

Beyond 'Push and Pull': Rethinking Medical Migration from the Philippines

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Increasing levels of skilled migration from less-developed to developed countries has been driven by a variety of factors, usually identified in the literature as 'push' and 'pull' factors. While it is analytically useful to specify factors that 'push' medical migrants from one location and 'pull' them to another, it is also imperative to recognize that various processes, at different spatial scales, are easily missed. For example, an underappreciated influence on migration is the emerging consensus among intergovernmental organizations (World Bank, IMF, regional development banks) that such migration is efficiency and welfare enhancing for both sending and receiving countries. This is paradoxically occurring as scholars are increasingly recognizing the necessity of human capital formation and public health infrastructure for sustainable development. While large developing countries such as India and Brazil seem to be able to benefit, on balance, from this form of migration (through remittances, 'brain gain,' and return migration) smaller countries have witnessed levels of skilled emigration that seriously undermine the possibility of sustainable development.

A particularly consequential form of emigration from developing countries is that of skilled medical workers (physicians, nurses, technicians). Increasing shortages in wealthy countries has 'pulled' large numbers of medical workers from developing countries. Key 'sending' countries include the Philippines, where a significant state apparatus encourages migration of skilled labor. For example, it is estimated that 85% of Filipino nurses are working outside of the Philippines (a significant portion of the 8 million Filipinos working abroad, nearly 10% of the total population). The demand for skilled medical workers in wealthy countries will dramatically increase with the demographic shifts of an aging population and increasing medical costs. It is a tragic irony that while billions of dollars of official and private foreign aid now flow to developing countries to mitigate the crisis of particular infectious diseases like HIV/AIDS and malaria, the health care systems of the developed countries are importing human resources from developing countries, leaving them with a collapsing public health infrastructure.

Dr. Jaime Galvez-Tan¹, vice chancellor for research at the University of the Philippines has argued “this is no longer brain drain, but more appropriately, brain hemorrhage.” The crisis of collapsing public health infrastructures will worsen unless and until innovative policy proposals are developed that attempt to deal with what is the very definition of an unsustainable process.

Management of the crisis in human resources for health has re-entered the global policy agenda after years of neglect, and “will constitute one of the prominent health policy issues for the next years to come” (Maybud & Wiskow 2006:225). In order to develop effective policies to counteract the negative effects of brain drain from developing countries, it is necessary to understand the causes for medical migration as well as its effects on the sending country. Because these causes and effects might vary by country and/or region, not all policies will have the same impact if implemented universally; “what works for one country may not work for another, and indeed, what works for nurses may not work for physicians” (Dovlo 2005: 378). In addition, there is unlikely one single policy intervention that will stem the flow of migration or address the multiple health, social, economic, and cultural effects of medical brain drain. The best solution seems to be a variety of proposed and potential policy solutions targeting different levels, factors, spheres and outcomes. Countries “must develop strategies that reflect their particular situation. However, the appropriate international environment for managing human resources is necessary if the strategies of developing countries are to achieve meaningful results” (Dovlo 2005: 379).

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Beyond 'push and pull'

Economic theories of migration are generally 'micro-founded' in analyzing the decisions of individuals, or sometimes households. The all too familiar notion of 'push' and 'pull' factors of migration has its roots in this approach. Push factors for a migrant are related to any number of conditions that might make migration attractive, such as low wages, lack of economic opportunity, poor quality of life, lack of educational opportunity, poor work conditions, etc. Pull factors would include the obverse—higher wages, better working conditions, and more opportunities. While the notion of 'push and pull' is useful for recognizing the migration process always takes place in the context of at least two geo-spatial locations, it also tends to downplay or ignore structural and historical factors that deeply influence migration decisions. In other words, the push and pull schema is highly agentic, while other theories emphasize structure over agency.

A good example of economic theories of migration is the Harris-Todaro model (1970) which sought to explain rural-urban migration in a developing country context. This model specified that rural to urban migration occurs on the basis of *expected* wages, and therefore rural to urban migration would continue, even in the face of urban unemployment, as long as the urban wage was higher than the rural wage. The *prospect* of higher wages is enough to generate migration, even though some will not realize the higher wage. The Harris-Todaro model has been influential in the economic literature precisely because it is micro-founded on the individual decision to maximize the *prospect* of higher wages. Essentially, rational economic agents are expected to maximize their income through migration.

Borjas, among the most prominent economists working on migration issues, has offered a "model of immigration" that formalizes the economic rationality of individual decision making about the migration process.

