

National profile of migration of health professionals – PHILIPPINES

Background

Introduction

In the diaspora of health professionals around the world, the Philippines has captured global attention in recent years as it has emerged as the leading source of human resources for health (HRH) most notably for professional nurses. Health professional production and deployment patterns have extended beyond national boundaries as many countries send health sciences students to the Philippines while Filipino health professionals practice in many destination countries. These include North America, the Middle East, Europe, and Japan as well as nearby ASEAN neighbours. While this may seem contradictory to Philippine health system goals, the aspirations of Filipinos for a better future for them and their families drive migration decisions.

The Philippine **health policy** aims to ensure that optimal health is attained by all Filipinos as espoused in the constitution. The country is characterized as low middle income unable to provide adequate employment to most of its young people. Hence, the Philippines implicitly supports emigration of its citizens who are able to work abroad and sustain the economy with remittances sent back home. Increased demand from first world countries that are in shortage of health professionals to care for their aging population has resulted to massive external migration. There is also minimal HRH internal migration from rural areas to job-rich cities. In all of these migration developments, the country seeks to manage its human resources for health (HRH) effectively at home towards meaningfully **managing migration so that health professional migration benefits both destination countries as well as source countries** like the Philippines. There is high interest in participating in international policy making to forge agreements towards ensuring mutually beneficial migration arrangements. Best practices are now in place for bilateral agreements between the Philippines and other countries needing nurses such as Canada and Bahrain.

Basic country Information covers geographic, economic, population and education information that will provide the backdrop for current HRH migration patterns. The Philippines is home to 90 million Filipinos who live in an archipelago made up of 7,107 islands. The Philippines is in Southeast Asia composed of three main islands groups namely, Luzon, Visayas and Mindanao. These big islands present different cultures and geographic characteristics and are home to many ethnic groups.

The Philippine per capita gross domestic product (GDP) based on current prices in 2010 is USD 1,957 comparable to that of Indonesia and Vietnam in Southeast Asia (SEA). Per Capita

GDP based on purchasing-power-parity (PPP) is USD 3,516, which is about 2 times the current prices GDP. Composite indices on quality of life showed that between 1980 and 2011 Philippines' Human Development Index (HDI) rose by 0.17% from the HDI value of 0.55 in 1980 to 0.644 in 2011 showing human progress in over-all income and well-being. The 2009 Human Poverty Index-1 (HPI-1) value of 12.4% was scored for the Philippines, ranking it 54th among 135 countries. Philippine HDI is lower than expected compared to its GDP accomplishment meaning the quality of life of Filipinos is lower than those who live in countries with similar GDP levels.

The **average annual family income** from 1997 to 2006 is US \$3519 or about US \$ 10/ day. This increased to US \$4324 or about \$12/ day in 2009. During this period annual per capita poverty threshold also increased plunging more families into poverty. Philippine poverty incidence was at 30% in 2003 but declined to 26.5% by 2009. As of July 2009, the national daily minimum wage was US \$5. Workers employed in the National Capital Region (NCR) receive the highest wages in the country, with a daily minimum wage of US \$7.50.

Labor participation rate fluctuated since 1997 but has not significantly improved over the years. The unemployment rate in October 2011 was estimated at 7.0 percent compared to 7.3 percent posted in 2010. More males were unemployed than females in 2011 (22.1%). Since 2007, underemployment has slowly declined, reaching 19.3% in 2011.

While there seems to be slight economic gains over the years, the **socio-economic situation** in the Philippines shows that quality of life is lower and family income situation is less desirable than that of other economically similar countries. Consequently, the country is unable to absorb everyone in the productive age group into the labor force. This has led to many Filipinos and in particular health professionals to actively seek employment overseas.

Young and productive Filipinos predominate the country's **population**. The Philippine population, which grows at a rate of 2.4% annually, is relatively young, with about 45% of Filipinos living in the country between the ages of under 1 year old to 19 years old. The productive age group (20-64 years) makes up the biggest group comprising 51%, while the elderly (65 years and over) is the smallest group consisting of 4.0% of the total population. With a fertility rate of 3 children per woman at present, the Philippines has the highest total fertility rate in Southeast Asia. According to the 2010 dependency ratio report, there are 64 dependents for every 100 persons in the working age group.

