. In addition bilateral and multilateral policies and negotiations utilizing social dialogue processes are recommended.

1. There is a need to ensure that government policies and programmes are brought together into a coherent health worker migration policy. The private sector should also be encouraged to participate actively in translating national policies into action. Similarly, the global policy framework should be taken into consideration to maximize the benefits of migration. An incentive structure should be designed to provide premiums for retention and repatriation programmes, in which recruiters and others might get involved.

2. Within the framework of the HRH Master Plan coordinated by the Department of Health, the following may be accomplished through synchronized strategies of national government agencies in migration management:

   (a) the setting up of a national network on human resources for health development, which would be a multi-sectoral body involved in health human resources development through policy review and programme development. This body could ensure and oversee the rational production and utilization of health human resources – including the redistribution of the existing workforce;

   (b) the exploration of bilateral negotiations and policies with destination countries to bring about recruitment conditions that would benefit both sending and receiving countries. Existing multilateral policies could be reviewed to determine ways to ensure effective implementation for the mutual benefit of sending and destination countries. Through bilateral negotiations, the Philippines might devise compensatory mechanisms to benefit the health organizations from which the health workers were recruited. These could be used to improve domestic postgraduate nursing training; upgrade nursing education; and increase nurses' compensation and nursing scholarships. Alternatively, multilateral negotiations might be forged with the guidance of international agencies such as the ILO and WHO;

   (c) national efforts should be exerted to attract migrants back to their home country and ensure that migration is predominantly temporary. Reintegration programs should be developed so that health workers with enhanced skills might apply what they have learned to enhance the performance of the health system. Given the value of migrants' contributions to the economy, their importance in national development is under-emphasized – if not ignored. At present, there is much political debate as to whether there should be national efforts to attract migrants back to their country and ensure that migration is temporary. Lessons could be drawn from India and other countries that deliberately enticed back migrants who had become experts in their various fields;

   (d) career-path development should be instituted, together with the requisite compensation mechanisms and conducive working environment. Domestic health careers should promote professionalism, minimize politicization and reward excellent performance;

3. Health-related organizations such as the Philippine Nurses' Association (PNA), Philippine Hospital Association (PHA), Philhealth, Philippine Medical Association (PMA), together with professional and regulatory bodies such as the Board of Nursing, should exercise police power to prevent domestic work-related exploitation since there are local hospitals that do not offer salaries to nurses in exchange for volunteerism and certification of experience in the hospital;

4. Orientation seminars for potential migrants could be expanded to include a short course in technical training and health-care system orientation to familiarize potential health-care migrants with the health-care systems in their destination countries. This

strategy might also shorten the migrants' period of adjustment. Negotiations with recruiting health-care organizations abroad could be explored to build in provisions for repatriation and temporary migration in the recruitment contracts;

5. The institution of the National Health Service Act (NHSA) would calls upon graduates, especially from state-run health science schools, to serve in the Philippines for a number of years equivalent to their years of study before they leave. This will prevent a mass exodus – that will ultimately undermine the health-care system;

6. It is vital to pursue the active participation of the Philippines in international debates moderated by international agencies such as the World Health Organization (WHO), the International Council of Churches (ICN) and the International Labour Organization (ILO), which have committed to address the global nursing shortage and health workforce exchange;

7. These health-care strategies might also be incorporated in an executive order, under discussion, to facilitate the urgent implementation of these programmes in order to ensure the global competitiveness of the health human resources sector in general.

8. Managed migration should be integrated with other domestic and international labour policies and programmes that would ultimately be instrumental in enabling Philippine health human resource development address the country's needs and help the Philippine health workforce meet the requirements of other nations. With clear priorities, human resources for health could be developed strategically and bring about an effective global exchange of mutual benefit to all.

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