POLICY BRIEF

Human Resources for Health Migration

Introduction

Health workers are vital to the health system and play an important role in improving access to health services and quality care. They are also important in international disease prevention and control.[1] [2] Hence, if they are in short supply and inequitably distributed, access of Filipinos to high quality primary care will be hampered.

One of the most important challenges of the Philippine health care system is international migration of health workers. Based on data from the Philippine Overseas Employment Administration (POEA) and the Commission on Filipinos Overseas (CFO) from 1990 to 2017, there has been a steady increase in migration of health workers. The same data also showed that nurses, among the all the health cadres in the country, has the highest demand abroad where the elderly population is growing but there is little production of health workers. Both the CFO and the POEA report that a total of 350,361 doctors, nurses and midwives have left the country for overseas work from 1990 to 2017. About 84% of the migrants work abroad temporarily, while the remaining 16% have moved permanently abroad. Of this total, 95% are nurses, 3% doctors and 2% midwives.[3] However, there is also domestic migration that causes inequitable distribution. A recent observation is that private sector health workers have moved to the public sector due to compensation differentials. In addition, more HRH have taken non health jobs in business processing outsourcing (BPOs) organizations.

Policy issue and magnitude of the problem

International migration. The Philippines' implicit promotion of labor exportation, introduced during martial law years in 1974 by way of RA 442, and leading to the creation of government agencies dedicated to facilitating migration[4] has, over time, led to the country's reputation as an ethical source of health workers. The total number of HRH migrants has been steadily increasing since 1990 until 2017 at an average of 19 percent per year.[5] [6] The bulk of migrants from 1990 to 2017 are temporary migrants accounting for 84 percent of the total. While the absolute number of temporary migrants are larger over the same period compared to permanent migrants, the growth rate has been the reverse. From 1990 to 2017, the growth of permanent migrants has averaged 10 percent per year compared to an annual growth rate of 6% for temporary migrants.

From 2000 to 2010, for both women and men, there are generally more temporary HRH migrants (102,591 women and 16,097 men) compared to permanent HRH migrants (22,738 women and 6,247 men).[7] [8] According to CFO data, a cumulative total of 60,000 HRH, mostly nurses between 25 and 34 years old, has been lost to permanent migration from 1990 to 2017.[9]

Factors affecting International Health Worker Migration. Push and pull factors affect the migration of HRH. **Push** factors are conditions in the Philippines that encourage HRH to leave the country. These include

poor working conditions in the Philippines which include low salaries, insecure jobs without tenured positions, unsafe and inadequate working environments, outdated healthcare technologies, and lack of employment and career opportunities. Additionally, poor health infrastructure, job insecurity, inconsistencies in practice, outdated or inappropriate curricula, institutional politics, and inadequate opportunities for specialty training influence migration decisions. Human rights abuses, peace and order issues especially in rural areas, are other push factors in HRH migration.

One of the key drivers of HRH leaving the country is the **pull** of international migration. Pull factors include the prospect of better social, economic, and professional opportunities abroad and the presence of relatives in the destination country. The attraction to destination countries include higher salaries, higher quality working conditions and technologies, and job vacancies with available positions due to local shortages. Finally, the policy and institutional support currently in place facilitate the migration of HRH. For instance, the destination countries' visa provisions allow family members to join the migrating health worker to facilitate family reunification.[10] [11] [12] [13] It does not help that policies across different agencies of government are not aligned and sometimes conflict with one another. For instance, the Department of Health promulgates policies that promote retention of health workers in the country while the Department of Labor. POEA, CFO create policies that facilitate and safeguard HRH migration to bring down unemployment in the country.

The pull factor is usually sealed by the salary differential offered internationally. Using the latest salary standardization for government workers and international salaries through PayScale,[14] the differentials are as follows: a) the highest paid government nurse will get about PhP 650,000 per annum compared to the lowest entry level nurse in Saudi Arabia getting paid PhP720,000, b) The highest paid midwife is to get an annual pay of PhP 432,000 which is lower than the entry level midwife in Saudi Arabia who is paid PhP 510,000, and c) the highest paid doctor will get PhP 1.4 Million in the Philippines which is lower than what Saudi Arabia can offer at PhP 1.6 Million per annum.

