

WOMEN AND INTERNATIONAL MIGRATION OF PUBLIC SECTOR HEALTH WORKERS

*Country Report
Philippines*

**Public Services Labor Independent Confederation (PSLINK)
December 2003**

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Introduction

This research focuses on the phenomenon of thousands of health workers migrating to work abroad, and its various dimensions: (1) its impact on the quality of public health service, (2) on women as workers and as consumers, and; (3) migration and national development. Limited materials made it difficult to provide updated and quantitative proof on migration's implications on these areas. Also part of this research is to be able to identify from stakeholders what measures can possibly be institutionalized in order to address issues brought about by migration. Part of the original plan was to conduct several follow-up activities where findings in this study will be presented to stakeholder agencies, organizations and individuals. However, due to time and manpower constraints this did not push through. It is hoped though that this can contribute to more concrete follow-up activities to either provide venues for consultation on what possible strategies can be adopted, as well as to fund local campaign and education activities which unions can initiate themselves. Work on this project started from October – December 2003. However, focus was only given to the study during the middle of November 2003.

The research is divided into two parts. Part I provides a general picture of migration, trends, push and pull factors, its implications on the quality of public services, women's access to health care, and how migration is related to the Philippine government's development strategy. Data used were taken from official statistics of government agencies such as the Philippine Overseas Employment Administration (POEA), the Department of Health (DOH), the Department of Labor and Employment (DOLE), the Department of Foreign Affairs (DFA), and the Department of Budget and Management (DBM). News clippings and existing studies on migration of health workers also were useful in providing specific examples. Interviews with government officials, health workers' organizations and a women's coalition also gave more in-depth insights.

For Part II of the study, a survey was carried out, and although inconclusive, could provide a micro perspective of why health workers choose to migrate and why some do not see migration as an option.

Research Methodology

For the secondary data gathering, researchers made use of the latest government statistics from the 1990s – 2003. For the survey on the other hand, the initial target was to get at least 30 health workers in a hospital and 20 health workers in a non-hospital institution. Two institutions were targeted: the Manila Health Department for the non-hospital category and the Rizal Medical Center (RMC) for the hospital category. However, due to the unavailability of medical staff in RMC, only **12** were interviewed, all of whom are nurses. RMC is a national government funded tertiary hospital. It has a 350 bed capacity, but has a catchment area of 14 towns, with a population of 1.7 million people¹. **Thirty-nine** of the respondents on the other hand came from

¹ <http://www.rizalprovince.gov.ph/>

the Manila Health Department which implements primary health care services to the city of Manila. It has a population of 1,654,761. Respondents from MHD come from District Health Offices, each catering to an average population of 35,000².

The original methodology of conducting one-on-one survey interviews was not followed due to the inconvenience which hospital officials expected it to cause. Thus, data gathering had to be more flexible, thus different methods were used: (1) one on one interviews, (2) FGDs, (3) or in some cases questionnaires were simply filled out by the respondents – whichever was convenient for them. In cases where interviews were possible, it was also difficult to get the respondent to provide adequate information since they were either too busy with their work or were uncomfortable. One of the observations in the conduct of the FGDs and the interviews was that most respondents were not comfortable with revealing their names, out of the apprehension that the study will be used against them and may hamper their plans of going abroad.

Questionnaires formulated by the PSI were revised in order to clarify some questions. These were questions on unions and women workers, since in the Philippines there is generally a low level of understanding on what unions are, there is also a general lack of awareness on gender issues. Some additions were also made in the questionnaires to provide researchers a clearer idea on the recruitment process, their motivations for not choosing to migrate (for respondents who do not have any plans), why they would still want or would not want to come back here in the Philippines after working abroad (for those who are about to migrate or those planning to). Furthermore, questionnaires were differentiated into two sets – Set A for those about to go abroad or planning to go abroad, and Set B for those who do not plan to migrate to work in the health service abroad.

Limitations

A major limitation to the research was the unavailability materials are important to establish migration's impact on the quality of health care in the country. For one data on migrant health workers are not segregated according to whether they were employed under the private or the public sector. Thus, it was impossible to get exact figures on how migration has impacted on staffing shortages in the public health system. Second, there is also no quantitative data on whether migration has led to a deterioration in the quality of public health services. Third, there is also no quantitative data that could directly link poor delivery of public services to the impoverishment of women. And last, it was also difficult to get information from recruitment agencies, as they were apprehensive that the research is just a ploy of another recruitment agency to get ideas on marketing strategies. It was also difficult to get information from the POEA regarding recruitment agencies catering to health workers, on how many have been closed down and specific cases, due to confidentiality.

As earlier pointed out results of the survey are not conclusive, though they may provide an idea on the profile of health workers who plan to migrate and a profile of those who do not have any

² <http://www.cityofmanila.com.ph>

such plans. The non-uniformity of how data for Part II was gathered also presents limitations in the analysis of responses. Also, the current shortage which the public health system faces is one major limitation to arranging for dates of interviews with targeted respondents. Data on the number of recruitment agencies catering for health workers which were ordered for closure were not obtained due to confidentiality.

PART I. A National Backgrounder on the Migration of Public Health Workers

Trends on the Out-Migration of Health Workers

Health workers comprise the earliest wave of the country's migrant workers, with nurses and doctors provided training and work opportunities in the United States by the American colonial government. Immigration policies were particularly liberal for nurses who want to work abroad, such as granting them immigrant status after only a few years of employment. And through the years demand for Filipino health workers has been persistent despite the opening up of other markets for Filipino manpower³.

Data from the Philippine Overseas Employment Administration (POEA) shows that after an average annual deployment of 9,310 from 1992-1995, deployment of health workers dropped to 7,482 from 1996 to 1999. This glut can be attributed to the US' decision not to hire any foreign nurses due to a brief period of surplus. However, with European labor markets need for health workers particularly nurses and caregivers, reaching crisis proportions average deployment from 2000-August 2003, has skyrocketed to 17,347. As a matter of fact from January to August 2003 alone 21,095 health workers left the country to work abroad. And during the past 11 year period, women have comprised more than a majority of migrant health workers: 81% from 1992-1995, 78% from 1996-1999, and 85% from 2000-2003.

Also evident from the POEA data is the overnight increase of caregivers migrating abroad. It is only in 2001, when the demand for Filipino caregivers increased did the POEA start documenting their mobility. After only within a two year period, demand for caregivers now comprises 26% of the total demand for health workers from 2000-2003. POEA data also show caregivers dominating demand for health workers from January – August 2003.

In terms of occupational grouping nurses form the bulk of migrant health workers with total demand at 62%, and 85% of the total deployment for nurses are female. Caregivers follow a far second with 26% of the total demand for health workers, and 95% of this demand are women.

³ Catherine Ceniza-Choy, *Empire of Care – Nursing and Migration in Filipino American History* (Ateneo De Manila Press, 2003).

Table 1

**TOTAL OVERSEAS DEPLOYMENT OF HEALTH WORKERS
1992-2003**

Subcategory	1992		1993		1994		1995		1996		1997		1998		1999		2000		2001		2002		2003		Total
	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	
Med. Asst.	5	3	5	4	16	23	7	8	10	30	3	2	5	2	3		1		6	51	4	37	2	5	232
Medical Dental Veterinary Related Workers	527	397	1		413	307		1	1	2		1		1	330	237	329	266			490	645	235	263	4446
Medical Dental Veterinary Related Workers (NEC)				519	365			407	333	510	489	372	338	356	290					397	604				4980
Midwifery Personnel		5				4		4		8		31	2	55	1	48		96		81		172		38	545
Midwives Professional	25	221	4	293	9	117	9	152	2	140	6	107	5	144		66		55	1	189	2	310		186	2043
Nurses Professional	680	5067	729	6015	1014	5685	1160	6424	665	4069	671	3511	666	3925	839	4574	1273	6410	2269	11267	1605	10261	638	5527	84944
Nursing Personnel	67	264	68	496	16	456	28	342	124	619	96	907	125	683	32	527	33	625	25	260	43	380	24	216	6456
Optometrists & Opticians	13	23	28	14	20	12			14	22	23	30	33	35	59	37	38	42	63	20	83	40	18	10	677
Pharmaceutical Asst.	22	30	29	88	12	20	12	23	9	49	10	55	4	33	9	42	13	86	23	146	30	82	14	66	907
Pharmacist	6	46	6	27	8	24	25	29	20	37	12	30	15	23	13	42	6	24	27	37	24	33	10	33	557
Physiotherapist & O.T	198	321	201	375	256	362	225	341	175	240	107	162	146	171	54	93	84	151	101	232	182	335	102	156	4770
Technicians Medical X-Rays	202	145	151	174	116	203	138	180	124	149	100	268	142	267	72	177	61	162	85	200	102	257	79	183	3737
Caregivers																			67	399	350	4833	417	12615	18681
Dental Asst.			11	41	14	61	13	60	11	72	23	101	12	160			25	146	132	469	52	289	18	56	1766
Dentist			8	14	12	28	12	38	7	29	11	42	3	29			6	27	16	42	11	51	4	22	412
Dietitian Public Health Nutritionist			27	101	9	52	25	57	10	30	7	65	17	81			9	36	12	52	7	91	19	59	766
Doctors Medical			48	23	38	19	36	27	21	17	37	23	31	24			14	13	28	33	64	65	46	34	641
TOTAL	1745	6522	1316	8184	2318	7373	1690	8093	1526	6023	1595	5707	1544	5989	1702	5843	1891	8140	2855	13875	3653	17881	1626	19469	136560