Neoclassical economic theory assumes that individuals maximize utility: individuals

"search" for the country of residence that maximizes their well-being...the search is

constrained by the individual's financial resources, by the immigration regulations imposed by competing host countries and by the emigration regulations of the source country. In the immigration market the various pieces of information are exchanged and the various options are compared. In a sense, competing host countries make "migration offers" from which individuals compare and choose. The information gathered in this marketplace leads many individuals to conclude that it is "profitable" to remain in their birthplace (*i.e.*, they find it expensive to migrate to another country). Conversely other individuals conclude that they are better off in some other country. The immigration market nonrandomly sorts these individuals across host countries. (Borjas 1989: 460-1)

Here Borjas represents the migration process as much like any other economic transaction, and emphasizes as much. In his own words,

It is important to note that although the idea of an immigration market is somewhat novel in the immigration literature, the notion that different agents are considering the allocation of resources among alternative uses and that this allocation is guided by a market basically defines economics. Formally, there is little difference between the problems of allocating individuals among countries and the problem of allocating individuals among jobs. In both problems, individuals consider a number of options to which they can allocate their time. (Borjas 1989: 461)

So, the migration process is really no different than any other decision made by rational maximizing individuals efficiently allocating scarce resources. If one understands liberal market economics, economic theories of migration are merely an extension of this logic. The migration of an individual from one country to another is essentially a mutually beneficial exchange (or it would not have happened)

and the puzzle of the migration decision narrows to formally modeling the equilibrium conditions of this market, and perhaps trying to understand why the predictions of economic theories don't always square with empirical evidence (Castles and Miller 2009: 23).

The case of medical migration from the Philippines can be easily explained through push and pull factors. Clearly, within the Philippines wages for nurses and doctors are comparatively low relative to what could be earned abroad. Other push factors include weak and often corrupt institutions, poor working conditions including a lack of reliable facilities for patient care, lab work, etc., and general quality of life issues, especially outside of Manila. But the analytics of push and pull miss so much in this case. Choy has argued that in the Philippines, the very "culture of migration" is "rendered invisible" by focusing on 'push and pull' (2003: 4). Choy claims that most studies of nurse migration from the Philippines reinforce "the popular notion that these contemporary Filipino nurse migrations are spontaneous flows made by individual Filipino nurses who rationally calculate professional earnings in both countries, and then migrate because the nursing salary is higher in the United States" (2003: 4). Beyond the "culture of migration" Choy also cites the historical (and highly unequal) relationship between the United States and the Philippines and both governments' policies (2003: 4-14).

Medical Migration from the Philippines

While large scale migration of both skilled and unskilled Filipinos largely begins after the 1973 oil shock and the Marcos-created labor export regime, the migration of medical professionals has much earlier roots. A primary reason Filipino nurses have so easily transitioned from healthcare provision in the Philippines to that of the United States is the colonial history of the United States in the Philippines. That history, beginning with the U.S. claim of the Philippines as spoils of war after the Spanish-American War in 1898 (and subsequent denial of even nominal Philippine independence until 1946) produced two important consequences: the introduction of English as a national language and the introduction of American medical techniques, terminology, and infrastructure, particularly the establishment of a

teaching hospital by the American colonial powers. These could be thought of as “the preconditions of professional migration” (Choy, 2003: Ch.2).

Beyond the importance of English and American medical training, the importance of the Cold War inspired Exchange Visitor Program cannot be underestimated. Envisioned as a U.S. government program that would spread American values throughout the “free” world by exchanging professionals for brief tours of duty, the program initially saw heavy exchanges between the U.S. and Europe. According to Choy, by the late 1960s some 80% of the program participants were medical personnel from the Philippines, with the majority comprising nurses from the Philippines (2003: 65). Of course, many of these thousands of visitors to the United States would seek to return as immigrants, but even those who returned permanently would carry with them descriptions of the United States and working in American hospitals that were shared with colleagues and friends who might consider migration themselves. In addition, changes in American immigration law, including the 1965 Immigration Act, which specifically allowed immigrant visas to be issued on the basis of professional categories, and a change in the 2 year “return” requirement of the Exchange Visitor Program, resulted in a large influx of Filipino medical professionals acquiring permanent residency in the United States (Ball, 2004; Choy, 2003: Ch. 4).

This first wave of Filipino medical migrants to the U.S. was quite different than the second wave, which was more geographically disbursed and arguably less professionally dedicated to health issues (as opposed to migration). The second wave was part of the overall labor export regime inaugurated by President Marcos in the early 1970s. Choy cites a Presidential Address that Marcos delivered to the Philippine Nurses Association in 1973 perfectly capturing the logic that would mark the formal and institutional labor export regime that would begin in 1974. Marcos, explains that he is ending the Exchange Visitor Program because Filipino nurses are exploited through the program while they should go to the U.S. as actual employees, not guests. He goes on to say:

“We intend to take care of [Filipino nurses] but as we encourage this migration, I repeat, we will now encourage the training of all nurses because as I repeat, this is a market that we should take advantage of. Instead of stopping the nurses from going abroad why don’t we produce more nurses? If they want one thousand nurses we produce a thousand more.” - President Ferdinand Marcos, 1973 (cited in Choy, 2003: 115-16)

