

# HUMAN RESOURCES FOR HEALTH MIGRATION IN THE PHILIPPINES: A Case Study and Policy Directions

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## ***Table of Contents***

Table of Contents	2
Executive Summary	3
Introduction	4
Philippine Human Resource For Health Context	4
Philippine Health Care System Context	7
Critical Philippine Human Resource for Health Issues	8
Stock of Filipino Health Workers	8
Filipino Worker Migration Patterns	23
Benefits and Costs of Filipino Health Worker Migration	24
Case Study Results	25
<i>Patterns and trends of Philippine Health Worker Migration</i>	25
<i>Migration Policies and Practices that Affect Health Worker Migration</i>	27
<i>Current Philippine Developments , Future policy and Program directions</i>	36
Bibliography	39

## ***Executive Summary***

Massive health worker migration is due to a number of factors, mainly an effective combination of low salaries for health professionals in the Philippines and the tremendous demand for health professionals abroad, especially for nurses and physical therapists. The overall result is the rapid increase in the deployment of health professionals from developing countries which severely need health services such as the Philippines.

Potential health worker migrants were perceived to be young between the ages of 20 to 30, female, middle class, mostly with basic undergraduate education. Physicians who migrate are characterized to be older when they leave, usually between 31-40, male or female, middle class, and with residency or fellowship experience. Those who leave, especially nurses and doctors are perceived to be well trained, skilled and experienced because of their specializations.

It was found that push factors for migration are usually economic-related, job-related together with socio-political and economic environment-related factors. In addition to financial reasons, the country's deteriorating political situation was highlighted. The concern for the security of the children was a recurring theme in the discussion with all the groups that reflects their anxiety over the prevailing social situation.

Positive and negative effects of migration on the individual and family, health professions, health care system, and economy were identified. The *health professions* benefit when the worker comes back and shares what he/she learned. The negative effects include depletion of the pool of **skilled** health workers and medical capability/trained medical staff; replacement of those who leave with inexperienced health, and demoralization of the non-doctors who take up nursing. *Health care system* is enhanced when the health worker returnees transfer the technology. However, there are negative implications on the sustainability and quality of programs required by the community as well as on the functionality and effectiveness of health facilities in the delivery of health services. The *economy improves* with the remittances from workers abroad. Unemployment is reduced with the migration of health workers and provides job openings to those left behind. Negatively, government resources are used in the education/training of health workers in state universities and in government hospitals; *resources are spent on training* of staff replacements; and government income is reduced from taxes of health professionals.

In general, formal policies viz (public, social and institutional ) as well as informal policies viz (standard 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. In this study, different levels of policies affecting patterns and practices of health worker migration. are analyzed with the case studies to provide potential solutions.

## ***Introduction***

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

This paper aims to provide information on the migration of Filipino health workers and the impact it has on the individual migrant, his family, professions and specifically the health care system. Further it discusses policy initiatives that have been established to both ensure the country's competitiveness in the global labor market as well as strengthen its capability to strengthen its health care system.

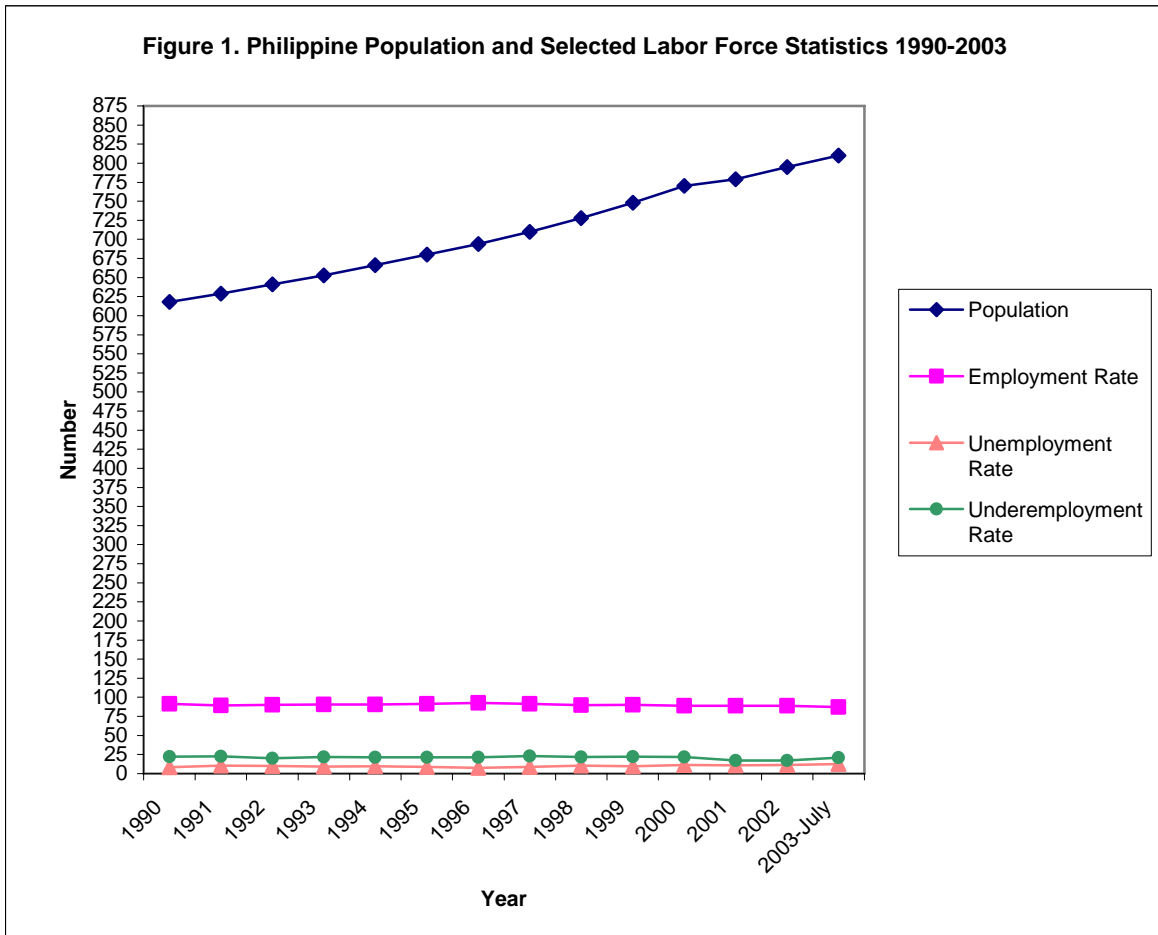
This paper utilizes data derived from records review including results of past Filipino health human resource studies including a country case study commissioned by the International Labor Organization (ILO) in 2004. It describes the Philippine Human Resource for Health (HRH) context; identifies three critical issues influencing HRH development in the Philippines; and focuses on migration in depth. Further, this report specifically 1) describes the motivations of health workers to migrate or to stay in the country; 2) discusses the impact of health worker migration on the country's health system, in terms of working conditions of remaining health workforce and health service provision; 3) analyzes existing migration policies and practices; and 4) identifies policies, strategies and practices for socially acceptable management of health worker migration.