In a study on the causes, consequences, and policy responses of migration of highly trained health personnel from the Philippines, survey respondents identified the following consequences: shortage of workers (42%), reduction in services being provided (20%), increases in errors/poorer quality of care being delivered (8%), and longer waiting times for essential services (7%). In general, health professionals with substantial training, experience, and skills are the ones who are recruited and leave for work abroad. The most obvious impact has been the uncontrolled expansion of health professions, especially nursing education. At the national level, the contribution of remittances of migrant workers to the economy has been a key reason why governments support labor export.[15] However, the overall net social benefit of HRH migration is lower than its social costs. [16]

Domestic Migration. Apart from international migration, a more recent outflow of HRH has been to Business Process Outsourcing (BPOs). The Philippines is one of the world's top provider of BPO services ranging from basic customer service, sales to the more sophisticated creative industries. Within the spectrum of services are health care related information management such as medical transcription, data management, medical coding and billing, revenue cycle management, and pharmaceutical benefits management, among others (IBPAP). As this kind of service requires basic knowledge of health care, the preferred workers are mostly those with health education and training. According to the Information

Technology and Business Process Outsource Association (IBPAP), there are an estimated 118,200 workers in the health information management segment as of 2016.

This demand for Filipino health workers in the BPO industry is expected to grow to about 210,300 by 2022 according to the IBPAP estimates. This is primarily due to the aging demographics in the US and Europe and their digitalization of records. Filipinos are in demand because according to the IBPAP, the country has the largest pool of US-licensed nurses outside the US and that the education system is patterned after the US allowing for easier adjustments to US standards.[17]

Moreover, in the last couple of years, it has been observed that private health workers have been moving to work in public health facilities because of compensation is now higher in the public sector. The public health sector has been more dutifully complying with policies that specify salary and benefit increases more that private health facilities. For instance, the Philippine Nursing Law has specified that entry nursing jobs nurse I (N1) must have salaries equivalent to salary grade 15 or around PhP 28,000. Many DOH retained hospitals have complied and pay their nurses accordingly and have adjusted higher level positions' compensation packages as well.

Need for policy support to manage HRH migration

While migration and movement of natural persons are human rights, the largely outward directional flow of health workers in the Philippines has had adverse impacts on the delivery of health care services, and by extension, to health outcomes. The breakdown of local health care systems has been partly attributed to the migration of health professionals leading to a dearth of health workers who provide essential health services and as a consequence results to poor health outcomes of Filipinos .[18] Hence, it is imperative that international HRH migration be managed to mitigate its deleterious effects on our health care system. The development and implementation of effective policies to facilitate beneficial migration, if at all possible, needs to be given urgent attention.

The original Migrant Workers and OFW Act of 1995 (RA 8042) and amended in 2010 (RA 10022) provide measures to protect and promote the welfare of migrant workers and their families. The acts aim to reintegrate returning Filipino migrant health and non-health workers into Philippine society to facilitate and motivate local employment and tap (and enhance) their skills and potentials for national development. RA 8042 notes 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 the benefits of development. The implementation of these policies however leaves much to be desired.

In addition to the above, the Philippine government has entered into bilateral and regional agreements addressing the international recruitment of health personnel since 2003. Mutual recognition agreements are in place with ASEAN member states for doctors, nurses, and midwives. Bilateral agreements with Japan, Germany, Canada, Spain, and Norway have provided for support for training, twinning of health care facilities, promotion of circular migration, and education programs (Philippine National Reporting

Instrument 2015). The effects of these agreements have not yet been felt, so it is not clear whether the policies in place are effective in managing migration. There is a need to craft policy support to manage HRH migration to mitigate its deleterious effects and to enhance its benefits.