The Philippines’ Labor Export Regime

While small-scale migration of various sorts has been seen in the Philippines for over a century, the large-scale migration of temporary workers overseas began in 1974 in response to the oil shock of 1973 (Rupert and Solomon, 2006: 87-90). Like many LDCs dependent on oil imports, the Philippines was particularly vulnerable to the quadrupling of oil prices following the OPEC-induced oil shock. The government of President Ferdinand Marcos established an innovative approach to dealing with the balance-of-payments crisis that quickly followed. In what was originally envisioned as a temporary program to generate hard-currency remittance income, the Philippine government established a policy of encouraging Filipinos to work overseas for fixed periods of time (established by contract before leaving the Philippines). The first region to receive large numbers of Filipino workers was the Middle East, especially oil-exporting countries suddenly flush with enormous revenues and unable to provide domestic labor for the large number of new infrastructure projects. Essentially, the Philippines dealt with the massive increase in price for oil imports by trading workers for oil. It should also be noted that this period marked a decisive break with the previous inward looking policy of import substitution. Tyner (2005: 33-37) has argued that the labor-export policy was part and parcel of Marcos’ “New Society” built around the promotion of foreign direct investment, export-led growth, and the disciplining of labor. Although the Philippines has been more or less integrated into the global economy since its founding, this period marked a strong turn towards a globalizing state in significant ways.

What was envisioned as a temporary policy became permanent, and an essential part of Philippine economic policy (Chin, 1998: 94-124). The initial goal of acquiring foreign exchange through sending workers overseas made clear to policymakers and state leaders the benefits of continuing the program. While initially organized under various departments of the Ministry of Labor and Employment (later changed to contemporary Department of Labor and Employment or DoLE), in 1982 these departments were merged to form the Philippines Overseas Employment Agency (POEA). The (POEA) is a government bureau charged with managing the documentation of overseas workers, encouraging overseas temporary migration, creating export markets, marketing Filipino workers abroad, and generally managing the outflow of temporary migrants. The POEA, at first, mostly regulated private sector recruitment and managed the various bureaucratic aspects of migration. Over time, the POEA became more active in managing migration and finding new markets for OFWs. Operating on a slim annual budget of approximately \$3.5 million dollars, the POEA has processed millions of overseas workers while actively seeking new markets for OFWs in a variety of sectors (in order to diversify the employment portfolio of OFWs and protect remittances flows if one sector is adversely affected by conflict in a region or receiving country policy changes). While such occupations as domestic workers, construction labor, and seafarers (laborers working in shipping) are no surprise, the POEA also actively seeks markets for teachers, information technology specialists, highly skilled healthcare workers, and other skilled positions.

Government policy around migrants has waxed and waned with regard to how much the state would acknowledge its role of encouraging migration as a development strategy. A good example is the response to the Flor Contemplacion case, a watershed moment in state policy and OFW reaction. In 1995 a Filipina domestic worker in Singapore, Flor Contemplacion, was hanged by the Singapore government for the murder of a fellow domestic worker and the employer's child. Although the facts of the case were contested, the inability of the Philippine government to stop the execution served as a

symbolic representation of how powerless the Philippine state was in protecting millions of overseas Filipinos. The response among Filipinos was global, igniting protests and mobilizing “opposition parties, church associations, women’s groups, labor unions” and other OFW organizations (Castles and Miller, 2003: 168-9). Massive pressure at home and abroad forced the Philippine legislature to pass the watershed Republic Act 8042, commonly known as the Migrant Workers and Overseas Filipinos Act of 1995. Though the act called for a variety of strengthened protections for migrant workers, the weakness of the Philippine state vis-à-vis labor receiving states has prevented much in the way of concrete achievements. What made the act so significant for OFWs was the ability of migrants and their allies to pressure the state into action. Not only were administrative changes made, the Philippine state publicly acknowledged that the welfare and rights of workers were to be a primary concern, not merely the satisfaction of economic goals. As Castles and Miller observe, the 1995 Act was a sort of ‘Magna Carta’ for OFWs (2003: 169). The language of Republic Act 8042 is telling, and demonstrates the contradictory nature of the state’s promotion of migration while denying it is an explicit development strategy:

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 existence of the overseas employment program rest solely on the assurance that the dignity of and fundamental human rights and freedoms of the Filipino citizens shall not, at any time, be compromised or violated. The State, therefore, shall continuously create local employment opportunities and promote the equitable distribution of wealth and benefits of development.

(Quoted in Tyner, 2005: 40)

While the Philippine state apparatus continuously evolves to promote migration and remittances, it also tries to maintain the fiction that migration is an individual act, thereby limiting the state’s responsibility.