The study utilized a descriptive analytic case study design. It used literature and records review, key informant interviews and focus group discussions for data collection. Responses from five cities--Manila, Cebu, Tagum and Valenzuela, and Laoag, representing urban, suburban and rural areas respectively, were included in the study. A total of 305 respondents from government and private hospitals, review and recruitment centers participated in the study. Information gathered from the interviews were transcribed, coded and then displayed in qualitative data matrices. Content analysis and pattern matching were used in the analysis of qualitative data. Quantitative data were analyzed using descriptive analysis. Triangulation with relevant trends and related findings in literature, records and interviews was accomplished to safeguard validity. While care was taken to have representative sampling of different socio-economic characteristics in several areas in the Philippines, only empirical health worker migration patterns within the study areas are reported and cannot therefore be generalized to represent the migration patterns in all areas of the Philippines.

## ***Philippine Human Resource For Health Context***

The Philippine's labor force was estimated in 2003 to be about 34.2 million or about 42% of the total number of Filipinos estimated at 82 million. Those who are part of the labor force comprise about 67% of all Filipinos of productive age. Of all those in service industry, about 8.83% are estimated to comprise health human resources (NSO,1997). From 2000 up to 2002, the unemployment rate was shown to be fairly stable at 11.2%, but increased to 12.7% in the first half of 2003 (BLES, 2003). Every year about 800,000

young people begin looking for work in a contracting and job-scarce economy (Business World, 2001).



<sup>a</sup> Population projections by NSO

Source: Philippine Population (National Statistics Office) and Selected Labor Force Statistics (2000 Yearbook of Labor Statistics and Current Labor Statistics, BLES, DOLE)

Note: Philippine Population in Millions expressed in 3 digit-values.

Even for many Filipinos who have jobs, the situation is not ideal. One out of every five employed workers is underemployed, that is, underpaid, working part-time or employed below his/her full potential. Underemployment has been fairly high at over 20% since 1987 up to 2000, rising again in 2003. It appears that the job opportunities have not increased correspondingly as population increases. At the same time, labor productivity has been stagnant over the past 12 years (1987-1999), growing by only six (6) percent per year on the average (Villalba, 2002). Philippine labor has not been as competitive as its counterparts in neighboring Malaysia and Thailand.

Deployment level increased in the number of overseas workers or international service providers from just 36,035 in 1975 to 841,438 in 2000. From 1995 to 2000, overseas

deployment continued to increase by 5.32% annually. Meanwhile, during the period 1995-2000, sea-based workers deployment of 198,134 was equivalent to 25% 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 have grown rapidly from a measly US \$290.85 million in 1978, to an all time high of US\$6.8 billion in 1999 (Francisco, \_\_\_\_\_).

Filipino overseas workers are considered international service providers. An international service provider is someone who: 1) has been sent by his/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, or 3) upon the request of his/her employer in the country of employment, engages in work that is transitory or brief for a restricted and definite period of time.

Many of the deployed Filipino overseas workers however are referred to as migrants regardless of their temporary or permanent residency status abroad. The Department of Foreign Affairs reports that there are about 7.2 million Filipino migrants all over the world. Of these about 40% or 2.96 million are documented workers, 26% or 1.9 million have been reported as undocumented workers while about 32% or 2.33 million are permanent residents in their destination countries (DFA, 1999).

Filipino labor migration was originally intended to serve as a temporary measure to ease the tight domestic labor market. Perceived benefits include stabilizing the country's balance-of-payments position, and serving as an alternative employment strategy for Filipinos. However, observations show that dependence on labor migration or international service provision, to address the problems of the domestic labor market has developed over the years.

Movement of health workers away from the Philippines either as migrant workers or merely as deployed overseas workers has been observed since the 1950s when the first group of exchange visitors' programs started with the United States. At that time, the objective of moving to another country was to get more advanced training and bring back the skills and learning to improve the quality of health services at home. After that, around the late 60's and 70's active recruitment to the Middle East and North America picked up. Those who went to Saudi Arabia and other Middle Eastern countries eventually all returned as specified by 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 like the US making recruitment offers more attractive and more permanent. The Philippines is now experiencing massive unmanaged migration of nurses and other health workers as a result of these changes.

## **Philippine Health Care System Context**

The nature of the Philippine health care system and its institutions influences the current state of health worker migration. Generally because of multifarious issues and problems, the system provides many push factors. An understanding of the system will assist one in analyzing what future policy and program implications there are that will provide potential solutions to the present migration issue.

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

With devolution of health services to the LGUs in 1990, the provincial and district hospitals have come under the jurisdiction of the provincial government while the municipal government now 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 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. This includes providing 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 1,700 hospitals in the country, about 60% are private. However, private hospitals and clinics are much smaller than the government facilities and quality varies widely. Non-government organizations (NGOs) also provide limited health services especially to marginalized, underserved groups.

Although the health care system is extensive, its access, especially by the poor, is hampered mainly by 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 those of our Southeast Asian neighbors.

### **Health Sector Reform**

The health status of Filipinos has been reported to have improved significantly over the past 50 years post World War II. However, in more recent years, the rates at which improvements have been realized have declined considerably. As an overall indicator of health status, infant mortality decline slowed down considerably 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 were observed to be 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. The triple burden of disease in these areas and in the whole country contribute to the need for health reforms as they continue to grapple with infectious disease control while dealing with increasing chronic diseases such as diseases of the heart and cancer as major causes of death. The third burden emanates from emerging and resurgent diseases such as SARS and drug resistant tuberculosis.

The ultimate goal of health sector reform is improved health status of all Filipinos. The Department of Health (DOH) has taken a 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 programs; 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 undertaking changes in five interrelated areas that affect the health sector namely: 1) Hospital reforms; 2) Local Health Systems Development; 3) Public Health Program Reforms; 4) Health Regulation Reforms and 5) Social Health Insurance Reforms (DOH, 1999, 2003). In all of these, it must be noted that attention to the development of human resources for health (HRH) has not been mentioned.

### ***Critical Philippine Human Resource for Health Issues***

A situational analysis of the current state of Philippine Human Resource for Health (HRH) revealed that a critical core problem was the lack of integrated HRH management systems in the country. This led to the perennial inequitable distribution of health personnel throughout the country. There were significantly more professional health workers in cities and other urban areas than in remote and impoverished places. Only midwives and village health workers were found to be in abundant numbers in the remote rural areas. While the Philippines produces a large number of health workers, their quality, competency and productivity were often doubtful. Many of the schools graduating HRH trained their students for export. This situation led to unmanaged migration of health workers.

This paper explores the issue of unmanaged migration of health workers in greater depth.

### ***Stock of Filipino Health Workers***

Historically, the Philippines has been shown to produce 9 major types of professional health workers in varying quantities. These include doctors, nurses, dentists, pharmacists, physical and occupational therapists, medical technologists, village (barangay) health workers, and other community health workers. The present stock of HRH is a result of production patterns that have changed over the years.

From the early 1900s to 1950 it can be gleaned that production patterns approximated 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 it has demand for. 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 magnitude of actual HRH graduates nor the actual need for health workers in the country.

Estimated production patterns in 2004 reveal that the most numerous health worker category produced are nurses and the category with the smallest number produced are occupational therapists. The estimated production trends are the following:

- Nurses (10,000/year) from 350 nursing colleges
- Doctors ( 2000/year) from 30 medical schools
- Midwives (1500/year) from 129 schools
- Dentist (2000/year) from 31 dental schools
- Pharmacists (1500/year) from 35 pharmacy colleges
- Physical Therapists (1000/year) from 95 PT/OT colleges
- Occupational (200/year) from 95 PT/OT colleges

(NSCB, 1997; PRC, 2004,CHED,2004)

The Philippines produces seven major types of professional health workers and in varying volumes. Table 1 cites these categories according to the recorded ever produced quantities since when the country started to produce these professionals, and estimated number employed by the government, private sector and those abroad. These health worker categories are: nurses, midwives, doctors, pharmacists, dentists, and physical and occupational therapists. Filipino nurses are the most numerous health worker category produced followed by midwives and doctors. On the other hand, pharmacists and physical and occupational therapists comprised the fewest health worker categories trained in the Philippines. Other newer categories produced since the 1980's include optometrists, caregivers, radiology and lab technicians. All in all there are 23 categories of HRH produced in the Philippines.