Policy Goals

The proposed policy on HRH migration management embeds three major policy goals.:

- Liberty is defined as the freedom to do as one wishes so long as no harm is done to others. The policy respects the choice of HRH regarding employment particularly their right to freedom of movement for growth and professional development.[19] However, this should be balanced so as not to jeopardize the needs of the Philippine health sector.
- Equity refers to fair distribution of resources (compensation, benefits), privileges of mobility and career progression and welfare (protection and security) among health workers and employers across different geographic areas.
- Safety is the "satisfaction of minimum human needs" which in this context means ensuring the safety of HRH in their place of work whether in the Philippines or in another country. A consideration should also be ensuring safety of Filipinos in health care provision that can be facilitated by having access to enough health workers in the country. In the Philippines, the government should focus on addressing the domestic needs and push factors that motivate health workers to work abroad.[20]

Policy Alternatives

Option 1. Allow market forces to operate (status quo)

Health workers select their places and terms of employment, guided by existing labor policies. This policy supports the status quo where workers may seek work abroad when the opportunity arises or are recruited to the central DOH office and its deployment program, by LGUs, and by the local private sector. Additionally, health workers can be employed in local non-health industries.

Option 2. Create and implement competitive compensation (salary and benefits) packages

The aim should be to make working in the Philippines as attractive as working abroad. One of the key advantages of this option is that this is supported by UHC law i.e. "health care workers shall be guaranteed permanent employment and competitive salaries". While wages, benefits, and opportunities might not be at the same level as working in destination countries in Europe, North America or the Middle East, working in the Philippines has the advantage of HRH being in the home country closer to their families and communities. This and other previously identified stick factors (e.g. not leaving their family, helping fellow countrymen, fulfillment derived from serving the country) should be utilized in order to encourage HRH to work in the Philippine health sector.

Option 3. Install regulatory migration policies

This option will limit the number of HRH that can be recruited by destination countries and provide time for the Philippine health sector to put in place production and retention strategies that will induce health workers to stay and work locally. Given that the lack of available health workers and inequitable distribution of HRH has been persisting for decades which directly impact the provision of health services and health outcomes, it may be time for government to directly intervene. However, this option limits the liberty of health workers to choose where to practice their profession.

Evaluating the Policy Alternatives

Three policy options are considered to primarily manage migration, and secondarily improve retention and address the inequitable distribution of health workers in the Philippine health sector. Each policy alternative is evaluated based on a set of criteria comprised of liberty, equity, technical feasibility, financial feasibility, and political acceptability in the following sections.

Liberty refers to the degree to which the policy option respects the choice of HRH regarding employment particularly their right to freedom of movement for growth and professional development.

Equity is the distributive capacity of the policy option to address variations in the numbers or locations of health workers, especially in geographically isolated and disadvantaged areas (GIDA) to improve distribution and retention of health workers so that more communities have access to quality and affordable health care goods and services. The goal is to provide health facilities with the necessary number and type of cadre to effectively deliver health care services and continue to make this service available at the primary care level.

Technical feasibility refers to the health care system's technical capability to implement the policy.

Financial feasibility is defined as the viability of the option in terms of cost to government and long-term financial sustainability.

Political feasibility refers to the expected level of acceptance of the policy option by decision-makers.

The first two policy goals have greater weight than the technical and financial feasibility criteria.

Option 1. Allow market forces to operate

Equity. This policy option respects the rights of HRH to seek the best socio-economic opportunities for themselves. However, it will not contribute to the ongoing efforts to address the inadequate number of HRH in the health sector and their inequitable distribution in the country. Overall, mixed health outcomes will likely persist as there will be no major change in the way health workers are distributed across the country and no incentives to encourage them to stay in their posts.

Liberty. This option favors migration, allowing health workers to work abroad once they achieve the necessary requisites by destination countries. This option also allows HRH to work in non-health sectors due to better pay and working conditions.

Technical feasibility. Market forces establish the links between demand and supply of health workers from the Philippines. The presence of agencies such as POEA, OWWA, and CFO help facilitate the out migration of health workers. Hence, there is not much requirement in terms of technical capacity to make this option work.

Financial feasibility. Little investment would be required for this option as it seems that nearly all mechanisms are present to help Philippine health workers work abroad. For instance, there are private recruitment agencies, and the number of private health science education schools increase depending on the international demand for health workers. The resources of private health science education schools in part funds the current labor market behavior that promotes or allows migration quite freely.