Contemporary Medical Migration from the Philippines

Earlier forms of nurse migration to the United States later expanded greatly due to the labor export policy of the Philippine government as well as the “culture of migration” discussed previously. Accurate data is hard to come by, but some trends are very clear. First, what began as migration to the United States has become global. While the United States is still the preferred destination for most, European countries, particularly the U.K. and Ireland, are also considered attractive working locations. The number one receiving country of Philippine nurses is Saudi Arabia, though jobs in the Middle East are widely considered to be less desirable than U.S. or European jobs. Ball (2008:36) cites POEA statistics showing that from 1993-2003 nearly 100,000 nurses emigrated from the Philippines, with over 46,000 going to Saudi Arabia, over 11,000 to the U.S. and over 16,000 going to the U.K. and Ireland. However, POEA statistics, while likely accurate for contract workers headed to the Middle East and other Asian destinations, are generally considered to be inaccurate for U.S. and European employment as many nurses leave the Philippines on a tourist or student visa and secure employment after arrival. Lorenzo et al (2005:1409) estimate that in 2003 there were approximately 332,000 accredited nurses trained in the Philippines, with nearly 200,000 of those actively employed. Almost 165,000, or 85% of those nurses who were employed were working abroad.

Yet it is not just nurses that are emigrating from the Philippines. Increasing numbers of Filipino doctors are abandoning their training and taking a course in nursing so as to allow for migration to the United States or Europe. Estimates suggest “that more than 3500 physicians left the Philippines as nurses between 2000 and 2006. Around 1500 passed the national licensure exams in 2003 and early 2004, and another 4000 physicians were estimated to be enrolled in nursing schools in 2005” (Masselink, 2007: 23). Further research is required to determine how many of these “doctor-nurses” are content to work as nurses abroad and how many may be seeking employment overseas to prepare for passing medical boards overseas. Regardless of their ultimate intentions, this phenomenon results in a

significant measure of “brain waste” even though one form of skilled employment is being exchanged for another. The Philippines Hospital Association issued a report claiming that by 2004 some 80% of public sector physicians had retrained as nurses (PHA, 2005). Of course, public sector physician jobs are among the least desirable in the Philippines but such a large percentage exiting the field should be noted.

Effects on Health Care in the Philippines

Even though the Philippines has seen enormous levels of nurse migration it cannot be said that the Philippines suffers from a shortage of nurses. In a sense, the real issue in the Philippines is a severe shortage of experienced and qualified nurses. Each year an ever larger number of students graduate from the expanding nursing education sector. Because most overseas jobs require experience (for U.S. nursing jobs this is usually a 2 year minimum), there are many freshly graduated nursing students seeking employment at any time. This tends to suppress wages in the nursing sector, making migration more attractive. There are even reports of nurses paying hospitals to acquire experience, though it is difficult to confirm such reports for obvious reasons. Ball (2008:37) reports shortages of qualified nurses and extremely high turnover rates leading to absurdly high nurse-patient ratios (as high as 1:120 in some instances). Lorenzo et al (2007:1413-14) report that by 2005, over 200 hospitals had closed due to shortages of both doctors and nurses with 800 hospitals partially closing for the same reason.

The World Health Organization reports that while public health in the Philippines has made gradual improvements, the rate of improvement has been much slower than in the rest of Asia and that the shortage of doctors and rapid turnover of nurses contributes to these trends (WHO, 2009). The WHO also notes the Philippines is similar to many less developed countries (LDCs) in suffering from severe shortages of medical professionals working in rural and remote areas. This problem is particularly pronounced in the Philippines where health resources are highly concentrated in the Manila area and the Philippine’s archipelago geography makes the provision of health care more challenging. Total

health spending in the Philippines is approximately 3.8% of GDP, well below the WHO recommended 6.5% figure. Similarly, the most recent WHO data suggests that in the Philippines there are 1.14 doctors per 1,000 population and 4.26 nurses per 1,000 population, significantly below the WHO recommendations. However damaging medical migration is for public health in the Philippines, it is imperative to recognize that the effects are much larger than the loss of doctors and nurses, or the remittances they send home. The “culture of migration” that has been created by the labor export regime begun in the mid-1970s has had a number of effects that are not easily captured in a push-pull analysis.

Commodification of Education

Over the past few decades, health education in the Philippines has been driven by the labor-export model. The Philippines has supported a private sector that has developed a training infrastructure specifically for the purpose of training health professionals for export to overseas markets (GFMD 2007). With up to 250,000 Filipino nurses already working abroad, it is estimated that 15,000 more nurses join their ranks annually (Tiongco-Cruda 2008). It has only been over the last decade, however, that the proliferation of nursing schools has reached an alarming level, especially when evaluated with other related trends in the medical professions in the Philippines. According to Galvez-Tan (2005), 85,000 Filipino nurses went abroad between 1994 and 2003 alone.

In the 1970's, there were only 40 nursing schools in the Philippines; by the 1990s, the number of schools reached 170, and by April 2004, there were 370. As the number of nursing schools increased to meet global demand, however, the rate of those who passed the national nurse licensure examinations decreased. According to Galvez-Tan, around 80 to 90 percent of nursing graduates passed the licensure examinations during the 70s and 80s, but from 2001-2003, the passing mark has been as low as 44 to 53 percent, reflecting the deteriorating quality of nursing education (Galvez-Tan 2005). At the same time, fewer Filipinos are applying for medical school: from 2002 to 2003, there was a decrease in the number

of examinees of the National Medical Admission Test (NMAT) by 24 percent (Center for Educational Measurement [CEM], 2004). There has been an average 47% decrease in first year medical school enrollment, and three medical schools had already closed down by 2005. Two private medical schools located in the rural areas showed a sharp drop in enrollment and are contemplating closing down (Galvez-Tan 2005).