<b>Table 1. Distribution of Health Workers Produced in the Philippines, 1998</b>					
	<b>Government</b>	<b>Abroad</b>	<b>Private</b>	<b>Others</b>	<b>Total</b>
Nurses	9778	39174	nd	214959	263911
Dentists	1963	242	10513	18320	31038
Doctors	7671	495	18425	38546	65137
Pharma.	229	302	nd	28324	28855
Midwives	15893	1196	nd	103412	120501
MedTech	1560	2090	nd	27396	31046
OT/PT	76	3300	nd	2602	5978

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

<b>Table 2. Filipino Health Human Resources Working Abroad 1992-2003</b>													
	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	5788	6739	6853	7597	4698	4282	3217	5413	7683	13536	11867	8968	86641
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	2090
Midwives	246	295	126	161	142	113	113	66	55	190	312	276	2095
Ot/Pt	542	608	645	581	426	289	209	147	235	330	517	371	4900
<b>Year Total</b>	<b>7053</b>	<b>8116</b>	<b>8053</b>	<b>8780</b>	<b>5653</b>	<b>5203</b>	<b>3941</b>	<b>5796</b>	<b>8063</b>	<b>14238</b>	<b>12944</b>	<b>9841</b>	<b>97681</b>

Source: POEA,2004

<b>Table 3 Regional Distribution of Health Human Resources Employed in the Government Sector: Philippines 2002</b>				
<b>Health Human Resources in Government</b>				
<b>Region</b>	<b>Doctors</b>	<b>Dentists</b>	<b>Nurses</b>	<b>Midwives</b>
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
<b>CARAGA</b>	79	54	130	613
<b>Phil.</b>	<b>3021</b>	<b>1871</b>	<b>4720</b>	<b>16534</b>

SOURCE: 2004 Philippine Statistical Yearbook National Statistical Coordination Board

**Table 4. Urban-Rural Distribution of Health Human Resources Employed in the Government Sector: Philippines 1997**

	Health Human Resources in Government							
	Doctors	Dentists	Nurses	Medical Technologists	Midwives	Pharmacists	PT/OT*	BHW**
<b>Urban</b>	<b>3536 (47%)</b>	<b>901 (45%)</b>	<b>4067 (42%)</b>	<b>485</b>	<b>3762</b>	<b>126</b>	<b>60</b>	<b>28942</b>
NCR	2759 (36%)	640 (33%)	3094 (32%)	356 (23%)	1552 (10%)	117 (51%)	54 (71%)	4218 (2%)
Reg. 4	777 (11%)	261 (12%)	973 (10%)	129 (9%)	2210 (14%)	9 (4%)	6 (6%)	24724 (15%)
<b>Rural</b>	<b>4135 (53%)</b>	<b>1062 (55%)</b>	<b>5711 (58%)</b>	<b>1075 (68%)</b>	<b>12131 (76%)</b>	<b>103 (45%)</b>	<b>16 (23%)</b>	<b>140558 (83%)</b>
CAR	248 (3%)	50 (3%)	325 (3%)	48 (3%)	597 (4%)	6 (3%)	ND	5283 (3%)
Reg. 1	324 (4%)	94 (5%)	430 (4%)	34 (2%)	1026 (6%)	5 (2%)	1 (1%)	19068 (11%)
Reg. 2	246 (3%)	69 (4%)	417 (4%)	61 (4%)	866 (5%)	9 (4%)	1 (1%)	7870 (5%)
Reg. 3	497 (6%)	161 (7%)	626 (6%)	156 (11%)	1342 (8%)	7 (3%)	ND	9055 (5%)
Reg. 5	426 (6%)	81 (4%)	428 (4%)	132 (8%)	1012 (6%)	6 (3%)	4 (5%)	11222 (7%)
Reg. 6	454 (6%)	129 (7%)	696 (7%)	65 (4%)	1586 (10%)	11 (5%)	3 (4%)	21204 (13%)
Reg. 7	530 (7%)	115 (6%)	807 (8%)	161 (10%)	1391 (9%)	13 (6%)	2 (3%)	14910 (9%)
Reg. 8	291 (4%)	92 (5%)	371 (4%)	91 (6%)	821 (5%)	10 (4%)	2 (3%)	16307 (10%)
Reg. 9	231 (3%)	59 (3%)	368 (4%)	97 (6%)	748 (5%)	7 (3%)	1 (1%)	7132 (4%)
Reg. 10	216 (3%)	62 (3%)	362 (4%)	83 (5%)	759 (5%)	3 (1%)	1 (1%)	10991 (6%)
Reg. 11	320 (4%)	34 (2%)	315 (3%)	39 (3%)	348 (2%)	17 (7%)	3 (4%)	3707 (2%)
Reg. 12	187 (2%)	36 (2%)	270 (3%)	51 (3%)	625 (4%)	9 (4%)	ND	3693 (2%)
ARMM	89 (1%)	28 (1%)	149 (2%)	22 (1%)	402 (3%)	ND	ND	2244 (1%)
CARAGA	76 (1%)	52 (3%)	147 (2%)	35 (2%)	608 (4%)	ND	ND	7872 (5%)
<b>Phil.</b>	<b>7671 (100%)</b>	<b>1963 (100%)</b>	<b>9778 (100%)</b>	<b>1560</b>	<b>15893</b>	<b>229</b>	<b>76</b>	<b>169500</b>

Source: National Statistics Coordinating Board - FHSIS  
Department of Health - Personnel Office

**Table 5. Average Monthly Wage Rates of Private Medical and Other Health Professionals, 1997-2002**

	1997	1999	2002
<b>Medical Doctors</b>	8121	9813	12971
<b>Medical Technologists</b>	6168	6899	9898
<b>PTs/OTs/SPs</b>	5849	6633	9869
<b>Professional Nurses</b>	5849	6633	9869
<b>Professional Midwives</b>	5162	5817	9194