Political acceptability. While this option may be politically acceptable due to the contribution to the economy of health workers by way of their remittances, this may not acceptable if health outcomes of LGUs do not improve. In many countries, migration has a negative relationship between disease burden and density of health workers.[21]

Option 2. Create and implement competitive compensation packages

Equity. Providing competitive compensation packages that include salaries and benefits is provided for by the UHC law. If properly implemented this could go a long way in addressing existing HRH deficits in rural areas and oversupply in urban areas, and producing better health outcomes. An important factor that drives HRH to migrate is low compensation packages in the Philippines and much higher wages in destination countries. Filipino nurses earn ~20 times more in the USA than in the Philippines.[22] Introducing competitive packages in the local health sector will serve as a strong encouragement to health workers and deter migration.

Technical feasibility. There are precedents in introducing wage increases, differentials, and benefits in the public sector that this option can learn from and adapt. Entities such as DBM, CSC, the DOH, LGUs and national legislative bodies will need to participate in introducing competitive compensation packages for health workers as provided for by the UHC law.

Financial feasibility. A rough estimate of salaries for one year for doctors, nurses, midwives, and medical technologists will entail Php 7.1 billion. This was calculated using the average entry salary of doctors, nurses, midwives, and medical technologists per month (PhP27,065) multiplied by 12 months and multiplied by the estimated gap in the number of total number of HRH (262,571) for the whole country. This is the absolute number derived from the gap of 24.8 per 10,000 population in 2018 needed to reach the WHO recommended ratio of 44.5 per 10,000 population. Note that except for nurses, the salaries for the other three cadres used in determining the average are the lowest grade. Adding benefits will further increase this amount. This might be a challenge to raise and be supported by decision-makers, especially in low-income LGUs.

Political acceptability. The cost of salaries, which take up the largest proportion of any health facility operations, will be a major stumbling block for decision makers to take up this option. It would be worth

emphasizing the benefits of retaining health workers and providing health services, particularly in underserved areas and GIDA. The argument should be made that improving competitive salaries will constitute an investment to derive better health outcomes for LGUs specifically and for the country as a whole.

Option 3. Install regulatory policies that links production to placement that deter out-migration

To reduce the number of HRH seeking work outside the country and not returning, migration policies can a) establish a set number of allowable emigrants by cadre based on the needs of the local health sector; b) establish stringent requirements before HRH are allowed to migrate; and, c) utilize policy instrument provisions such as the UHC law that provides incentives for health workers to stay and work in the Philippines from production (scholarship based recruitment especially in state universities and colleges, to health workforce placement (RSA and placement in areas where the health worker hails from).

Liberty - There is likely to be resistance over the right of HRH to seek better employment and career opportunities outside the Philippines not only from individuals but also from private recruitment agencies.

Equity. While this will contribute to the resolution of the inadequate number of HRH in the health sector and the inequitable distribution of HRH across the Philippines particularly in GIDA, this impinges on the rights of health workers to choose where they will work. This option is likely to be effective in the short term in addressing the migration issue. However, there are provisions in the UHC law that specify interventions such as return service agreements (RSAs), provision of scholarships tied up to RSAs and the like. The experience of Indonesia show that by engaging in government to government agreements, the number and qualifications of out-migrating professionals can be moderated, and help reduce the negative consequences to local health systems.[23]

Technical feasibility. Regulating migration will involve collaboration among the DOH, DOLE, Department of Foreign Affairs (DFA), Bureau of Immigration (BI), POEA, OWWA, licensing bodies, and the private sector. Prerequisites for migration (i.e. requirements in destination countries and in the Philippines before HRH are allowed to leave) need to be clearly established. The number of allowable migrants by cadre will also have to be determined. Links between, health worker recruitment and production, training and post training placement incentives will have to be established and will require effective networking.

Financial feasibility. Implementing this policy will not require a huge outlay at local levels. Costs include recruitment, scholarship and placement costs which can be borne by national government agencies (NGAs). Additional costs will include regulatory costs also at national level that will determine, establish, and implement quotas for health worker out-migration and the prerequisites that will be required by the Philippine government before workers are allowed to leave.

Political acceptability. This option is unlikely to be acceptable to decision makers due to the potential resistance to actions intended to reduce migration. Resistance will not only come from individuals and

their families but from the private education sector. The private education sector benefits from increases in international demand for health workers, especially for nurses.