The table below shows the top destination of nurses from 1992 to September 2002

Table 2. Deployment of Nursing Professionals

Main Destinations	1992-YTD September 2002
Saudi Arabia	43,238
United Kingdom	11,471
United States	11,292
Singapore	3,105
Libya	2,723
UAE	2,581
Ireland	2,455
Kuwait	1,886
Oman	647
Qatar	444

Source: POEA

Furthermore, data from the Commission on Overseas Filipino Workers under the Department of Foreign Affairs show that nurses also constitute the single largest group of Filipino medical professional emigrants, accounting for 53.5% of the total emigrants.

Table 3. Emigrant Filipino Professional Medical Workers, By Field of Specialization, Philippines: 1988-2001

Year	No. of Emigrants (Medical Professionals)	Professional Nurse	Professional Midwife	Therapist	Other Medical Professionals
1988-1990	6,943	3,860	244	39	2,800
1991-1995	10,911	5,577	434	411	4,489
1996-2000	6,175	2,863	310	109	2,893
2001	2,388	1,575	44	56	913
Total	26,417	13,875	1,032	615	10,895

Source: Department of Foreign Affairs

Push Factors for Out-Migration

The various interviews conducted with government agencies as well as leaders of health professional organizations, and NGOs consistently cited five reasons that “push” the country’s health workers to work abroad: (1) low salaries and inadequate / non-implementation of benefits, (2) lack of job opportunities/ underemployment, (3) work overload, (4) lack of medical supplies and facilities, and (5) political factors.

Data from the Department of Budget and Management on plantilla positions for public health workers under the national government show that 64% of national-government funded health workers are living below the poverty threshold income of Php16,073.00.

Table 4. Tally of Positions by Salary Grade of Health Workers, FY, 2003

Salary Grade	Filled	Unfilled	Salary Range
04	3526	14	6522-7751
06	1705	26	7606 - 9042
07	42	-	8139 -9675
08	812	9	8079 -10351
09	1	-	9318-11,075
10	3,993	32	9939-11,815
11	463	6	10,535-12,522
12	3478	22	11167-13274
13	255	1	11837-14070
14	2838	21	12,546 - 14914
15	851	5	13300-15810
16	1885	15	14098-16758
18	2882	56	15841-18830
19	129	1	16792-19959
20	997	27	17799-21158
21	222	5	18510-22003
22	1291	19	19251-22883
23	678	9	20020-23,799
24	423	13	20823 -24752
25	124	4	21655-25742
26	35	5	22521-26771
27	11	-	23422-27842

Data from the Department of Budget and Management also show that among dentists, doctors, nurses and midwives (occupations which are more predisposed to go abroad to work either as nurses or caregivers) whose earnings are below the poverty threshold income, 86% are women.

Table 5. Sex-Disaggregated Data of Specific Public Health Service Positions Under the Poverty Threshold Income

Position	Salary Grade Level	Female	Male
Dentist 1	SG 13	122	28
Medical officer 1	SG 14	15	7
Midwife 1	SG6	225	3
Midwife 2	SG8	580	9
Midwife 3	SG11	133	1
Midwife 4	SG13	41	0
Nurse 1	SG10	2884	671
Nurse 2	SG 14	2144	287
Public Health Nurse	SG12	2976	454

It is difficult to obtain data on the salaries of public health workers employed under the local governments though, since local governments draft their own pay scales. This system has in a way caused disparity in the salaries of health workers not only between high income and low income local governments, but also between local governments and nationally-funded hospitals.

In 2002, RA 7164 otherwise known as the Nursing Law was amended to increase the salaries of nurses with entry-level pay pegged at Salary Grade 15 or Php13,300. However, there are no funds for its implementation. This is also the problem with the Magna Carta for Public Health Workers which sets the minimum terms and conditions of employment for those in the public health service. A review by the Congressional Oversight Committee revealed that only 25% of local governments fully implement the provisions of the Magna Carta⁴. Table 6 itemizes the list of benefits which health workers are entitled to under the Magna Carta, and the status of implementation of each benefit.

The inability of the local labor market to absorb all health workers is also another problem. A study by the University of Manila Institute for Health Policy and Development Studies revealed that in 1998 while the country had a supply of 306,110 registered nurses, the demand generated both locally and internationally was only 178,045, which meant a surplus of 128,065 nurses who were either unemployed or underemployed. In the public sector which is the biggest source of local demand for nurses turnover rate is only at 1,000 positions a year. And now according to the DOH nursing surplus stands at 218,000⁵.

One interesting case of underemployment is the absence of any plantilla position for midwives in the Philippine General Hospital, which is the biggest and considered best public tertiary health care institution in the country. However, the PGH requires all its nursing attendants to be licensed midwives. Thus, its around 400 nursing attendants are all professional midwives⁶. And while Midwives can receive salaries ranging from Php7,606.00-Php14,070, Nursing Attendants can only receive salaries ranging from Php6,522 –Php9,042⁷. And according to Alice Sanz Dela Gente, President of the Integrated Midwives Association of the Philippines (IMAP), the lack of midwifery positions is what pushed many midwives in the 1980s to the present to work as domestic helpers abroad.

⁴ “Report of the Committee on Oversight on the Implementation of Magna Cartas”, House Committee on Oversight, House of Representatives, October 2003, p. 25.

⁵ Neil Villegas Mugan, “Despite Exodus No Shortage of Nurses in RP, says DOH” The Manila Times, 13 November, 2003, A.10

⁶ Emma Anas, Integrated Midwives Association of the Philippines-Philippine General Hospital, interview by Cerilyn Pastolero, tape recording, 14 December 2003, San Juan Manila

⁷ Monthly Salary Schedule for Civilian Personnel, Effective July, 2001, Department of Budget and Management

Table 6. Provisions of the Magna Carta for Public Health Workers and Status of Implementation

Magna Carta Provisions	Status of Implementation / Issues
<ul style="list-style-type: none"> a.) subsistence allowance not less than Php50.00 / day or Php1,500.00/ month as certified by the Head of Agency b.) longevity pay equivalent to 5% of the basic monthly pay for every 5 years of continuous service c.) laundry allowance of 125 per month for those required to wear uniforms d.) remote assignment allowance equivalent to 50% of the basic pay for health workers assigned in remote stations whose positions have not been filled for the last two years e.) free living quarters for those forced to stay in the hospital premises or quarters allowance f.) free medical examination, medical treatment and / or hospitalization g.) compensation for injuries h.) granting an automatic one salary grade increase in the basic salary, with retirement benefits to be computed on the basis of the highest salary received and paid i.) salary increase of 2% upon completion of post graduate studies j.) hazard pay 	<p>So far, the DOH is able to regularly grant only the subsistence laundry allowances, and give the highest basic salary upon compulsory retirement. Salary increase after post graduate studies, longevity pay, and hazard pay – are provided irregularly since they are chargeable to agency savings. Night shift differential pay and the remote assignment allowances do not have guidelines yet as to their implementation.</p>
<p>Public health workers shall be paid:</p> <ul style="list-style-type: none"> a) 50% of regular wage – on call b) overtime work c) work during rest days d) during holidays e) night shift work (differential of 10% of his or her regular wage 	<p>The last two benefits the night shift differential and overtime pay – are almost not provided at all</p>
<p>Upgraded salary benchmark for rural health physicians</p>	<p>There are local government executives which opt not to fill the position of Rural Health Physicians, since the salary of said position is much higher than that of the mayor</p>
<p>Security of Tenure</p>	<p>Devolution of public health services led to the politicization of health care at the local level, with local government executives either hiring non-essential health personnel or firing</p>
<p>Staffing patterns based not only on population but must also consider other factors such as terrain, road network, etc</p>	<p>According to the International Confederation of Nurses (ICN), Filipino nurses are the second most overworked nurses in Asia (next to Mongolia) as they render an average of 14-24 hours of overtime in a month. It is also normal for doctors to work on 36 hour shifts.</p>

Dr. Kenneth Ronquillo, Director of the Department of Health's Human Resource Development Bureau cited work overload as another major reason why health workers are leaving the country. In an interview he said “ *If they (nurses) have a ratio there (abroad) for example one nurse is to five patients or one nurse to two patients. Eh dito kahit pa na sabihin mo eight beds yan, pero yung bed natin tatlong pasyente- so times three kaagad yun (Here even if you only have eight beds but on each bed there are two to three patients, then you multiply that by two or three). So imagine one nurse taking care of 40-50 patients. Because of staffing shortages it is not unusual for government nurses in tertiary hospitals to take care of as much as 100 patients a day, and to go on 16 straight hour work shifts*”.