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

**Figure 2. Average Monthly Wage Rates of Private Medical and Other Health Professionals**

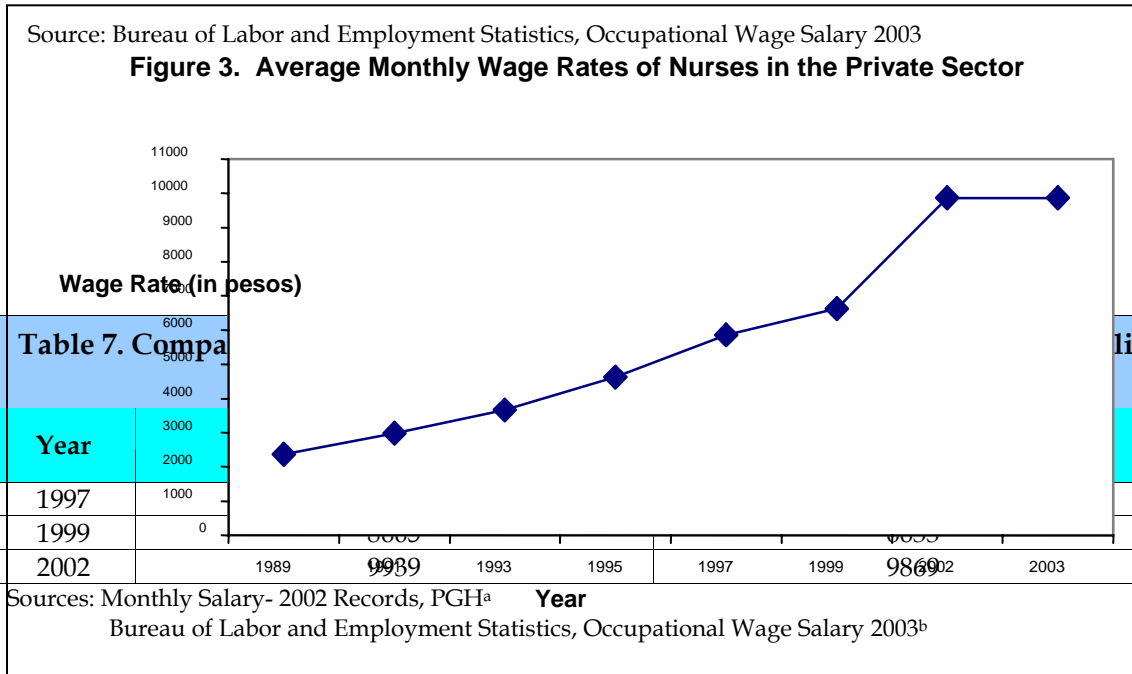
Source: Bureau of Labor and Employment Statistics, Occupational Wage Survey

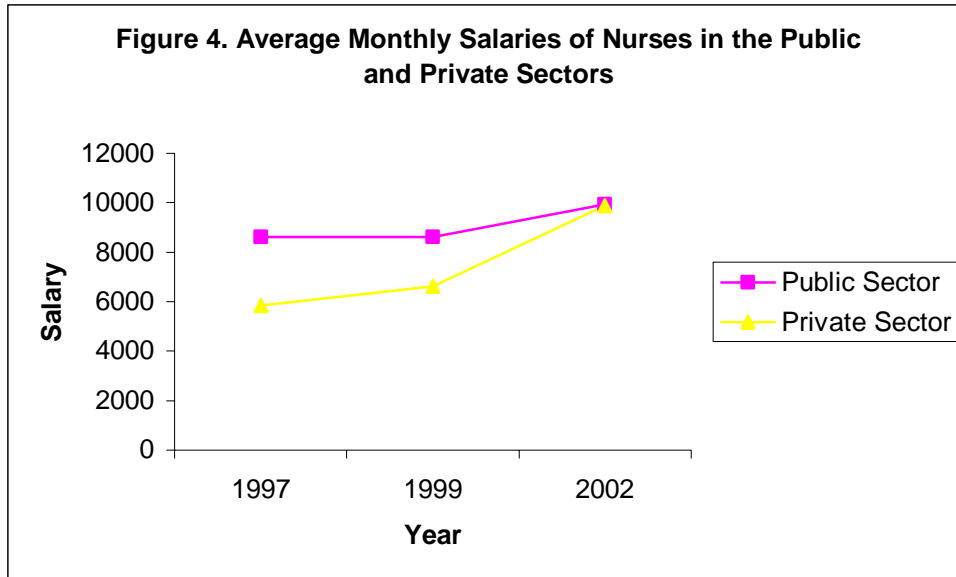


Table 6. Average Monthly Wage Rates of Nurses in the Private Sector (in pesos)	
Year	Nominal Wage
1989	2363
1990	2887
1991	2985
1992	3393
1993	3661
1995	4627
1996	nr
1997	5849
1998	nr
1999	6633
2000	nr
2001	nr
2002	9869
2003	9869

Note: nr-no records

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





Sources: Monthly Salary- 2002 Records, PGH<sup>a</sup>

Bureau of Labor and Employment Statistics, Occupational Wage Salary 2003<sup>b</sup>

Assuming that urban areas in the Philippines are limited to the NCR and region 4, Tables 3 and 4 show that medical technologists, midwives and barangay health workers mostly serve in the rural areas. Doctors, nurses and dentists have almost equal representation in urban and rural areas while the physical and occupational therapists are mostly located in the urban areas. However, there are urban areas in many regions such as in regions 7 and 10. From observation, one would note that health professionals in the Philippines usually gravitate around urban areas i.e. cities of rural areas.

There are clear inequities in the distribution of health human resources in the Philippines. Most of the professional workers are reported to be practicing in the urban areas. Only medical technologists, midwives and Barangay Health Workers are shown to be predominantly located in the rural areas. Moreover, other regions aside from the national capital region (NCR) that is Metro Manila and region 4, which are fast developing into the suburbs of Metro Manila, share very low percentages of professional health resources ranging from one per cent to a high of seven to eight per cent.

Demand for all categories of health professionals was not possible to measure systematically because of lack of recent and accurate information. Hence, data on nursing that the researchers have previously compiled are used to depict the patterns of demand and distribution. According to the DOH, in one decade (1991-2000) the Philippines had produced 337,939 registered nurses. This has been shown to be about 400 times the number the country was producing in the seventies. The nurses manning domestic health facilities were distributed in the following manner in 2000:

- 17,547 jobs are employed in various government agencies,
- 7,535 in privately run health facilities
- 2,078 in nursing educational institutions.

Corcega, Lorenzo and Yabes in 2001 estimated that demand for Filipino nurses consisted of 178,045 positions in local and international markets. Of these, 150,865 jobs or 84.75 percent are attributed to the international market while only 27,160 or 15.25 percent were demanded in the domestic market. Total demand was estimated based on known positions available in the domestic market and recorded deployment abroad.

Recent data from the POEA shows that from January to August 2002 alone, they deployed 7,855 nurses. This number is considered by POEA to represent an unusually high demand and can be explained by the fact that it was during 2000 and 2001 that the demand for nurses in the United Kingdom kicked in together with the deployment in the Netherlands and other European countries, and the United States. One must remember that this number is merely a fraction of the number deployed as most deployments are transacted by the private sector.

It is widely perceived that the magnitude of deployment abroad is largely due to unavailable nursing positions domestically. 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. One of the NGOs, Migrante International pointed out that if public nurses will be given positions in local government units, and these are divided by the total population and number of barangays, there can be substantial additional nurse positions added to the present demand. This will result to a more favorable nurse to population ratio of one nurse for every 16,723 Filipinos and approximately one nurse for every nine barangays (Opiniano, 2003). There were attempts to legislate this in the past but did not prosper.

Another reason for migration to other countries usually given for by health workers is the low and variable wage rates in the country which do not allow health workers to earn "decent living wages". Table 5 and figure 2 show that there are professional wage rates levels that have been maintained over the last five years. Average wage rates have risen during the period mainly because of governmental mandate. However, it is observed that 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 wage rates of the private and public sectors are exhibited in Tables 5-7 and figures 2-4. DOLE has attempted to close the gap by mandating upgraded salaries for nurses. However implementation and monitoring has been poor; hence, many private sector doctors and 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 most impacted by migration attrition largely due to global nursing shortages. Widely publicized shortages in first world countries and other nations up to 2020 have stimulated very high interest in nursing education investments as well as in nursing recruitment.

Overseas employment of nursing staff started in the 1950s but has increased markedly, impacting the expansion of nurse supply. In the 1970's 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, Lorenzo, Yabes, 2002).