Nurses are being produced for export in another way, which may also partially explain the decrease in medical school applicants. Not only are many young Filipinos drawn to nursing as a profession, many practicing professionals, including doctors as mentioned above, but also physical therapists, teachers and lawyers, make career shifts to nursing, which is seen as a stepping stone to work abroad (Lorenzo et al. 2006). Findings from a baseline survey of nursing-medics in the Philippines (Galvez Tan et al., 2004) showed that 3,500 Filipino medical doctors have left as nurses since the year 2000. About 1,500 passed the national nurse licensure examinations in 2003 and early 2004 (PRC, 2005), and an estimated 4,000 doctors are now enrolled in nursing schools all over the country. Preliminary findings from that baseline study also show that there are at least 43 nursing schools offering an abbreviated nursing course tailored specifically for medical doctors.

(Internal) Brain Drain and Institutions?

What this effectively means is that even before the migration journey begins, a kind of internal brain drain is occurring in the Philippines, drawing the best and brightest from across sectors in the Philippines into nursing. It is not only doctors who are unable to resist the possibility of a better life through migration as a nurse, but untold numbers from other professions. Simply put, the possibility of migration through nursing has radically distorted the market signals for education and various professional sectors in the Philippines. The Philippines is producing far too many nurses, and not enough doctors, lawyers, and other professional degrees. This has several implications. First, this process results in sub-optimal outcomes for various other sectors. But more importantly, and this follows for fields

other than nursing, the large scale migration of skilled labor from the Philippines seriously undermines the long-term growth potential of the country.

While various economic models of skilled migration can render insights about the effects of migration given certain assumptions, they don't really provide an answer to the question of how skilled migration affects any particular country. Context matters. The size of a country and magnitude of skilled migration relative to domestic stocks can have an enormous influence on the effects of skilled migration. The sector that migrants are drawn from is also highly consequential. As we can see in the case of the Philippines, the migration of medical workers such as doctors and nurses can have profound consequences for the home country that is qualitatively different from other sectors. Even within a particular sector, like health care, significant migration from one category (whether doctors, nurses, or medical technicians) can disrupt the rest of the sector. While we should be wary of strong claims made about the effects of skilled migration, Kapur and McHale (2005, 2006) have advanced the argument that a particularly important role of skilled migrants rests with their ability to improve and sustain the development of institutions.

Most attempts to understand the impact of skilled migration have modeled wage and price effects of skilled emigration. While there is certainly tremendous value in such approaches, the conclusions flowing from a particular model are highly dependent on initial assumptions, elasticity of migration, etc. These approaches are unable to effectively model the complex contribution of institutions like the rule of law, efficient and professionalized bureaucracies, universities, health care systems, and effective systems of governance. While "endogenous growth" or "new growth" theories (Romer, 1986; Lucas, 1988; Barro, 1991) are certainly an improvement over neoclassical economic models of growth that considered human capital exogenous, they similarly suffer from the inherent simplifications such models are forced to provide. Kapur and McHale have argued forcefully that it is precisely in the area of institutional development where skilled migration is likely to have the most

profound effect. While the logic of the argument is intuitive, convincing evidence remains necessarily anecdotal. In their words,

There is one source of loss [from skilled migration] that we think is particularly important, and yet it is also surprisingly neglected. It is sometimes said that it is better to have brain drain than “brains in the drain,” implying that educated persons would be badly utilized at home because the lack of well-functioning institutions presents obstacles to realizing their skills. But who is going to improve domestic institutions, and thus raise the development prospects of developing countries, if not educated and skilled people? Talented individuals are likely to be critical sources of both the supply of and demand for better institutions. These are the people who could, for example, improve the organization of health-care systems or perform managerial functions. But due to frustration with existing institutions they may be strongly tempted to give up and seek better working conditions and pay elsewhere. While by no means universal, the middle class—professionals and intellectuals—has typically played an important role in processes of democratization, thus in effect demanding better institutions. The more educated and internationally marketable are often better positioned to exercise “voice” and press for change in the status quo.

(Kapur and McHale, 2006: 312)

This argument has the virtue of being intuitive. While it may be impossible to empirically demonstrate that small countries with an 80% emigration rate suffer from poor institutional quality *because* of skilled out-migration, the high rate of correlation between high emigration rates, small country size, and poor institutional quality are certainly suggestive of the importance of skilled migrants. Another virtue of the Kapur and McHale argument is the recognition that the ‘brain gain’ argument simply fails in the face of large scale skilled migration.