Lack of adequate medical supplies and facilities can also cause frustration on the part of health workers. As Dr. Jose Sanchez, President of the Philippine Medical Association said “ *Kapag ang pasyente mo may sakit na TB o high blood tapos mamamatay, dahil walang pambili ng gamot, very frustrating sa mga doctor yan. Minsan kahit dextrose wala (If your patient dies of mere tuberculosis or high blood because they do not have money to buy medicines, its very frustrating for us doctors . Sometimes there is even no dextrose to use*”).

Low salaries and unimplemented benefits, understaffing and work overload and inadequate medical supplies and equipment - all these boil down to the dwindling appropriations allotted by the national government for health care, as shown in the Table below.

Table 7. Department of Health Comparison of Appropriations (In Thousands Pesos)

Year	Amount	% Share to National Government	Ranking by Department
1992	10,227,744	5%	5 th
1993	6,914,732	2.22	5 th
1994	7,332,191	2.30	5 th
1995	8,534,076	2.20	5 th
1996	9,237,053	2.30	5 th
1997	10,937,857	2.50	5 th
1998	12,943,217	2.40	6 th
1999	11,265,838	1.90	6 th
2000	10,738,905	1.60	6 th
2001	9,456,263	1.50	7 th
2002	11,278,237	1.44	7 th

Source: Department of Health

And 2004's Php10.4 billion budget for health for next year is a sharp decline to the Php14 billion allocated this year⁸.

In the interviews conducted one recurring comment from those interviewed is frustration over the country's politics. Dela Gente, of IMAP cites how difficult it is to rise above the ranks in the bureaucracy if one is to rely on merit and talent alone - an MBA is a prerequisite (MBA means May Backer Ako or "I have a patron to back me up"). The decentralization of health

⁸ "House Oks Php864-B 2004 Nat'l Budget", The Philippine Star, p.A1.

services has further politicized health delivery with security of tenure dependent on local government executives. There are cases when non-essential health support providers are hired when in fact very important positions are left vacant for years. And in many cases, health personnel closely identified with the previous local chief executive are transferred without due process, or worse terminated once a new municipal mayor or provincial governor is elected.

Another dimension on why many health workers are now leaving the country is frustration over too much politicking among the Philippines’ leaders, which they perceive to render the economy and its institutions unstable. It is also perceived that economic and political instability lead to peace and order problems. This was pointed out by Dr. Sanchez of the PMA, since doctors are widely perceived to be earning a lot of money, they have become the target of kidnap for ransom groups. Dr. Sanchez also mentioned the Medical Malpractice Bill, which would impose harsh penalties on doctors, nurses, midwives, dentists and pharmacists. He said this bill was purely politically motivated and unnecessary since the country’s Revised Penal Code already provides for sanctions on cases of medical malpractice. If this was passed, this would lead to the practice of “defensive medicine” in the country as well as trigger the costs of medical services, he added.

Pull Factors for Out Migration

The growing demand for health care workers is primarily what drives the increasing number of Filipino health workers to migrate. It is expected that this mass exodus will steadily increase in the next 10-15 years. Since 2000 more and more countries are now joining the Middle East, and the US in competing to hire Filipino nurses. For instance, the Netherlands needs 7,000 nurses, Canada will be needing 10,000 nurses every year until 2011, the UK needs 7,5000 nurses, Italy needs 1,000 nurses and Norway needs 3,500 nurses⁹. This demand can be attributed to developing countries’ experiencing longer lifespans, while the number of graduates from the medical and allied services are rapidly declining because of the availability and diversity of career options for young people.

The amount of salaries which await health workers once they start working abroad is enough reason for them to re-think about staying here to work as the Table below shows:

Table 8. Comparative Basic Monthly Salary of OFW Nurses Worldwide

Aspect	Phil	Sing	KSA	UK	US
Basic Monthly Salary	8,500	42,000	54,000	119,000	216,000
% Increase		390%	530%	1300%	2900%
Tax/ Net		10% 7650	15% 35700	None 54000	30% 151,200

Source: Patricia Adversario, “ Philippines Suffers from Hemorrhage of Nurses”, The Manila Times, 21 April, 2003 , A1

⁹ “Nursing in the Philippines”, Department of Health, _____

Most health care institutions in need of health workers, are also granting generous benefit packages such as housing and food or grocery allowances to those they hire. In the case of the US, examination fees for the US National Licensure Exam (NCLEX), Test on English as a Foreign Language (TOEFL), and the Commission on Graduates of Foreign Nursing Schools (CGFNS), plane fare to take the exams, and pocket money for one's stay there are also paid for by some of the hiring institutions or recruitment agencies. The applicant also need not worry about processing his or her papers in immigration, as long as the documents are complete the agency takes charge of processing them. Immigration policies in labor-receiving countries have also been relaxed in order to get more health workers the shortest possible time. International Quality Manpower, a recruitment agency in the Philippines which is one of those that pioneered the "full sponsorship program" in the hiring of nurses for the US has also reduced the processing period for accepted applicants from 18-30 months to only 8 months. Recently, the US included nurses in the granting of H-IB visas, which used to allow only technology professions, doctors and others with distinguished merit and ability" into the country. This now means processing time for qualified nurses can be reduced to as little as 90 days¹⁰.

The UK too has relaxed its immigration policies, granting the families of health workers the chance to migrate with them within six months after they start their employment. Canada on the other hand does not give points for Filipino nurses to practice their profession in the local health service, but they are hiring aggressively for caregivers under their Live-In Caregiver Program, which also gives migrants and their families permanent resident status within six months after employment¹¹. For nurses and other health workers, working as caregivers in Canada is an easier and shorter way to work abroad. According to respondents interviewed in the survey, immigration interviews are more often mere formalities.

Filipino RNs Living It Up in New Zealand
The Philippine Star, Sept 1, 2002

"Discover a new nurse in you." This is a slogan that does wonders for Filipino nurses in New Zealand where they enjoy a good quality and peaceful life they wont experience anywhere else.

In New Zealand, nurses, only after three months at work, can already apply for permanent residence and are qualified to buy their own houses. To buy a house in New Zealand, a nurse need not put up cash for down payment. What they simply need is certification of employment and a guarantee from the employer. In quite a number of instances, nurses where able to acquire brand new cars by simply showing their pay slip and bank account number. After completion of the one year contract, the nurse, should she pt to renew her contract, can apply for citizenship with option to petition her family

Recruitment agencies are also more aggressive in their recruitment strategies in order to lure the country's best and the brightest nurses. John Hopkins for instance regularly sends full-time recruiting directors who come to the country's major cities to conduct symposia and headhunting campaigns. The UK's Department of Health has also made the application process more convenient as applicants can now submit their applications online. Now,

¹⁰ "Increase in US Work Visas to Benefit RP Nurses", Manila Bulletin, 1 June, 2003

¹¹ <http://www.cic.gc.ca/English/pub/caregiver/caregiver-4.html>

recruitment of nurses starts early on in the production process, with the “farming out” of nursing scholarships.

Long-term demand, high salaries, minimal expenses, assistance in the application process and aggressive recruitment strategies has in recent years been “pulling down” other medical professions as well. Now it is estimated that there are around 2,000 doctors who are taking up nursing¹². And last year’s Nursing Board exam top-notch is an ob-gynecologist. This is because while practicing medicine in the States will mean virtually starting again for doctors, going abroad is a walk in the park for them if they get accepted as nurses. They also cannot be blamed for making such a career decision since the monthly salary they receive as government doctors which ranges from \$300-\$400 is measly compared to the Php119,000 they will be earning as nurses in Britain or the \$216,000 they will be earning in the United States. This de-skilling is not only confined in the medical profession, as many from non-medical fields are also taking up nursing in the hope that this will be their ticket for a better future.

**Rymek Extends Deadline on Nursing Scholarship
The Manila Times, January 22, 2003**

Last January, RYMEK Ent. Inc, a health care personnel specialist in the US launched its “Nursing Students Dream USA Program”, which tried to attract nursing students with the promise of free nursing board exam, review fees to the CGFNS, TOEFL and TSE and fees in the immigration process. And for its 2,000 nurses it will be spending P14 million.