The top three countries of destination of Filipino nurses for the last decade include Saudi Arabia, USA, and the United Kingdom as shown in Table 8 and Figure 5. Other preferred destinations include Libya, United Arab Emirates, Ireland, Singapore, Kuwait, Qatar and Brunei (POEA, 2003). It can be discerned that Saudi Arabia has been consistently the top destination of many nurses in the last decade accounting for a low of 38% to a high of 85% of all nurse deployment. The United States was dominant from 1992-1996 even surpassing Saudi Arabia deployment numbers in 1995. After 1995, nurse deployment in the US declined significantly dropping to a low of .1 percent of all deployment for 1998. The United Kingdom (UK) on the other hand has been a dominant destination from 2001 to 2003 second only to Saudi Arabia in those years but surpassing even Saudi Arabia as top destination in 2001 when deployment to the UK accounted for a high of 40% of all Filipino nurse deployment. Saudi Arabia accounts for 57 percent of all Filipino nurse deployment while the US and UK have garnered almost 14% and 12% of the Filipino nurse deployment market respectively as exhibited in table 9. Trends show that Filipino nurse deployment started to peak again beginning 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 in the horizon. Largely due to these, there were as much as 200 applications for new nursing programs for the school year 2004-2005 alone. Only 24 were approved for regular permits. Many nurse recruiters and review centers have expanded and are beginning to open franchise agreements because of the demand for their services.

The nursing education market has grown tremendously over the years. In the seventies, there were only about 80 nursing programs in the country. As of 2004, there are 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 will take and pass the board exam (ICNLE, CHED-TCNE). The average Filipino nurse is young, 31.8 years (the youngest age group is 21-25, comprising 18.4% of the RN population), female (95%) receiving as low as P3,000.00 per month in private health care organizations. As of 1998, Philippine nurses, working as nurses in and out of the Philippines are past the 177,000 mark, 85% (150,085) are estimated to be working overseas. The remaining 15% are employed in different parts of the Philippines (Corcega, Lorenzo, Yabes, 2002; Filipino Nurses Guide, 2002).

#### Migration and the Philippine Labor Market

Before the seventies, the movement of highly skilled Filipino professionals, though significant was principally a private initiative among the 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 OWWA. With 36,035 workers leaving on contract work in 1975 increasing to 214,590 workers in 1980, a need emerged for a mechanism to guarantee an orderly movement of workers and the process of recruiting them. The annual number of contract workers deployed including the new hires and those who are renewing their contracts had risen to more than 791,000 by 1998 covering practically all skill levels (Albuero and Abella,2002).

The Filipino migrant workers' destination areas in the 1960s and 1970s was Europe due to the economic growth which drew Filipino migrants to the service sector as hotel workers, hospital workers and domestic helpers. Women migrant workers dominated the migrant flow, proceeding primarily to Italy. Then in the mid-seventies and the early eighties, there was a concentration of Middle East countries as prime destinations. In the 1970s, US, UK and Japan were the top receiving countries of land-based Filipino workers. Destination of Filipino nurses diversified in the recent decade. Aside from the US and the Middle East as major destination areas, Asia and Europe particularly Singapore, Hong Kong, Japan Taiwan and UK respectively became attractive recent destinations of Filipino nurses (POEA, 2001).

However, recent POEA records show that permanent migrants still show preference for the US across three categories of health workers including doctors, nurses and midwives. Medical technologists were reported to show preference for Canada over the U.S (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 on permanent migration and those temporarily migrating. But there are significant differences in location. Permanent migration is dominant in North America (U.S. and Canada) and Oceania (Australia) while the predominant temporary migration destination is mainly the Middle East and Asia.

Brain drain is a phenomenon of well educated professionals permanently migrating from developing countries to industrialized ones. Permanent migrants consist of higher skill professionals, are unlikely to return during their productive years and therefore entail larger social losses to the country (Albuero,F and Abella, D, 2002). Factors attributed to the migration of the professionals include:

1. colonial mentality
2. economic need
3. professional and career development
4. attraction of a better quality life or a higher standard of living

The Philippines has a distinct record in the dramatic increase in migration since 1980's from only 36,035 mostly professionals in 1975. Now Filipino migrants far outstrip other countries in Asia. The Philippines deployed 747,696 in 1997 compared to 210,000 from

Bangladesh, 162,000 from Sri Lanka, or 172,000 from Indonesia. The Philippines has continued to increase its overseas deployment to 866,590 in 2001 with remittances progressively increasing up to \$7 Billion with high unofficial estimates of \$12 Billion (Tujan,\_\_\_\_). A significant contributor to this is the large share of predominantly female nurses and other health workers, as well as the predominantly female domestic helpers and retail workers.

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

The UK is one of the many countries worldwide trying to address national nursing shortages. The managers are proactive in trying to fill vacant positions through intensive recruitment open days, advertising campaign and family-friendly practices. The UK government spent £1.2 million on national recruitment campaign aimed at dispelling old-fashioned perception of nurses. But since homegrown nurses are not enough to fill vacant position, UK employers seek abroad for the nurses they need. International recruitment has been seen by many employers as a short-term solution to nurse recruitment problem.

The Philippines is the biggest health service provider of overseas nurses globally. According to UKCC figures for 2000-2001 (UKCC, 2001e), the Philippines is the major source of nurses and midwives in UK with 3,396 registered for the first time. This increase in the number of Filipino nurses complements the data obtained from POEA. For the period of January to June 2001, 2,683 nurse professionals (613 males and 2,070 females) were deployed to the UK topping Saudi Arabia as a favorite destination for nurses for many years with only 2,242 nurses (210 males and 2032 females).

UK 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 that has been published (DOH, 2001). This code of practice promotes high standards in the recruitment and employment of health professionals from abroad. This code provides guidelines on obtaining value for money in dealing with recruitment agencies, recommendations about ethical recruitment and fair treatment of overseas nurses during the recruitment process and employment in the UK. The code further provides fair and open treatment and full support to nurses during necessary adaptation courses and throughout their employment.

In recent years, the number of overseas-trained nurses or internationally recruited nurses entering the UK has increased markedly. Final figures for 2000-2001 show an increase of 41% where 8,403 nurses and midwives who trained overseas but outside the Europe Union registered with the United Kingdom Central Council for Nursing, Midwifery and Health Visitors (UKCC) as compared with 5,945 in 1999-2000 and 3,621 in 1998-1999

(Tujan, \_\_\_\_). 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 RCN and some human resources and personnel centers in the UK, found out that low pay, insufficient resources, poor job prospect, low morale, stress, increase work loads and poor staffing were the underlying reasons affecting nurse recruitment, retention and turn-over (Buchan,2002).