The idea that the migration of a significant fraction of a country's best and brightest is not particularly harmful and may even be beneficial to the country is simply unwarranted. As we have shown, although the effects are undoubtedly complex, the fundamental reality is that countries need talent to ensure innovation, build institutions, and implement programs—the key pillars of long-term development. (Kapur and McHale, 2005: 207)

Although it is certainly plausible that a country could gain from net human capital gains and the possibility of return migration or other network effects (e.g. the rise of the software/information technology sector in India centered on Bangalore), policy makers should not mistake the possibility of some gains from skilled migration for reassurance that skilled migration is, on the whole, beneficial for economic development.

Policy Proposals

So what is to be done in the case of the Philippines? What sort of policies, if any, could ameliorate some of the excesses of medical migration? To be clear, the “culture of migration” is so deeply entrenched, and the magnitude of migration already, it is politically infeasible to contemplate some radical departure from the current labor export regime. Any such change would need to be implemented gradually and even then would face serious obstacles. Given that continued migration at high levels is likely, what sort of policy proposals make sense in the context of the Philippines?

Existing policy suggestions can be divided into two primary categories: those that attempt to reduce or prevent health workers from migrating in the first place, and those that aim to manage the impact of past, current and future migration. Within each of these categories, some policies require action from the countries from which health workers migrate, others require action from those countries to which they migrate, and others demand global-level attention. The policies focus on different aspects of brain drain: some focus on human resources development, others on economic implications, and others on ethical issues. Of course, there is some overlap in this conceptualization of

brain drain policies; for example certain policy schemes (such as improvements in training) might help to prevent migration as well as minimize the impact of existing losses. Here, we focus on a few select types of policies that have been implemented in the Philippines (community health workers, bonding), that are currently being discussed by policymakers there (bonding, bi-lateral agreements), or that seem to have potential for addressing the problem but have not yet been attempted (Bhagwati tax).

In sending countries, policies that attempt to limit the numbers of health workers who migrate from less to more developed countries focus on incentives for medical workers to stay in the country or on placing restrictions on those who leave. Compulsory social service of health professionals, also known as “bonding,” is one suggested way to retain new graduates. The practice of requiring recent graduates to give several years of service in return for their training has been widely used throughout the developing world. For example, “[i]n Ghana, doctors have to give five years of service to their country to defray the costs of training or pay a fine if they do not comply. However, inflation and currency depreciation reduce the real cost of the fine and consequently its deterrent effect. Developed countries such as Singapore also maintain bonds as a prerequisite for medical graduates going overseas on government grants for further training” (GFMD 2007: 8). According to the WHO, “The practice of bonding is widespread yet its effectiveness is poorly understood. Experience of bonding is mixed: it does ensure coverage, but it is strongly associated with low performance among workers and high turnover rates” (WHO 2006:103). Bonding schemes have worked better in some regions than in others (HLF 2004). While restrictions placed on health professionals can temporarily halt migration, they do not prevent it. As Mejia noted as early as 1978, restrictive measures merely postpone or divert movements (Mejia, 1979), and do nothing to address the underlying push factors. In terms of effectiveness, “[c]oercive measures to prevent departure, taken in low income countries that are losing staff, work poorly; worse, they can intensify pressures to leave” (Mensah et al. 2005:4).

The Philippines, the only country in Asia with no service requirement until now, recently instituted

a new “return service” policy at the elite University of the Philippines-Manila School of Medicine. Students entering in academic year 2009-2010 will be required to sign a service contract that obligates them to three years of service as a doctor in the Philippines. Students who wish to leave before their service requirement has been fulfilled will be required to pay a fine equal to double the costs of their education (UP-Manila, 2008). Dr. Alberto Roxas, Dean of the UP-Manila’s College of Medicine, claims that while the new requirements will not, by itself, address the medical personnel shortage in the Philippines, it will be enforced in a novel way. If a student fails to fulfill their obligation the university will not validate their credentials when foreign employers request their transcripts (Roxas, 2008). As information technology improves it may become easier for countries and educational institutions to enforce bonding requirements. However, given the coercive nature of bonding and the low performance levels associated with it, it is unlikely to substantially mitigate the harm of skilled migration.

Increasing attention toward policies aimed at managing or alleviating the impact of migration may reflect the reality that migrant health worker flows will likely continue. Such policies can be initiated by sending or receiving countries, and bi-lateral agreements have also been suggested. These policies might focus on the medical worker (as in taxation of their foreign earnings), or on the broader health care system (such as training and employing community health workers to fill health care provider gaps).