When candidates pass the CGFNS or the NCLEX they will be sponsored for the I-40 (immigrant visa petition by the sponsoring facility. This includes free visa petition application fee, free legal fees and free visa fee. Other benefits of the placement package include choice of assignment among 35 states all over the US; choice between hospital and long term care facility; free plane fare from the Philippines to the US, and; three months free housing upon arrival. Immediate family members can be included in the petition.

Migration and Public Health Services

Currently, the country is in dire need of health workers to implement the government’s preventive, curative, rehabilitative and promotive health strategies. As attested to by those interviewed in the two targeted institutions the Rizal Medical Center and the Manila Health Department as well as the Department of Health’s Human Resource Development Bureau, nurse to patient ratio now ranges from 1:30 to 1:60. This can even go up in the case of big medical centers¹³.

This is worsened by the maldistribution of health workers, as shown in Table 9, with 51% of doctors employed in the National Capital Region, Region IV, Region VI and Region VII - all

¹² “Doctors Want to be Nurses”, Malaya, 29 September, 2003, p.9.

¹³ Jeremiah Opiniano, “Global Congress to Tackle Nursing Crisis in RP”, The Manila Times, 26 March, 2003, A7.

of which are urbanized, and where most of the provincial or regional tertiary health care institutions are located. Furthermore, 52% of dentists are in only three of the country's 15 regions, while 41% of the country's nurses are deployed in only 4 of the country's regions. Thus, while doctor to patient ratio in the Philippines may be a little over international standard, there are regions in the country where the ratio is 1 doctor to 40,000 of the population. For dentists, the ratio can reach to 1:100,000 in some areas.

With turnover rates at an estimated 40-60% annually, which means that for every 100 nurses 40-60 leave every year, it is no surprise that top causes of morbidity in the country remain to be easily preventable illnesses. In the case of nurses, there is no shortage in terms of absolute numbers as pointed out earlier. But rather as Dir. Ronquillo of the DOH said, the shortage is more in terms of the health care system losing experienced nurses who have 5-15 years of nursing experience. This is attested to by Marie Flores, of the RMC, as much as the hospital would want to adhere to high standards in the hiring of new nurses to replace the ones who migrated, they have no choice but to be flexible. If before RMC required its nurses to be an IV Therapist, with Nursing Board rating at 80% above and with at least two years hospital experience, now as long as an applicant is a registered nurse and has good moral character or a patron, then she can be accepted - hospital experience can already be waved.

Table 9. Demographic Report of Total Number of Health Workers in LGUs, 2000

Area	Population	Doctors	Dentists	Nurses	Midwives	Nutritionists	BHWs	Trained Birth Attendants
Philippines	76,348,114	2,943	1,943	4,724	16,541	1,634	194,577	38,742
National Capital Region	10403081	702	560	861	1241	91	4979	120
CAR	1,403,570	75	36	138	566	5	5,326	1,564
Region I	4,146,687	157	93	216	999	10	18,609	1,435
Region II	2,799,209	115	55	210	829	16	5685	1870
Region III	7,697,356	246	248	349	1,511	19	17,999	1,012
Region IV	11,324,634	334	242	653	2340	41	28,984	6445
Region V	4,755,076	155	94	276	1036	15	13,056	3659
Region VI	6,328,666	252	113	411	1689	24	22626	5087
Region VII	5544211	230	114	399	1409	12	16370	3011
Region VIII	3746241	139	85	221	880	6	15618	3668
Region IX	3153922	88	42	204	736	3	7608	2562
Region X	2774977	87	66	172	813	5	11401	3230
Region XI	5238014	155	90	244	889	1363	10975	0
Region XII	2661179	61	30	119	553	7	4438	1727
Caraga	218438	74	53	142	579	11	8938	2598
ARMM	2186943	73	22	109	381	11	1965	761

Source: Department of Health

The government's scrap and build policy, which prohibits the creation of new positions without the prior abolition of another position, affects the government's ability to adjust to the vacancies because of. Often health workers who plan to migrate inform only their immediate supervisors and not the Personnel Office. The Personnel Office may have an inkling on the health workers' plans since he or she either starts incurring more and more absences or starts using up his or her accumulated unused leave. In some instances, the

Personnel Office is the last to know that the health worker has already left the country. Applying for abroad is usually done in secrecy since health workers would still want to keep their jobs as a fall back in case their employment conditions in the host country do not work out. Only after a certain period that the health worker has been on AWOL, can his or her position be declared vacant. Hiring a replacement is also another matters, since this is dependent not only on the availability of funds, but also on the hospital or the local government unit's chief executive. According to Abelardo Manece of the Manila Health Department's Personnel Office, this often takes more than a year.

There are various efforts to cope with the shortage. In the Manila Health Department, present staffing requirements are maximized, with instances where a doctor is made in charge of two districts, each district having an average population of 35,000¹⁴. In the RMC to avoid errors due to high turnover rates among nurses, the Nursing Office developed the "call a friend" system, where nurses are given permanent assignments. If ever one nurse in a specific area has to take an emergency leave, the one to take over her shift is someone also from the same unit. Through this system, nurses in a specific area become more familiar with the peculiarities of the work required, the kind of caring the patients need, and their medical history. This is contrary to the practice of some hospitals where if one unit has a shortage then a reliever is taken from another unit., which according to the RMC Chief Nurse means greater chances of errors. Leaves are also limited, as only three nurses are allowed to go on leave in a month.

**Table 10. Ten Leading Causes of Morbidity
No. & Rate 100,000 Population
2001**

Cause	No.	Rate
1. Diarrhea	845,526	1085.0
2. Bronchitis/ Bronchiolitis	694,836	891.7
3. Pneumonias	652,585	837.4
4. Influenza	499,887	641.5
5. Hypertension	318,521	408.7
6. TB Respiratory	110,841	142.2
7. Diseases of the Heart	47,040	60.4
8. Malaria	40,543	52.0
9. Measles	24,494	31.4
10. Chickenpox	24,359	31.3

Source: Department of Health

¹⁴ Abelardo Manece, Manila Health Department, Personnel Office, interview by Janet Morales, December 12, 2003, Manila

For many local governments, volunteer nurses or midwives are tapped to address the shortage. These volunteers receive nothing but perform duties of those who would be regularly employed in the same position, either to get experience or chances of regular employment¹⁵.

Aside from the local measures adopted by hospitals and other public health care institutions, the Department of Health also has a pool of doctors, nurses, midwives and other vital health workers which it sends to depressed areas that cannot afford to pay for either a doctor or a nurse. Those deployed on the other hand are not only specialists in their respective fields, but are also trained in systems development so that they can build the community's capacity to improve health service delivery. Some of these programs include the Doctors to the Barrios, the Medical Pool, and the Rural Health Team Replacements. But according to Dr. Ronquillo, there is also a shortage of plantilla positions in these programs, thus the Department cannot respond to all requests. The DOH has also started several consultations on Workforce Planning to help the Department and other stakeholder organizations and agencies approach the migration issue more holistically in terms of determining how many nurses the country will be needing, how many graduates should nursing schools produce, how many nursing schools will the country need to produce this many nurses, what changes should be made on the curriculum, and how many should the government deploy. The Department has also started consultations in the drafting of a Nursing Development Program which hopefully can wean the nursing profession away from migration, and instead set up mechanisms to encourage more nurses to pursue professional development in the country¹⁶.

On ensuring just terms and conditions of employment, Bilateral Employment Agreements are now seen as a mechanism to set standards not only on the rudimentary procedures in the recruitment of migrant workers, but also as a means to ensure that migration does not lead to staffing problems in the country's health care system. If before these Agreements were the purview of the Department of Foreign Affairs and the Department of Labor and Employment, now DOH is also taking a more active role. In the Agreement with Netherlands which is still in the drafting stages, there is a provision where nurses deployed will only work for a specific period of time. And during that time the employers will ensure their training and professional development. After the expiration of their contract, the Philippine government will then ensure their re-entry into the health system where he or she is expected to share her expertise. If the provisions of this Agreement is agreeable to both the Philippines and the Netherlands then this can be a model Agreement which can be used in the future. Talks are also underway for a similar contract with the Japanese government¹⁷. The Bilateral Agreement with the UK is also being reviewed. Other schemes being explored are : (1) the possibility of offering subsidies to the source hospital to compensate for the hiring of Filipino nurses; (2) an exchange program with local hospitals providing re-entry of nurses into the local workforce after completing their contract, and (3) the posting of bonds for nurses about to migrate to ensure their return, once the nurse does not return the bond will be forfeited and used for training and development¹⁸.