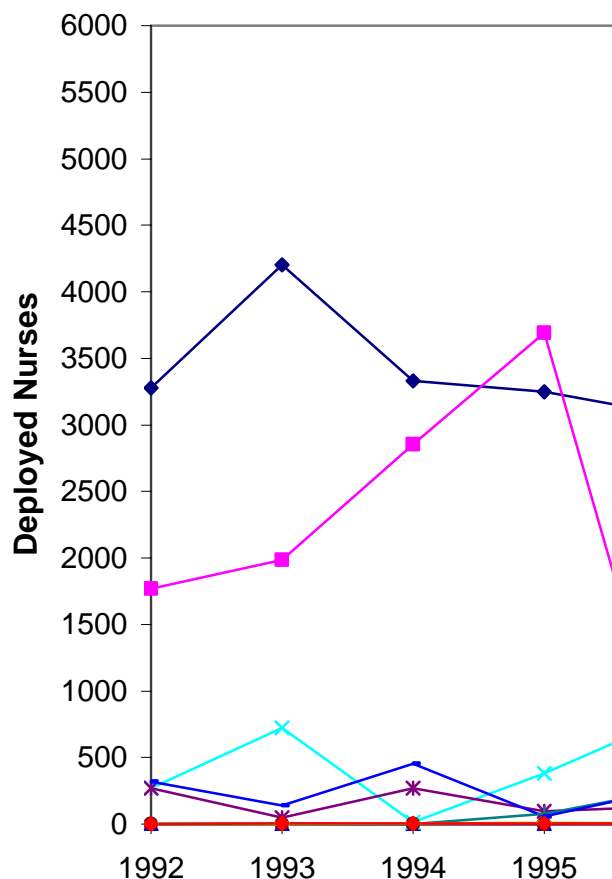
**Table 8. Deployment of Filipino Nurses by Country of Destination, Philippines 1992- July 2003**

Saudi Arabia		United States		United Kingdom		Libya		United Arab Emirates		Ireland		Singapore		Kuwait		Qatar		N
Num	%	Num	%	Num	%	Num	%	Num	%	Num	%	Num	%	Num	%	Num	%	N
3279	55.52	1767	29.92	0	0.00	269	4.55	271	4.59	0	0.00	0	0.00	320	5.42	0	0.00	
4202	59.17	1987	27.98	0	0.00	721	10.15	47	0.66	0	0.00	0	0.00	139	1.96	0	0.00	
3332	48.04	2853	41.13	0	0.00	15	0.22	270	3.89	0	0.00	0	0.00	455	6.56	6	0.09	
3249	42.93	3690	48.75	1	0.01	380	5.02	94	1.24	0	0.00	79	1.04	59	0.78	10	0.13	
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	
3794	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	
4098	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	
4031	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	
4386	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	
5045	38.07	304	2.29	5383	40.62	9	0.07	243	1.83	1529	11.54	413	3.12	182	1.37	143	1.08	

5704	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
3405	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

Philippine Overseas Employment Administration, 2003

**Figure 5 Deplo**

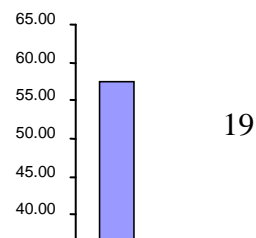


**Table 9 Leading Destination Countries and Percentage Distribution of Deployed Filipino Nurses 1992-July 2003**

Country of Destination	Number	Percentage (%)
Saudi Arabia	47596	57.58
United States	11468	13.87
United Kingdom	10265	12.42
Libya	2955	3.58
United Arab Emirates	2760	3.34
Ireland	2749	3.33
Singapore	2228	2.70
Kuwait	1901	2.30
Qatar	664	0.80
Brunei	69	0.08
<b>Total</b>	<b>82655</b>	<b>100.00</b>

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

**Figure 6. Leading Destination Countries and Percentage Distribution of Deployed Nurses**



19

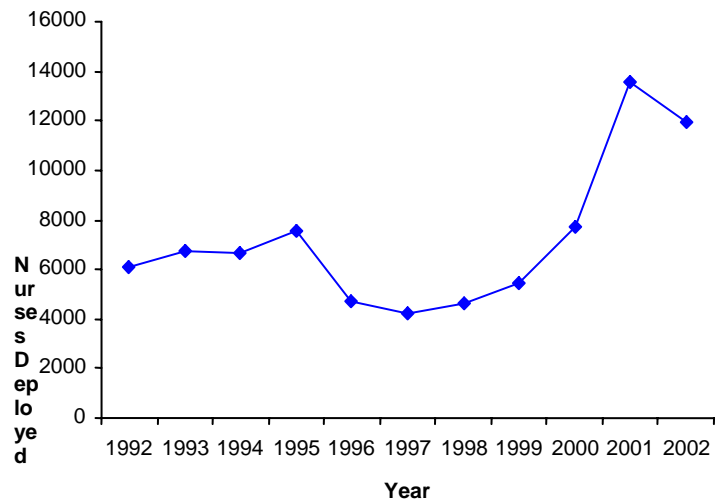
Source: Philippine Overseas Employment Administration, 2003

**Table 10. Deployment of Filipino Nurses 1992-July 2003**

Year	No. of Deployed Nurses	
	Number	Percentage (%)
1992	6078	7.67
1993	6744	8.51
1994	6699	8.46
1995	7584	9.57
1996	4734	5.98
1997	4242	5.36
1998	4591	5.80
1999	5413	6.83
2000	7683	9.70
2001	13536	17.09
2002	11911	15.04
Total	79215	100

Source: Philippine Overseas Employment Administration

**Figure 7. Deployment of Filipino Nurses 1992-2002**



Massive health worker migration is due to a number of factors, mainly an effective combination of low salaries for health professionals in the Philippines and the tremendous demand for health professionals abroad, especially for nurses and physical therapists.

This demand for labor in many developed countries has been exploited by labor recruitment agencies which charge fees for recruitment services to hospitals and other health institutions or earn from manning contracts.

The overall result is the rapid increase in the deployment of health professionals from developing countries which severely need health services such as the Philippines and India to staff hospitals, nursing homes and similar institutions besides working as domestic helpers or as caregivers in the rich countries of the north.

Impact of health worker migration are reduction of health manpower, heavier workload for the remaining nurses, third world professional are deskilled while third world countries are drained of skilled professionals.

### ***Filipino Worker Migration Patterns***

Patterns were first derived from an intensive review of records and literature and later compared to empirical data. Filipino overseas migration reflects the issues of Philippine socio-political and economic life. Overseas migration results to the loss of millions of skilled and unskilled Filipino workers to first world countries due to the dearth of employment opportunities and the inadequacy of wages in the Philippines. Worker migration is supposedly a temporary measure to alleviate inadequate employment generation. However, observations show that overseas migration has become persistent in the Philippines. The Department of Foreign Affairs reports that there are about 7.2

million Filipino migrants all over the world. Deployment level increased in the number of overseas workers from just 36,035 in 1975 to 841,438 in 2000.

Brain drain is a phenomenon of well- educated professionals permanently migrating from developing countries to industrialized ones. Factors attributed to the migration of professionals include: colonial mentality, economic need, professional and career development, and attraction of a better quality life or a higher standard of living (Alburo, F. and Abella, D., 2002). A common reason for migration to other countries usually given by health workers is the low and variable wage rates in the country, which do not allow health workers to earned "decent living wages".

Filipino nurses are the most numerous health worker category produced followed by midwives and doctors. There are a number of reasons given why health workers migrate. Economic reasons seem to be strong drivers but among the professionals who beyond survival levels, they seek a "better quality of life" for them and their offspring.

The top three countries of destination of Filipino nurses for the last decade include Saudi Arabia, USA, and the United Kingdom. Other preferred destinations include Libya, United Arab Emirates, Ireland, Singapore, Kuwait, Qatar and Brunei (POEA, 2003). It can be discerned that Saudi Arabia has been consistently the top destination of many nurses in the last decade accounting for a low of 38% to a high of 85% of all nurse deployment.

Due to external demand trends, a boom in Philippine nursing education has been observed. As much as 200 applications for new nursing programs were submitted for the school year 2004-2005 alone. Only 24 were approved for regular permits. Existing nursing schools have increased their capacities drastically from only one to two sections of 40 to 50 students to as many as 60 sections for the freshmen.