Alongside early discussions of skilled migration came a policy proposal from Jagdish Bhagwati, a trade economist, arguing for the extension of the sending country’s tax authority to migrants living outside of the home country. While endorsing the idea of such revenue as a kind of recompense for the lost education investment of the home country, Bhagwati’s argument was much more extensive. In a wonderful reversal of a familiar phrase from American political culture, Bhagwati argued that the country of one’s citizenship represents *all* its citizens and therefore citizens who avoid paying taxes by virtue of emigration are beneficiaries of “representation without taxation.” This form of equity

argument certainly lowers the bar in terms of arguments against a “Bhagwati tax,” leaving only the admittedly difficult task of specifying how such a tax could be effectively and fairly administered. Among the advanced industrialized economies only the United States utilizes a taxation system where citizen’s income is taxed regardless of the country in which it is acquired (taxation based on citizenship not residency); but the fact that the U.S. has been able to more or less effectively levy and enforce taxation on citizens abroad stands as an important example of the possibility of such taxation, as well as an instance of representation *and* taxation of citizens globally. The issues of fairness and feasibility have always been problems for the Bhagwati tax, but they are not insurmountable. The fairness of a Bhagwati tax must be considered in the context of the incredible income gains achieved by migrants and the morally arbitrary nature of a migrants ‘selection.’ I argue the feasibility issue must be confronted in terms of technical and political dimensions. The technical issues, while complex, are not disqualifying and could be overcome with appropriate political determination. Political feasibility will continue to be a very challenging hurdle. However, emerging demands for more effective institutions of global governance, the growing salience of transnational identity, and openness to innovative policy proposals to mitigate the North-South gap all suggest that scholars and policy makers will keep returning to these kinds of fiscal responses to brain drain.

Community Health Workers

Many countries have begun to focus on human resources as a key to improving health systems, including training community health workers (CHWs) to fill the gaps left by migrating health workers. Although the concept of training local health workers in basic skills to use in their communities has been around for at least 50 years, the “renewed focus on the use of CHWs has its rationale primarily in a recognition that service needs, particularly in remote and underprivileged communities, are not met by existing health services, particularly given increased needs created by HIV/AIDS in many countries and worsening health worker shortages” (Lehman & Sanders 2007: 6). Because highly trained medical

professionals “can only use their skills productively in advanced hospitals, [they] may not be the best health personnel for areas with few modern amenities” (GFMD 2007:7), including underserved rural areas, and they are more likely to be recruited by and attracted to developed countries. Programs that continue training doctors and nurses “to the high standards in modern medicine” may increase the pool of skilled health workers who remain in country (GFMD 2007:7), but most of these health professionals remain concentrated in urban areas, leaving rural areas persistently underserved. CHW programs provide training focused on basic skills that match local needs and conditions, which limit workforce attrition (WHO 2006:102) since these workers are “less prone to the attractions of migration” (Dovlo 2005: 378) and are not as marketable internationally (GFMD 2007).

There are other arguments for training CHWs. They can be trained and retained at a fraction of the cost of a nurse or doctor. Depending on local health conditions and national health systems, the role of CHWs can be appropriately adapted; they might focus on preventive, curative and/or developmental activities, or be trained for very specific interventions (Lehman & Sanders 2007). In addition, CHWs can be trained to provide basic healthcare, triage more serious cases up the hierarchy of a public health system to larger cities and clinics with more resources. “Perhaps the most important developmental or promotional role of the CHW is to act as a bridge between the community and the formal health services in all aspects of health development.... the bridging activities of CHWs may provide opportunities to increase both the effectiveness of curative and preventive services and, perhaps more importantly, community management and ownership of health-related programs” (Kahssay, Taylor & Berman, 1998). The role of CHWs in the broader health system is illustrated at Partners In Health (PIH) sites in Haiti, Peru, Chiapas, Boston, Rwanda, and Lesotho, where paid “community health workers connect clinics with local communities by serving as counselors, educators, treatment providers, and advocates experienced in local needs. By delivering services to patients in their

homes, community health workers improve adherence to treatment and reduce the burden of time and money on both patients and health care systems” (PIH 2006).

In the Philippines, CHWs are called barangay health workers (BHWs). Since 1981, government-trained health volunteers have been operating in rural villages (Lariosa 1992: 30), and according to the Department of Health, there are now 1.3 million BHWs working throughout the country. In 1976, the University of Philippines (UP) College of Medicine started the Institute of Health Sciences of Leyte, a school “designed to develop community-oriented health workers and counteract the twin problems of ‘brain drain’ and the maldistribution of health care;” this became the School of Health Sciences (SHS) in 1989 (Antonio-Santiago 2009; Siega-Sur 2005). In 2008, an extension campus opened a second SHS in the Luzon region. To be admitted to the program, a student is recruited, endorsed, and supported by the community, and then must pledge to return to their community to render service as a health worker (Siega-Sur 2005). These students have the opportunity to progress through a step-ladder curriculum of four levels. The program “integrates the training of barangay health workers (BHW), midwives, nurses and physicians in a single, sequential, and continuous curriculum” with multiple levels of entry and exit (Siega-Sur 2005). A vital component of the program that is built into the curriculum is the service leave between each step, “which allows students to serve and learn at the same time.... In between program levels, the scholars return to their home communities to render health and community development services for a minimum of three months or for as long as they wish” (Siega-Sur 2005).