¹⁵ Alice Dela Gente, Integrated Midwives Association of the Philippines, interview by Cerilyn Pastolero, December 11, 2002, San Juan Manila

¹⁶ Dr. Kenneth Ronquillo, Department of Health, interview by Janet Morales, December 12, 2003, Manila

¹⁷ Dr. Kenneth Ronquillo, Department of Health, interview by Janet Morales, December 8, 2003, Sta. Cruz Manila

¹⁸ Philippine Overseas Employment Administration, written response to request for interview, December 5, 2003

Meanwhile, the country's health service continues to suffer. Some hospitals are now cutting down on complicated operations such as open heart surgeries by as much as 50% due to lack of skilled nurses to assist. In the Rizal Medical Center, the opening of another 10 bed ward was shelved because of lack of nurses to man it. In San Pedro Hospital in the south of Philippines the surgical intensive unit was merged with the ICU also due to lack of nurses to man it. In the same region a survey of 8 hospitals revealed that from 1998 to 2001 those who resigned to work abroad increased from 4.74 in 1998 to 28.75 in 2001. In another hospital an internal survey was carried out to assess the extent of migration's impact on their services and results revealed that 82.5% of their nurses are planning to leave. At the Davao Medical Center, Mindanao's leading tertiary hospital there are on the average, 5 resignations every month¹⁹. In Laguna, one hospital in Region IV, the Provincial Hospital was closed down because most of its nurses and doctors have already left for abroad.

And it is not only big hospitals or health care institutions which are affected. With the increasing number of doctors who are taking up nursing many local governments are now faced with more and more of their doctors migrating in the next few years. One example is Dumaguete City, which was awarded last year for its best practices in the delivery of community health service. Officials of the Provincial Health Office are worried that they may no longer be able to sustain this, since 50 out of their 300 doctors are taking up nursing and are about to leave in a month and a half's time. The Negros Provincial Hospital is already experiencing this, as all of its Department Heads are now nurses. In Biliran, another province in the island of Visayas 70 of the province's doctors are taking up nursing²⁰

Ms. Alice Sanz dela Gente, of IMAP also revealed her concern over how the emigration of midwives as caregivers can hamper health service especially in areas where there are no doctors. She added that in many barrios in the country, midwives and the services which they deliver are the only form of governance which the people receive. Furthermore, she expressed her dismay over how policy-makers are not paying attention to the migration of midwives.

According to Jurgette Honculada, Board Member of the Women's Action Network for Development (WAND), another gender dimension of the migration of health workers is how this poor quality of public services translates to women, who are the primary carers in the Filipino family, carrying the burden of caring for the sick, the young and the elderly. This not only means more reproductive work for women but also in terms of they may have to forego some career options to care for the family. And since the burden of budgeting for the family also falls on women, it is they who worry and try to find out ways to provide for the family's health care needs.

Also, whether the country can be assured of quality graduates of health related course is also another matter. In the case of nursing, the demand has led to a mushrooming of nursing schools. From 189 nursing schools in 1998, this number increased to 305 by this year²¹. Records from the Philippine Regulatory Commission, on passing rates in the 2002 nursing licensure examinations, show that those who passed the exams dropped to 43.6%, when in

¹⁹ *ibid.*

²⁰ "Exodus of Docs Abroad Threaten Medical Services", Manila Bulletin, January 29, 2003, p.3

²¹ Commission on Higher Education _____

fact from 1994-1998, board passers in the nursing licensure examinations were usually more than 57%. Furthermore, out of the 223 nursing schools which participated in the Board exams 136 or 61% posted passing rates that were below 50%. However, there are hardly any nursing schools which are closed down. In the Nursing Law, which gives the Commission on Higher Education (CHED) the authority to regulate nursing schools to ensure their quality, schools which offer nursing can only be closed down if they posted a passing rate of 3-5% or lower for five consecutive examinations²².

Low passing rates are not surprising since many of these nursing schools do not have deans and faculty members to handle the nursing program, since many of the experienced nurses who are also in the academe are themselves migrating to work abroad. Because of this, it is now common for nursing schools to have “portable deans” or “ghost faculties” who merely lend their names to nursing education institutions²³. And sections in these schools have also ballooned, from 4-6 in the 1990s to more than 10 or 15 since the latest boom in demand started in 2000. Consequently, this has brought about stiffer competition for internships in hospitals, with students to patient ratio increasing from 1:25 to 1:30.²⁴ What this translates to are nursing graduates who may have very little hands-on practice.

Health Worker Migration and Governance

But health worker migration should be seen within the much larger context of how the country is governed. According to Elmer Collong, Vice President of the Alliance of Health Workers (AHW), migration is very much a political issue as well as it is economic. He added that it is political not only in terms of how the country’s politics causes frustration among health workers, but also in terms of the government’s stand on health worker migration. He added “*Paano tayo magiging strong republic kung ang tao mo ay palaging sakitin, kabit-kabit po iyon, pag sakitin ang tao, di siya makapagtrabaho, nagiging pabigat, pulubi.*” (*How can we be a strong republic if our people are sickly, its interrelated, if a person is sickly he cannot work, he becomes a burden, and becomes poor*)²⁵

Sec. 2 –c of the Migrant Workers and Overseas Filipinos Act of 1995 boldly states that:

“While recognizing the significant contribution of Filipino migrant workers to the national economy through their foreign exchange remittances, the State does not promote overseas employment as a means to sustain economic growth and achieve national development... The State therefore shall continuously create local employment opportunities and promote the equitable distribution of wealth and benefits of development”

The country’s Medium-Term Development Plan for 2001-2004 also explicitly states that the generation of domestic employment shall remain as the country’s priority over overseas employment. The Plan also states that “focus will be in making use of selective deployment

²² RA 9173, An Act Providing for More Responsive Nursing Profession, Repealing for the Purpose RA No. 7164, Otherwise Known as the Philippine Nursing Act of 1991.

²³ “Quality of Nursing Education Deteriorates”, The Manila Times, April 22, 2003, p. A1.

²⁴ “More Nursing Schools, But Quality Down”, Philippine Daily Inquirer, August 11, 2003, p. A1

²⁵ This statement alludes to President Gloria Arroyo’s rallying cry that the country is a strong republic.

to more labor friendly host countries”, and that diplomacy shall be used to “ensure equal protection and safe working conditions for OFWs, particularly migrant workers”.

However, as Collong said, these are irrelevant as long as the POEA’s role on the issue of migration is not clarified. The Administration was created in the 1970s, with the conflicting mandates of regulating the recruitment industry and “developing markets” for Filipino manpower. With government promoting overseas employment, recruitment agencies especially for health workers has spawned.

Table 11. Number of Recruitment Agencies Deploying Health Workers

Skills	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Caregivers and caretakers	13	106	161	166	174	184	187	199	196	189	182	190
Dental Assistants	21	24	28	28	24	32	32	37	39	48	46	45
Dentists	18	21	22	28	20	15	20	31	30	29	35	23
Dietitians and public health nutritionists	29	28	26	23	17	19	20	20	23	26	20	18
Doctors medical	33	37	26	31	22	26	28	24	18	22	39	26
Midwives professional	28	26	24	30	18	23	26	19	29	33	31	32
Nurses professional	205	212	229	207	189	149	145	184	202	222	265	271
Pharmacists	23	16	14	22	20	11	13	18	18	23	21	20
Physiotherapists and Occupational therapists	69	81	73	59	58	51	44	44	58	61	73	65
Technicians life sciences/ technologists	104	102	93	82	54	53	49	55	66	61	59	40

Source: POEA

The Philippine government plays a facilitative and an active role in labor migration based on three premises: (1) it eases unemployment in the country, (2) it brings in badly needed dollar remittances, and (3) increases productivity as it enables skills transfer. However, more than two decades of government’s active promotion for overseas work has not in to improvements on employment levels, productivity or even economic development. In terms of remittances, Filipino workers are now one of the top senders of dollar remittances in Asia, contributing the biggest share to a country’s economic output amounting to \$6.4 billion or 9% of the Philippines’ GDP²⁶. However, there is a weak link between these remittances and economic development, particularly on how these remittances pave the way for migrants and the government to be less and less dependent on overseas employment. And in the case of health worker migration, the granting of immigrant status to their families presents a possibility that remittances may decrease. On whether migration of health workers eases unemployment levels is also another questionable premise, since those who leave are not the unemployed but the highly skilled and gainfully employed. Those who replace them on the other hand are ill-equipped to provide quality health care, and in the process compromising health services. Skills transfer is also doubtful if there are no incentives for the migrant to

²⁶ “MFI Sector Can Curb Money Laundering”, The Manila Times, July 3, 2003, p.B4.

return to his or her former profession which in the case of health sector, is severely underpaid, overworked and demoralizing.