### ***Benefits and Costs of Filipino Health Worker Migration***

The social costs of migration are heavy. Alburo and Abella pointed out that those who usually migrate are also the ones with prior training experience and are highly skilled. Negative effects of migration include compromised patient outcomes when nursing staffing shortages occur. Lowered nurse staffing can result to higher cross infection rates, adverse events after surgery, increased accident rates and patient injuries, and increased rates of violence against staff (O' Brien-Pallas in Buchan, 2004). Excessive loss of domestic labor can lead to brain drain of the young, highly skilled labor, depletion of work force and severe reduction in the availability and quality of services. Lesser workers in a country will lead to a reduction in productivity that could 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).

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 nurses.

## **Case Study Results**

In order to validate Filipino health worker migration patterns derived from reviews of literature and records, a case study was undertaken in selected areas of the Philippines. Results consist of perceived profiles of health worker migrants, patterns of migration, reasons give why health workers migrate and perceived effects of migration on individuals and their families, health care institutions and effects on the nation. Primary data collected for this study was crafted into five case studies that aimed to establish the magnitude and patterns of health worker migration and explore the reasons and motivation of health workers to migrate or to stay in the Philippines. A cross case analysis was then accomplished to synthesize and compare patterns of health worker migration across the cases.

A total of 271 respondents participated in the focus group discussions conducted by the study. Among the active health worker practitioners who participated in the study, there are almost equal numbers of those who plan to migrate (45.76%) and those who do not have plans of moving to another country (44.65%). However, of those who have plans of leaving, about half (63 or 50.81%) of the respondents have plans of moving to another country within two years, while about a fourth (32 or 25.81%) plan to move out of the Philippines in three years and the smallest group of 29 respondents or 23.39% in 5 years.

### ***Patterns and trends of Philippine Health Worker Migration***

The description of Philippine health worker migration includes the perceived migrant profile, preferred destinations, push and pull factors and impact of migration.

### ***Perceived Health Worker Migrant Profile and Preferred Destinations***

Potential health worker migrants were perceived to be young between the ages of 20 to 30, female, middle class, mostly with basic undergraduate education. This describes the characteristics of potential nursing and midwife migrants. Migrant physical and occupational therapists and medical technologists have the same characteristics except that there were more male therapists who were perceived to migrate than females. Physicians who migrate are characterized to be older when they leave, usually between 31-40, male or female, middle class, and with residency or fellowship experience.

Those who leave, especially nurses and doctors are perceived to be well trained, skilled and experienced because of their specializations. The respondents specified that those who left were skilled and experienced as most of them (74 or 93.6%) were in their positions between 1-10 years.

**Push Factors** are the conditions in the country that drive away people to other countries. It was found that these are usually economic-related, job-related together with socio-political and economic environment-related factors. In addition to financial reasons, the country's deteriorating political situation was highlighted.

**Pull Factors**, on the other hand, are conditions in other countries that entice health workers to work abroad. They show the complements of those identified as push factors that in fact validate their importance. The concern for the security of the children was a recurring theme in the discussion with all the groups that reflects their anxiety over the prevailing social situation.

For those who choose to stay in the country the predominant reasons given focused on the worker's satisfaction with the present situation, the desire to serve the country and to be with the family.

The U.S.A. is a priority destination country of all categories of health workers, the reasons for such were the following: a) *working conditions* are better in terms of the professional development opportunities provided and the use of high technology facilities and equipment; b) availability of *social support* from relatives and friends; and c) chance for family *migration and citizenship* is high. The United Kingdom is also a preferred country, particularly by nurses and midwives because of the *shorter time involved in the processing of application and qualification requirements are less stringent*. For midwives, the ease experienced in applying makes Canada one of the favorite destination countries.

### ***Perceived impact of migration***

**For the individual and family**, the positive effects were related to the individual's personal development and pursuit of better quality of life for the family. On the other hand, migration exacts a toll on both the individual and his family. Negative effects were related to homesickness that may lead to depression, and disruption in family/marital relationships when members are left behind.

The health professions are positively affected when the worker comes back and applies/shares what he/she learned. The negative effects, on the other hand, include depletion of the pool of **skilled** health workers; depletion of medical capability/trained medical staff; the increase in inexperienced health workers in the pool of health workers who replace those who leave, and demoralization of the non-doctors who take up nursing because of their disadvantaged position in the job market.

The *health care system* is directly affected when health workers who are in the frontline of the system leave. The positive effects can result when health care is enhanced when the health worker returnees transfer the technology; and aggressive staff replacements that are eager to learn may give a new dimension to what they do. The negative effects on the system have implications on the sustainability and quality of programs required by the community as well as on the functionality and effectiveness of health facilities in the delivery of health services.

The *economy improves* with the remittances from workers abroad. This contributes to the development of the country; except when health workers migrate with their families, hence reduced remittances to the country. Unemployment is reduced with the migration of health workers and provides job openings to those left behind. Negative effects include the *loss of government resources* used in the education/training of health workers in state universities and in government hospitals; *resources are spent on training* of staff replacements; and *reduced government income* of the province and country from taxes of health professionals.

### ***Migration Policies and Practices that Affect Health Worker Migration***

In general, formal policies viz (public, social and institutional )as well as informal policies viz (standard 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 level), national and international levels may affect patterns and practices of health worker migration. These are further analyzed with the case studies to provide potential solutions.

### **Professional Practice Acts:**

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 work 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).

These practice acts embody the evolution of the nature and scope of health professional practice in the Philippines. These Laws and their recent revisions include:

- The Philippine Nursing Law RA 877 first passed 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
- Optometry law of 1917 amended by RA 1998 of 1957, further amended by Revised Optometry Law of 1995 RA 8050

It should be noted that these practice acts were enacted without consideration of rationalizing frameworks such as the National Health Plan, National Health Care Objectives or Health Sector Reform Agenda or a National Health Human Resource Development Plan.

Some health professional practice 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 the discussions with ophthalmologists over their proposed expansion of their scope of practice. These renegotiations are occurring because career paths and frontiers of many health care disciplines have remained static and narrow that contribute 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, Access Work Conditions and Career Path Development**

**The Magna Carta for Public Health Workers of 1992 embodied in RA 7305** was a pioneering legislation that attempted to comprehensively address the policy issues on the quality of life, quality of service, and motivation for the retention of health care workers especially in remote and poor rural and urban underserved areas.

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

The essential provisions of this law that could possibly increase the number of health workers deployed in underserved areas pertain to the provision of : salary, hazard allowance, subsistence allowance, longevity pay , laundry allowance and 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 satisfaction on the job and consequently facilitating retention of public health workers, implementation problems gave rise to wider health worker dissatisfaction and fueled 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 transferred from the national government to local governments who were then mandated to grant the

benefits that the law provided for. While many poor local governments could simply not afford to pay these benefits, there were also many who showed no political will to enforce the law as they feared that the law 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 who were mostly in poor remote underserved areas. There were observed transfers from the municipal and provincial health system to the national health department offices or to the private sector and inevitably ended in migration abroad. As a result many devolved health services deteriorated.