Rating the policy alternatives

To determine the best policy option that will balance the migration of HRH with the needs of the Philippine health sector, each policy alternative is evaluated based on a set of criteria aimed to meet policy goals. Policy options are scored on each criterion and assigned a score between 1-3. The score of "1" means that the policy alternative is least likely to achieve the policy goals. The score of "2" means that the policy alternative is likely to achieve the policy goals, but some factors may inhibit its achievement. The score of "3" means that the policy option will most likely achieve the policy goals. Due to the importance of the two policy goals, the criteria of Liberty and Equity will be weighted higher i.e. given a weight of 2 and 3 correspondingly, compared to the other instrumental goals i.e. technical, financial and political feasibility with no weights. Table 2 below presents the evaluation of the policy alternatives based on liberty, equity, and feasibility.

Criteria/ Goal	Definition	Policy Alternatives		
		Allow market forces to operate (Option 1 Status Quo)	**Create & implement competitive packages (Option 2)**	**Regulate migration of HRH (Option 3)**
Equity (Wt=3)	Ability to address variations in the distribution and retention of HRH	1x3 =3	3x3=9	3x3=9
Liberty (Wt= 2)	Ability to successfully achieve individual health worker preferences	2x2=4	3x2=6	1x2=2
Technical feasibility	Capacity of the agency to implement the policy	3	2	2
Financial feasibility	Least cost to government and long-term financial sustainability	3	1	2
Political feasibility	Acceptability to the decision-maker	2	2	1
	TOTAL	**15**	**20**	**16**

Option 1. Allow market forces to operate

Implementing Option 1 will require very little technical and financial inputs from the public sector except for regulatory processes, allowing the private sector to continue helping health workers to work abroad.

It is politically acceptable as this will not be seen as contravening the rights of individuals who are searching for employment that would bring them the most benefits. However, this option will least likely to contribute to ensuring the availability of health workers and bringing about the equitable distribution of health workers across the Philippines since migration will remain unchecked. It will also be the least effective course of action to address the prevailing issues in the HRH sector. Hence, the likelihood that health outcomes of the Philippines will improve is low.

Option 2. Create and implement competitive compensation (salary and benefits) packages
This option follows the provisions of the UHC law in providing competitive salaries and benefits and will have a high chance of encouraging HRH to stay and work in the local health sector. An increase in the number of HRH working locally will provide needed health services and help improve health outcomes. However, this will be the most challenging to implement because of the high cost associated with it.

Option 3. Install regulatory migration policies
Regulating HRH migration will increase the number of health workers in the country. However, they may not be necessarily in the health sector as many health workers have moved to other sectors due to better economic opportunities. Linking production incentives i.e. placement driven scholarships to incentives for placement in areas needing health workers in the domestic market might be successful in curbing out-migration. The Philippines can learn from the experience of other countries such as Indonesia, which has had success in controlling the outflow of its health workers by establishing migrant quotas.

Conclusion

From the results of evaluation of the policy options, it seems that option 2 which will create and implement competitive compensation and benefits is the best especially in achieving the two main policy goals. This option directly addresses key push factors which are low salaries and little benefits. In addition, the government and private sector employers can increase efforts to retain health workers by providing better working conditions. These measures would require long-term commitment and good governance, and may need the support of the international community. Secondarily, the third option that creates a linked policy regime from production to placement seems to be a good alternative to fulfill the policy goals of equity and liberty primarily. However due to the amount of policy coordination and alignment that this option requires from many national government agencies, technical and political feasibility is low. Financial feasibility may be mediated by the effective implementation of the provisions of the UHC law that facilitates the linkages across different sectors and national agencies. The first option where the market forces are allowed to operate, as in the current situation will not help in creating and implementing meaningful changes in the domestic health labor market. This option is the least acceptable as it will not help in resolving issues that continue to plague the HRH sector particularly the inadequate number of HRH in the health sector and the inequitable HRH distribution. Hence, status quo health outcomes will prevail with this option which is not acceptable.

As migration will be impossible to stop, it behooves the government to continue to negotiate mutually beneficial agreements with other countries to manage health workforce migration.

International migration is a given in a globalized economic environment but understanding the "why" is critical to making strategic decisions around the management of migration. Addressing the issues of

misalignment of production as per changing trends in domestic and international demand, as well as factors compounding retention domestically should be taken into consideration.[24]

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