How government extends support services and protection to migrant health workers is another matter. Although, as OWWA Director Dela Fuente says they encounter only a minimal number of cases involving health workers. POEA says this may not be the entire picture as complaints are usually made in the grapevine, and are not filed formally. And several headlines this year emphasized the extent of Filipino health worker migration. In August of this year, the WHO came out with a study that revealed more Filipino nurses are now afflicted with HIV, compared to those working as entertainers abroad, because of medical accidents²⁷. Six Filipino migrant health workers also died of SARS abroad²⁸. In Libya, nurses are either not paid, or underpaid²⁹. Some are also not given accommodations. Canada on the other hand is criticized for its Live-in Care Giver Program which forces many Filipino migrant health workers to do 24-hour-a-day household work for Canadian families³⁰.

These examples raise the need for migrant health workers to organize and set up support mechanisms to fight for fair working conditions, however according to the POEA and OWWA this has worked to the disadvantage of the workers themselves. In some countries where Filipino workers tried to unionize they were seen as “trouble-makers”. In some cases this may affect the market for Filipino workers³¹.

²⁷ Sheila Crisostomo, “More RP Nurses Than Entertainer are HIV Infected”, Philippine Sta, 8 August, 2003

²⁸ “6th Pinoy Dies of SARS Abroad”, People’s Tonight, 15 August, 2003, p.16

²⁹ Philippine Overseas Employment Administration, written response to request for interview, December 5, 2003

³⁰ “Violating Migrants Civil Rights”, Philippine Star, 6 September, 2003, A2

³¹ Philippine Overseas Employment Administration, written response to request for interview, December 5, 2003

Part II. SURVEY OF PUBLIC HEALTH WORKERS

Findings :

- **Gender**
 - In both Sets there were more female respondents than there were male respondents - 35 (90%) in Set A and 8 (67%) in Set B and. Over-all, out of the 51 respondents, 43 (84%) are women.

- **Age and Financial Stability**
 - From the survey, migration appealed more to those who are in the 31-40 age bracket, followed by the 20-30 age group . On the other hand, most of those who do not have any plans of migrating to work abroad are in the 41-50 age group. This somehow indicates that younger nurses are more predisposed to consider working abroad, compared to those who are older, more experienced and relatively stable in life. Looking at the responses of **25** respondents in the 21-30 and 31-40 age brackets, 22 or **88%** are earning salaries lower than the prevailing poverty threshold income. Furthermore, 41% of this **88%** are their families' breadwinner.

- **Educational Background**
 - It is also apparent from the results of the survey that respondents are academically qualified for their positions with all of them graduates of baccalaureate degrees. Thirty two (63%) of the respondents **in both Sets** spent 5 or more years in their studies. Twenty (39%) on the other hand are either taking up or have finished their graduate studies. **Of those in Set A, 18 (46%) are either taking up or have finished their graduate studies, while 7 (18%) are either dentists or physicians.**

- **Hours Worked / Work Overload**
 - On **average hours currently worked 30 (59%)** of the respondents said they work 40-50 hours in a week, **19 (39%)** on the other hand work 30-40 hours. On **average overtime rendered in a week, 25 (49%)** said they render overtime every week ranging from less than 2 hours to more than 10 hours. **Twenty five (50%) on the other hand either said overtime is not applicable, or did not answer at all. In Set A 18 (46%) of the respondents render overtime every week.** However, these answers are misleading as it was admitted by the Personnel Office of both targeted institutions that their health workers render overtime work when necessary - but overtime in the government service is not paid. As expected, 10 (77%) of respondents in the Rizal Medical Center said they do render overtime work. RMC being a tertiary and national government funded hospital provides curative and rehabilitative health care, whereas the Manila Health Department on the other

hand provides promotive, preventive and a certain degree of curative health service.

- On the question of how many patients are the respondents responsible for, **29 (57%)** said they took charge of more than 20 patients on a daily average. Of those who are either about to go abroad or are seriously considering to work abroad, **24 (62%)** takes care of more than 20 patients.

▪ **Wages**

- Based from the survey, **29 (57%)** of the respondents earn incomes lower than the poverty threshold level.

<i>Salaries</i>	<i>Number of Respondents</i>
Php6,522	2
Php7,606	1
Php9,000	2
Php9,939	4
Php9,996	1
Php10,000	3
Php13,000	1
Php14,098	8
Php14,000	3
Php14025	1
Php14028	1
Php15992	1
Php15946	1

- As pointed out in Part I of the study, the lack of plantilla positions for health care workers exacerbates the shortage. Among the respondents, there were two whose positions are Clerks, but who are registered nurses. Aside from their duties as Clerks, they perform nursing duties whenever the Health Department is need of additional nurses. One of them is also a graduate of a midwifery course. They are earning Php6,522.00 (\$118)
- **Twenty of the respondents (39%)** for both Sets are the sole breadwinners in their families. It is also important to note that 69% of nurses interviewed in the targeted hospital, which is nationally paid receive only Php9,000-Php10,000.00. Whereas, in the Manila Health Department, all Public Health Nurse still receive wages pegged at Php14,098. These cases exemplify the non-implementation of the amended provisions of the Nursing Law, approved last year. According to the said law, entry level pay for nurses will be pegged at SG 15, and their pay scale will be adjusted accordingly.

▪ **Recruitment and Employment Abroad**

- Of the **37** respondents who were able to cite specific countries where they would like to work or where they are applying for a job the preference of **32 (86%)** of the respondents. **A far second is the UK, Canada and Saudi Arabia each with 3%**
- The extent of the migration of health workers is exemplified by **38 (74%)** of the respondents saying they have colleagues or friends who have already migrated to work abroad as health workers.
- This is reinforced by the next question on from whom did the respondents learn about opportunities to work for abroad, and **25 (68%)** in Set A said they learned about it through friends and colleagues, **9 (24%)** from family and relatives, **6 or (16%)** said information came from recruitment agencies, and 1 (3%) said information came from seminars.
- Surprisingly, only 17 (43%) of the respondents said they used a private recruitment agency, while 20 (51%) said they did not use a private agency. There can be two interpretations for this. One they applied through the POEA's Government Placement Services, or they do not know as of yet whether they will be using a private agency or the Administration's services since they are still planning and have not yet submitted the necessary documents.
- The table below summarizes the terms and conditions of employment which respondents expect in their new work environment abroad. It should be stressed though that not all of those in Set A are already leaving, many of them are still seriously considering going abroad in the near future, but have not finalized the processing of their documents yet. Thus, many may have no idea yet as to what the contents of their contracts will be.

Questions	Yes	No	I don't know yet	<u>Not Applicable</u>	<u>No Answer</u>
1. Will your employer or recruitment agency pay the full costs of your travel abroad?	9	10	15	<u>1</u>	<u>4</u>
2. Will your employer or recruitment agency pay the full cost of your visa and work permits?	<u>7</u>	10	<u>15</u>	<u>3</u>	<u>4</u>
3. Will/ does your contract cover the cost of your airfare to take home leave during the period of your contract?	7	7	<u>18</u>	<u>3</u>	<u>4</u>
4. Are there any other fees you will have to pay in order to migrate	<u>18</u>	4	12	<u>0</u>	<u>5</u>

5. Will your contract have any provision that allows family members to migrate for family reunification?	18	3	11	<u>1</u>	<u>6</u>
6. Will your employer provide health or pension benefits?	<u>11</u>	<u>1</u>	<u>18</u>	<u>2</u>	<u>7</u>
7. Will your employer provide additional training	11	<u>2</u>	<u>19</u>	<u>2</u>	<u>5</u>
8. Will your employer provide any cultural orientation	12	1	<u>19</u>	<u>2</u>	<u>5</u>

- On the question of whether there are any other fees which the respondents had / will have to pay in order to migrate 18 out of the 32 who responded (56%) said YES, and 4 (10%) said NO.
- On the kind of fees paid for or to be paid for by the respondents one of them said she or he had to pay Php300,000.00 for the agency fee, placement fee, visa fee and her plane fare to the host country.
- Thirteen (38%) of the respondents said they had to incur debt in order to pay for certain fees to facilitate the processing of their application papers. This further attests to the aggressiveness of some recruitment agencies or health care institutions abroad, making it easier and faster to process an applicants' papers.
- On whether the position they will be transferring to is of the same, or higher, or lower skill level compared to their current position , 17 (46%) answered HIGHER, 8 (23%) answered LOWER, ten (27%) answered THE SAME and 2 (5%) answered I DON'T KNOW. These answers are misleading though since foreign nurses usually start at entry level positions. This can be interpreted though as the respondents' perception that the jobs they will be landing abroad will require more skills in terms of operating more sophisticated machineries and exposure to complicated operations
- On respondents' perception of whether they will find difficulty in integrating to the workplace of the new institution, 13(36%) said no, while 15 (42%) said maybe, and only 8 (22%) said yes. On whether they can easily integrate into the society of the host country, 15 (42%) said no, 18 (50%) said maybe and only 3 (8%) said yes.
- On the question whether they still plan to return to the Philippines to work, 19 (50%) said yes they still would like to return while 8(21%) are undecided. If the issues these respondents raised are not adequately addressed then chances are they might opt not to work in the local health system anymore. It is also important to take note that these statements may still change once the person is already in the host country, earning more and enjoying better benefits. For those who said yes they would still want to return in the Philippines to work, reasons which were given were:

- To be with the rest of their families
 - Only wants to gain experience abroad
 - Love for country
 - Desire to serve their fellowmen more
- Those on the other hand who no longer have any plans of going back, cited that they may no longer have any job to return to here. This was echoed by those unsure of whether they still want to return to work or not since it is difficult to get a job in the government if you do not have the proper connections.
- **Reasons for Migrating and Not Migrating**
 - On what factors were influencing respondents in Set A to migrate, the following were the responses:
 - To earn more / improve their financial condition – 33 (85%)
 - Economic crisis in the country - 25 (64%)
 - Low salaries – 24 (62%)
 - Overwork/ understaffing –24 (62%)
 - Poor retirement benefits –21 (54%)
 - Demoralization / inadequate recognition for their effort – 21 (54%)
 - No overtime pay – 9 (23%)
 - High taxes – 9 (23%)
 - Overdemanding patients – 9 (23%)
 - Lack of adequate facilities – 9 (23%)
 - For better future and advancement of their families 6 (15%)
 - New experience – 5 (13%)
 - Professional advancement – 5 (13%)
 - Increased crime rate – 3 (8%)
 - Political situation is chaotic – 3 (8%)
 - Relatives are in the States – 2 (5%)
 - In an interview with Overseas Workers Welfare Administration Director Dela Fuente, he said that OWWA mainstreams the family of migrant workers in their programs, since they are cognizant of the fact that what pushes migrant workers to look for greener pastures abroad is to give their families better lives. This is rooted on how Filipino values are generally family-centered. In the survey, of those planning to work abroad 67% are married and 38% are breadwinners, which means there is greater pressure on them to provide their families better lives.
 - On the other hand, in Set B 50% are the sole breadwinners in their families. When asked what reasons can make them decide to go abroad, all of them cited economic-related factors such as if the country experiences another economic crisis, or if he or she personally faces a financial crisis. Given that

they are the sole breadwinners, they are more likely to change their minds in the future on whether to migrate or not

- Two non-economic and work-related factors were cited as well - the country's political situation and the crime rate which got 8% each.
- In Set B, respondents were also asked what were the reasons which made them not to see migration as an option- 9 (75%) cited family related reasons such as who will be taking care of the children. Two of these 9 respondents though said they may consider this once their children are already old enough. Three (25%) on the other hand said they do not want to migrate because they are already contented with their life, while only 1 (8%) said he or she is committed to serve here.
- Those in Set B, were asked further on what they think are the reasons that can make them decide to migrate - 9 (75%) said they will consider migrating if the time comes and they already need to earn more and other economic relate problems, 2 (17%) on the other hand said they will consider migrating if their husband prods them to, and if their kids are already old enough. Other reasons were: if they can no longer bear the working conditions, if the quality of public services has deteriorated so much, if they want to experience other cultures, and if they can bring with them the entire family.
- **What Should Be Done to Address Issues Brought About by Migration**
 - On what are the respondents think should be done to encourage more public health workers to remain in the country instead of working abroad, the following strategies were cited:
 - Health workers should be properly compensated – 39 (76%)
 - Granting of better benefits - 29 (56%)
 - Upgrade facilities and equipment – 24 (47%)
 - Increase manpower in the workplace – 22 (43%)
 - Implement the Magna Carta for Public Health Workers – 20 (39%)
 - Lessen the workload – 12 (24%)
 - Peace and order in the country – 12 (24%)
 - Adequate recognition with one's work – 12 (24%)
 - Graft and corruption – 11 (22%)
 - Lessen tax deductions – 10 (20%)
 - Address slow promotion process and strict implementation of merit and fitness standards in career development – 3 (6%)
 - Improve work conditions – 3 (6%)
 - A good president to lead the country – 1 (2%)
- **Can Unions Help Health Workers in the Country**
 - On whether they think workers' organizations have an important role in improving working conditions of health workers in the country, 30 (59%) gave

positive responses, whereas 13 (35%) said workers' organizations do not play any important role. Issues which respondents said should be addressed are:

- Providing more trainings and seminars – 11 (22%)
- Give moral support to workers and in helping them fight for improved work conditions – 5 (10%)
- Lobby with Congress for improved work conditions of health workers – 5 (10%)
- Airing to management workers' problems – 4 (8%)
- Negotiating with management – 3 (6%)
- Give protection to workers rights – 2 (4%)
- Give information about workers rights – 2 (4%)
- Reviewing the benefits and salaries of workers – 1 (2%)

- One respondent who said she does not think unions can help improve working conditions of health workers in the country said unions are only concerned with money-making schemes.
- It is also noticeable that although more than a majority of the respondents agreed that workers' organizations can help in improving the working conditions of health workers in the country, all the recommended strategies got less than 25%. This somehow reflects a low understanding of what unions do. This is not surprising since unionization rate is does not even comprise 25% of the entire bureaucracy. This is reinforced by the earlier finding that of the 51 respondents only 7 (14%) are union members.

- **Can Unions Help Migrant Workers**

- On the question whether the respondents think workers' organizations can help migrant health workers, 26 (51%) said yes, 10 (20%) said no, 4(8%) said It depends, another 4 (8%) said I don't know and 2 (4%) said maybe.
- In terms of concrete ways by which unions/ workers organizations can help migrant health workers the following strategies were given:
 - Giving information / orientation to migrant health workers on what they need to know once they are already there - 14(27%)
 - Giving support in case he or she has problems / support the worker in his problem – 7 (14%)
 - Monitoring the workers' condition in the host country – 2 (4%)
 - Protecting their rights – 1 (2%)
 - Sponsoring deserving health workers for scholarships for career development opportunities – 1(2%)
 - Identifying legal and OFW friendly recruitment agencies – 1 (2%)
 - Setting up of satellite offices – 1 (2%)

- **Unions and Women Migrant Health Workers**

- On the question of whether they think there are problems/ issues which women health workers particularly face, 31 (61%) said yes, while 18 (35%) said no.
- When asked what these problems are which women health workers face in particular, the following problems were cited:
 - Sexual harassment- 22 (43%)
 - Discrimination – 18 (35%)
 - Overwork – 3 (6%)
 - Abuses –1 (2%)
 - Security and safety risks – 1 (2%)
 - Exposure to hazards – 1 (2%)
- Similar to the question on whether respondents think there unions can help improve work conditions of health workers, the question on gender issues which women health workers may face in particular also got more than a majority of responses which acknowledged that there are such problems. However, when asked what these problems are less than half of the total number of respondents were able to identify any.
- On the question on whether they think workers’ organizations can help women health workers in the country, 18 (35%) said yes while only 14 (27%) said no, another 18 (35%) said they do not know and 1 (2%) said maybe. This reinforces the earlier finding that there is a low understanding of the kind of work that unions do.
- In terms of giving concrete ways by which unions can help below are the following responses:
 - Protecting the rights of women 5 (10%)
 - Provide orientations –4 (8%)
 - Awareness raising – (6%)
 - Giving assistance to workers who are abused - 2 (4%)
 - Helping those who do not know their rights – 1 (2%)
 - By representing and raising workers concerns’ with management – 1 (2%)
 - Lobby for the rights of women and in the passage of the Magna Carta for Public Health Workers - 1 (2%)
 - Setting standards pf fairness – 1 (2%)
- On whether they think workers’ organizations can help women migrant health workers, 24 (47%) said yes, while 14 (27%) said no, 8(16%) on the other hand said maybe and 5 (10%) said I don’t know.
- On specific ways by which workers’ organizations can specifically help women migrant health workers, suggestions were
 - Giving information on women’s rights – 13 (25%)
 - Providing a women’s desk in foreign countries which can give assistance – 2 (4%)
 - By giving workers’ security assurance – 1 (2%)

- Giving women migrant health workers legal information they need in their work and to protect themselves – 1 (2%)
- Giving women migrant worker information on what their rights are – 12 (23%)
- Providing them with the right employer/ referring them to jobs abroad
- Giving education and training – 1 (2%)
- Giving support in work related problems – 3
- By giving orientations – 1 (2%)
- Helping them settle in the host country – 1 (2%)

Conclusions

The current wave of health worker out-migration has brought about a complex web of issues which reflect the kind of governance in the country. Its primary effect is shortage of skilled replacements, as shown in the specific examples cited and also in the case of the two target institutions. Examples were given on how hospitals are trying to cope with the problem by setting up mechanisms that leave the remaining health personnel overworked and disgruntled. And policies or systemic problems contribute to the shortage by making the hiring process too bureaucratic or politicized.