The Magna Carta law affected a wide range of health and health related workers as the act envisioned to provide benefits for *all health workers* defined as:

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

Another similar policy was RA 7883, the Barangay Health Workers Benefit and Incentives Act of 1995 but affected only the benefits accorded to Barangay Health Workers (BHWs) or voluntary village health workers. For primary health care, barangay health workers 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: hazard allowance, subsistence allowance, educational programs with step ladder curricula, continuing education, study and exposure tours, grants, field immersions, scholarship benefits, special training programs, and civil service eligibility after 5 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 or RA 7875 does not directly govern health human resources. However, it impacts the deployment and employment of all health workers as it:

*Adopts an integrated and comprehensive approach to health development which shall endeavor to make essential good, health and other social services available to **all** the people at affordable cost, prioritizing the needs of the underprivileged, sick, elderly, disabled, women and children ...*

When all Filipinos are members of the national health insurance system, then the requirements for health workers should increase so that the vision of universal coverage of social health insurance benefits could be realized. If these requirements would be converted into budgeted positions, then with the hiring of more health workers into the system, working conditions might improve thus positively influencing satisfaction of health workers and consequently facilitating their retention.

### **Public Policies that Affect Health Worker Migration**

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

The Philippine government first adopted an international labor 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 or RA 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, MT 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 labor markets and promotes 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 centers for the protection and promotion of workers' welfare and interests; and reintegration programs 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" labor 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, MT in OECD,2004).

### **Typology of National Policies that May Impact Migration Patterns**

Health Human Resource 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:

I. 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.

Four types of strategies to address the severe shortage of health professionals in rural, isolated or peripheral areas:

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, such as Fiji and Oman, to fill critical gaps and as 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.

II. 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 but attention to other health human resource categories needs to be balanced.

III. 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).

Philippine health human resource policy development should utilize the aforementioned policy framework. The Human Resource for Health Master plan policy development efforts is designed around this framework.

### **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 liberalise 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; 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 labor 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 fulfill a service contract a self-employed or an employee of a foreign service supplier).
- Are normally confined to one sector (as opposed to workers who enter under general 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 labor 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 MFN, 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 subsector 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.

The commitments made by member-countries in the WTO-GATS under Mode 4 relate to the entry and temporary stay of foreign nationals as service providers in their territory. The GATS agreement is aimed at dismantling the barriers and this may have been significantly achieved so far under other modes, but there is a dearth of progress yet in Mode 4 (Francisco).

Licensing and qualifications systems pose additional entry barrier. One of the problems in this aspect is brought about by the variation in educational system of member countries. For instance, completion of education up to tertiary level in the Philippines takes 14 years, while in other countries it takes 15 or 26 years. Because of these variations, entry of service providers becomes limited. In many instances, they are given lower positions, salary or benefits even if actual qualification or skills is comparable.

### *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 UK sets the example of setting up a code of recruitment practice that promulgates ethical recruitment of health workers from abroad. The international recruitment guiding principles include:

1. International recruitment as 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 UK.
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 UK 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. It also ensures a level of transparency about the requirements that are 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 has similarities to the labor codes that some multi-national 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 UN institutions, the ILO has a commitment to implementing basic labor standards and is promoting opportunities for decent and productive work.

### *Policy Options*

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

1. An informed and transparent labor migration admissions system designed to respond to measured, legitimate labor 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. Institutional mechanisms for consultation and coordination with social partners in policy elaboration and practical implementation.

Alternative policies that may be crafted include: Policies for labor mobility – freedom to move – in regional integration areas; Changing terms of aid, trade and international relations to facilitate development in more equal terms; Creation of 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 Elaboration of gender sensitive policies and implementation focusing on ensuring both 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).

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 92<sup>nd</sup> 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 Program directions**

At present, health sciences programs are the most popular courses in the country especially nursing. Many professionals, notably doctors, physical therapists, teachers and lawyers make career shifts to nursing. However, they use nursing as a steppingstone to land jobs or migrate abroad. As a result, many of the underserved areas 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 there were nurses who assumed the posts 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 some private hospitals have closed.

The trade and investment sector of the country is also showing interest in developing the sector 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.

A presidential executive order has been proposed and is being prepared to ensure integrated and unified government and private sector policy in HRH development. Moreover, the DOH has embarked on an ambitious Human Resource for Health Development Master Plan covering 2005-2025 that lays out long term policy and program strategies to manage migration, improve retention and establish career tracks and other HRH management systems to ensure quality HRH for the Philippines in the long run.

At the national level, the Philippines has different executive departments that may serve to implement significant solutions measures that will ensure that health worker labor migration is well managed. Their functions are proposed to be embodied in 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 extend immediate assistance including the repatriation of distressed or beleaguered migrant workers and other overseas Filipinos.

***Department of Labor and Employment*** shall see to it that labor 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 centers or hospitals

***Philippine Overseas Employment Administration***-Subject to deregulation and phase out as provided under section 29 and 30 herein, the administration 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.

***Overseas Workers Welfare Administration***- the Welfare officer or in his absence, the coordinating officer shall provide the Filipino migrant worker and his family 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 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 brought to his attention.

#### *Responsibility of the Government to Professionals and Highly-Skilled Filipinos Abroad*

Pursuant to the objective of encouraging professionals and highly-skilled Filipinos abroad especially in the field of science and technology to participate in, and contribute to national development, the government shall provide proper and adequate incentives and programs so as to secure their services in priority development areas of the public and private sectors.

#### *POEA Programs*

The POEA shall adopt policies and procedures, prepare and implement programs toward the eradication of 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. Prosecution of illegal recruiters
3. Special operations such as surveillance of persons and entities suspected to be engaged in illegal recruitment
4. Information and Education campaign (Bach, 2003).

#### Philippine Nursing Sector Initiatives

In an attempt to address the crisis of massive runaway nurse migration and its deleterious effects to Philippine health services, the nursing sector formulated its strategic plan in 2001 that proposed initial strategies and were later refined focused that became components of a still evolving Philippine Nursing Development Plan . Some of these strategies were echoed by other health professionals in an attempt to integrate their professions' concerns into the snowballing efforts to address nurse migration. Further, these strategies were incorporated in the Department of Health led Human Resource for Health Development Plan that was embodied in the 25 year HRH Master Plan covering 2005-2030.

These strategies include:

1. The institution of a national network on Human Resource for Health Development, which would be a multi-sectoral body involved in health human resources development through policy review and program development.
2. Exploration of bilateral negotiations with destination countries for recruitment conditions that will benefit both sending and receiving countries. Through the bilateral negotiations our country can ask for compensatory mechanisms that will be used to improve domestic post graduate nursing training, the upgrading for nursing education, increases in nurses compensation and nursing scholarships.
3. 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 \$1000 at 2002 prices for two years) would be remitted to the hospital where the nurse has been recruited so that the hospital can use this amount to train the next tier of nurses who will staff the hospital.
4. If hospital nurses will be hired by their foreign counterparts, they should be given a six-month leave to return and train local hospital nurses. Health care organizations should have returnee integration programs 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 from state-run nursing schools to serve locally for a number of years equivalent to their years of study.
6. Health related organizations such as the Philippine Hospital Association, Philhealth together with Nursing bodies such as the Board of Nursing and the Philippine Nurses' Association (PNA) must exercise police power to prevent work-related exploitation since there are local hospitals that do not offer salaries to nurses in exchange of volunteerism and residency requirements.
7. To pursue the active participation of the Philippines in international bodies such as the World Health Organization (WHO), ICN and ILO that have committed to address the global nursing shortage.

These strategies are part of a proposed executive order that is envisioned to facilitate the urgent implementation of these strategies in order to ensure the competitiveness of the nursing sector and the health human resource 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.

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PRC Board of Nursing Souvenir Program of 2003 Page 49

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