According to the Philippine Information Agency (PIA), not only have students maintained above average performance on the National Licensure Examinations, the program “has successfully inculcated patriotism among its graduates such that 100% of its midwifery and nursing alumni, and 99.6% of its doctors, have remained working in the Philippines” (PIA 2008). Siega-Sur (2005), a professor at SHS, notes that “the step-ladder approach cultivates the culture of service to the country.” This is significant in a country where many rural hospitals are, in essence, “considered ‘closed’ since these [untrained

BHWs] could only offer first aid and delivery assistance.... For instance, three hospitals in Mindanao and two in Isabela have stopped operations because they have no more doctors and nurses” (Makilan 2005).

In support of this CHW model, the Philippine government enacted the Barangay Health Workers Act in 1995, which granted benefits and incentives (such as subsistence allowance, transportation allowance, career enrichment programs, recognition of years of primary health care, special training programs, and preferential access to loans) to accredited BHWs (Bhattacharyya et al. 2001). While this act made BHW positions more appealing and provided workers with more incentives to continue their work, it did not effectively improve their ability to provide better health care services to their communities. Galvez-Tan suggested in 2005 that other public medical schools be converted into this step-ladder curriculum in order to fill the need for health human resources in underserved rural communities. The step-ladder curriculum has been evaluated internationally and nationally, and has been found to be an effective educational strategy to address health care gaps in underserved rural areas (Galvez-Tan 2005). In 2009, “An Act Creating the Barangay Health Worker Education and Training Program” proposed “to scale up the capabilities of barangay health workers through the institutionalization of an innovative 'step ladder' training program that the University of the Philippines has initiated” (House Bill No. 6536). This act will give the 1.3 million BHWs working all over the country the opportunity to move through this step-ladder curriculum to be trained as midwives, nurses, or eventually doctors, filling the gaps of medical professionals who have chosen to work overseas. According to the bill, the first step would be mandatory basic training on community health care delivery, the second step would include more comprehensive training on community health care where they could specialize in such areas as midwifery, occupational therapy, or pharmacology. The more rigorous and specialized third step is a 15-month nursing program that culminates in eligibility to take the Nursing Licensure Board Examination. The fourth step allows BHWs to take another five-year program that includes courses on Medicine and upon completion of this program they may take the

licensure exams for doctors (HB 6536 2009; Montenegro 2009). Between each step, the BHWs would serve in their community of origin.

Conclusion

Medical migration from the Philippines can certainly be explained in terms of push and pull factors. Indeed, the millions of Filipinos working abroad would no doubt rank the “pull” of a chance for a better life for themselves and their family as a primary motivation in making the migration journey. Moreover, working conditions in much of the medical sector are such that push factors certainly include more than low wages. However, an exhaustive cataloging of various push and pull factors would not tell the whole story, and that is the key finding of our research in the Philippines. Going beyond push and pull factors allows a better understanding of both the modalities of medical migration and possible policy responses.

In terms of the modalities of medical migration, we argue that it is imperative to understand how the combination of an earlier wave of medical migration combined with the labor export regime developed in the 1970s. The result was an ever expanding flow of medical migrants, doctors becoming nurses, and medical schools with declining enrollments along with an explosion of for-profit nursing schools and a general degradation of the quality of the average nursing student. While many are aware of the problem of thousands of Filipino doctors seeking careers abroad as nurses, we argue that an unappreciated element of this process is a kind of internal brain drain whereby nursing is pulling many of the “best and brightest” away from other fields. Moreover, this “internal brain drain” must have an effect on the overall quality of institutions in the Philippines, though measuring such effects is likely impossible. With regard to policy, we argue that the “culture of migration” is so institutionalized and pervasive that policies like ‘bonding’ of medical graduates would be impossible to implement in any substantive way. In light of this, we argue that the expansion of community health workers, particularly the ladder curriculum pioneered by the School for Health Sciences, is an important policy response to

the lack of doctors and nurses, especially in underserved rural areas. We also argue that the Bhagwati tax, a much debated idea in policy circles, makes a lot of sense for the Philippine government to pursue. Obviously, such a policy measure would require cooperation with the United States, but the very concentrated nature of medical migration from the Philippines to the U.S. might make this more plausible.

The future of medical migration from the Philippines is bound to evolve. While the government has taken some steps to address the problem of human health resources, much remains to be done. Government policy is often contradictory given the need for both improvements in public health and the desire for more remittances. The system of medical education in the Philippines seems to be near the breaking point as nursing schools become factories for overseas nurses and medical schools find lower and lower enrollments. While we have offered some policy ideas, more research is required to determine their likely effectiveness. For example, the School of Health Sciences curriculum is promising but what sort of costs would be associated with scaling this model to various regions of the country? Moreover, how plausible is it to envision the expansion of medical education when medical educators are subject to the same siren call of overseas employment. Ultimately, whatever immediate costs are associated with medical migration, the long term effects are likely much greater than poorer public health and a shortage of human health resources. The effect on institutions in the Philippines—hospitals, universities, government bureaucracies—is difficult to measure but likely profound. Migration policies set in motion decades ago to facilitate economic development may ultimately render economic development unobtainable, at least at home.

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