Part II provides a picture of what the profile is of migrant health workers – with most of them young but experienced, and highly trained and educated with a majority having taken up or finished their graduate studies. Part II of the provides on a micro level a picture of how overworked and underpaid are the country's health workers. Those who have plans of migrating are provided with assistance from the processing of their papers, to their integration in their new working environment. But what lures health workers the most is the possibility of bringing their families to migrate with them. The study only reaffirms data and insights from Part I, as those who plan to work in health care abroad cited economic reasons particularly low salaries and inadequate benefits or non-implementation of existing benefits, understaffing and demoralization at work as the primary reasons. One finding in the study is that migration is not just about economics - of health workers wanting to earn more, but in the case of the Philippines it has taken on a more political character. Several respondents and leaders of stakeholder organizations in particular have consistently expressed dismay over the country's political culture of patronage, which can be seen from the workplace level as merit and fitness is disregarded, to the national level, and of how governance has been transformed from a process of ensuring that services are given to the people, to a system where personalities, political favors and bickering take center stage.

The strategies which they suggested on how unions can help health workers here and women health workers in particular, focused more on capacity building through trainings and seminars, assistance in lobbying for better terms and conditions of employment, information dissemination. Strategies suggested on how unions can help migrant health workers and women migrant workers in particular mentioned information dissemination on workers and women's rights, monitoring their working conditions, linking them up with employers with best practices and the setting up of satellite offices. It is noticeable though how respondents have very little awareness on what unions are and what they do.

But the issue of migration should not be taken in isolation and should rather be seen within

the context of how the government governs, in terms of what strategies does it adopt to promote growth and employment. In this case, there are inadequate mechanisms to ensure that the migration of health workers has a trickle-down effect on the people's access to quality health care. Furthermore, the migration issue also reflects governments' priorities, of which accessible and quality health care is not a part. This phenomenon should also be seen in terms of how it manifests gender relations, with more and more women now carrying the burden of improving their families' lives. Cutbacks in health spending, which is a basic service puts women at a further disadvantage as the responsibility of caring for the elderly and the young are left for them to shoulder. Being the household managers, they also have the responsibility of trying to meet the family's health needs.

Another dimension of this phenomenon is that if before their families here in the Philippines were the primary reason why migrant workers return to the country, with more lax immigration policies what will keep them from settling down abroad, where not only are salaries and benefits way better, but where public services are stable, efficient and accessible. This may change in the Filipino values system, as a new middle class will rise composed of the families of these migrants who will inevitably idealize Western culture, and whose dreams will be of some day working abroad.

However, any effort to ensure that the migration of health workers contributes to the country's over-all development and whether migrant workers' rights are protected, also requires the clarification of government's stand on migration.

Unless the issues raised in the study, through the secondary data gathered, from leaders of stakeholder organizations, and from the respondents themselves, then the country will continue to suffer from a brain hemorrhage of its competent and highly skilled health workers

Recommendations

The rapid out-migration of health workers is brought about by a complex set of issues, and its effects are also multi-faceted. Thus, strategies to address these must also involve all stakeholders. Furthermore, stakeholders must realize that migration cannot be stopped - it is everyone's right to look for greener pastures, and the Philippines simply cannot compete with the salaries and benefits which receiving countries offer. Addressing migration means managing it so that those who leave are given incentives to return here and practice their profession again, that replacements are still capable of delivering quality health care, and that public health services benefit through migration.

To make short term and long term strategies sustainable and more realistic, there is first a need for more in-depth research on the effects of migration, particularly evidence-based quantitative research on how it leads to poor health care services. As of now most of the data available are from the media and are anecdotal in nature, and they only provide a fragmented picture of migration.

Strategies, whether they be long term or short term should target the policy level and local levels as well, since there is also a need to raise the awareness of those people directly affected by migration. **On short term strategies, policies on personnel administration particularly in health care institutions should be reviewed.** Health care institutions or

local government units should be given some form of disincentive for not filling up crucial health-related positions within a specific period of time. But these appointments must be based solely on merit and fitness. Personnel managers on the other hand should be given more independence in filling up vacancies as long as funds are available, this means de-politicizing the personnel administration especially in local government units. The processes involved in the hiring of crucial health related positions should also be lessened. Crucial health related positions may vary basically on the importance and sensitivity of the position.

But **long term strategies** should lessen the country's dependency on migration. Yes we cannot compete with receiving countries, but policies or measures that will provide more incentives for health workers to serve here can be institutionalized. First, the **pay structure in the health sector should be seriously reviewed, and funding should be provided for its implementation.** Non-monetary benefits that can indirectly increase health workers disposable income, can also be explored. Broader career paths for health workers should also be developed, particularly among nurses and midwives. **The phasing of the Magna Carta for Public Health Workers should also be reviewed** so that it can match available resources without sacrificing health workers's rights to better terms and conditions of employment.

This also means **lobbying** by unions, consumer groups, community organizations and professional health organizations for adequate budgetary allocations for health. A look at the government's budgetary allocations show that its priorities are more dictated by politics rather than what would make services more efficient. Thus, lobbying for increased spending for health care should be strengthened to take on a more political character too. But the strength of lobbying efforts is dependent on whether unity among stakeholders is forged. The DOH's initiatives on Workforce Planning is a good start for different groups to identify issues where they can unite, what actions should be taken and what the opportunities and weaknesses are in case concerted lobbying efforts are taken. The key would be to popularize the issue of migration and its effects on public services, on families and communities. Thus, the need for the **production of education and advocacy materials** appropriate for each sector affected by the migration issue.

Bilateral Employment Agreements should also be maximized to promote partnerships between governments and employers to ensure fair and decent working conditions for Filipino health workers, or provide limits on the number of health workers the country can deploy, or any investments they can make to improve health care in the country. These agreements should be pursued in countries where health workers are exploited such as in the case of Canada's Live-in Caregiver Program and Libya where nurses complained of delayed or non-payment of salaries. Migration for development should also be pursued, establishing a mechanism where there is a direct link between health workers' remittances and improvements in public health services. A fund can be created for education and training or additional benefits for health workers in the country.

Awareness raising for health workers should start as early as in the production stage. Curriculum in health related courses particularly nursing should be inculcate the **value of nationalism**, and should include more immersions in communities so that students early on will realize how their skills will be more important here. Higher standards should also be implemented for schools which offer health related courses, particularly nursing. And for

these standards to be relevant there should be clear monitoring mechanisms on whether these are followed or not.

There are a lot of areas where unions can intervene. In the local health system, suggestions given in the survey were more on **training and capacity building**, although respondents did not specify on what areas, unions can focus on **negotiating skills** to improve terms and conditions of employment since they identified “representation with management” and “negotiating with management” as other areas where unions can help them. Unions should also be more active, consistent and strategic in pushing for better terms and conditions of employment, and the Magna Carta for Public Health Workers is an issue which can make health workers more aware of what unions are. This is important since the survey shows that although respondents are positive that unions can help in solving issues brought about by migration, they could not specify concrete ways by which unions can help. This was also the case with respondents’ when asked on how unions can help women health workers in the country and women migrant health workers. They could identify various problems which women face, but they had difficulty identifying how unions can help.

Aside from training and capacity building, unions need to **raise health workers’ awareness on the importance of unionism, and starting with small gains at the workplace level** can create good impression. Since labor management relations in the Philippines remain to be adversarial, unions can find alternative ways by which to achieve these small gains through non-adversarial means.

Unions can also explore the possibility of a **twinning process** with unions in labor receiving countries, in terms of ensuring the protection of Filipino health workers there and that recruitment does not compromise the quality of health care in the country. Such a twinning process can also mean automatic union membership once a health worker migrates to the receiving country, or the provision of service to help him or her settle down. The need for alternative sources of information for those about to migrate was also identified by the respondents. In the Philippines this can mean unions getting **accreditation as providers of Pre Departure Orientation Seminars**, where they can give those about to leave other contacts. The PDOS can also provide a mechanism by which unions can educate migrant workers not only of what their responsibilities are but also of what their rights are. Also, unions can **popularize recruitment procedures** for the information of those wanting to go abroad, as well as the content of **Bilateral Employment Agreements**.

But the success of any effort to manage migration depends largely on whether the cooperation of all stakeholders. The exodus of the country’s skilled health workers for abroad is not just about economics, its about governance, its about everyone’s right to quality health care in order to lead productive lives.