Education is very highly valued by Filipinos. This is evidenced by the high basic literacy rate of 95.6% although functional literacy rate is much lower at 86.4%. Further, only 5.4% of the population, were reported to not having undergone any

education at all. Most uneducated Filipinos are from the indigenous groups. However, completion of education is a challenge for many Filipinos. The gross elementary education enrolment rate was reported to be about 85.01% for School Year 2009-2010 but only 72.18 % were found to have completed this level. On the other hand, the gross enrolment rate in secondary education was 82.15% with a 73.74% completion rate. But there were proportionately more high school graduates (20.8%) than those who had some uncompleted high school education (15.7%). Filipinos with a college degree or higher were reported to be about 22.8% of the total population. There were no significant differences reported between the education experiences of Filipino men and women. However, the most common fields of study slightly differed between the genders. Men pursued degrees in business administration and related programs as well as in tourism. While business administration degrees and related fields were also popular with women, in addition, they took up degrees in health, social and other community development service programs.

Health

The average Filipino is expected to have a life expectancy of 72 years. Filipino females outlive males by approximately five years. Using life expectancy as the parameter, the **Filipino's health status** is similar to that of Indonesians and Vietnamese (71.5 and 71.3 years respectively) but not at the level of what the Thais already achieved (75 years).

The Philippines has a **triple burden of disease**. Filipinos suffer from infectious diseases such as tuberculosis and malaria as well as lifestyle diseases which are major causes of morbidity and mortality across all ages. The third burden comes from emerging diseases such as severe acute respiratory syndrome (SARS) and drug resistant forms of tuberculosis and malaria. The top five causes of morbidity include diarrhea, lower respiratory tract infection and pneumonia, bronchitis, influenza and hypertension. The leading five causes of mortality reported in 2009 were diseases of the heart, diseases of the vascular system, malignant neoplasm, pneumonia and accidents.

Filipino infant mortality rate is high at 12 deaths per 1,000 live births as of 2011. Infant deaths are mostly due to perinatal conditions, bacterial sepsis and pneumonia. Maternal mortality is also high pegged at 97 per 100,000 live births. Other complications related to pregnancy occurring in the course of labor, delivery and puerperium, hypertension and post partum hemorrhage were reported as leading causes of maternal mortality.

The Philippine **health care system** is made up of the public and private sectors. The public sector, composed of national and local government facilities, provides health care generally given free at the point of service financed through a tax-based budgeting system. The Department of Health (DOH) is the guardian of health care that continues to provide policy and program directions and manages a limited number of specialty, regional and provincial hospitals. Most of health care delivery is delegated to the local government units as these were devolved to the local government units. While the government is expected to provide the backbone of essential health

services for the country, there are more private hospitals and clinics providing care. Private health services predominantly provide primary and secondary care but the country's premier tertiary facilities are also private. Government hospitals are usually bigger than their private counterparts in terms of bed capacity but have difficulty providing and maintaining with state-of-the-art equipment.

Government's share of total health expenditures in 2007 was only 26.2%. The expansion of social health insurance in recent years showed its potential to be a major source of health financing. In 2007, PhilHealth or the Philippine Health Insurance Corporation (PHIC), covered 8.5% of all health expenditures. The private sector, on the other hand, is largely market driven where health care is paid through fees for service. Private expenditures for health care account for 64.8% of the total in 2007.

The country has a total of 22 health professional and sub-professional categories in the **health workforce** as indicated in the 2005-2030 HRH master plan. The major groups include doctors, nurses, midwives, medical technologists, physical therapists, occupational therapists, dentists, pharmacists, optometrists, nutritionists and dieticians.

Doctors

Based on the current doctor to the population ratio of 107 per 100,000 population, the Philippines has enough doctors at first glance. The Professional Regulation Commission (PRC) reported that as of 2008, total registered physicians since 1910 are 96,661. It is estimated that out of these, 90,515 are in active practice after subtracting those who retired from practice. However, distribution of doctors is inequitable. Survey results from the Department of Health reported that 10% of Philippine municipalities are doctorless. Most doctors practice in urban settings like the National Capital Region (NCR) where Manila, the nation's capital is located. The NCR has the highest number of doctors in the country. In another survey by the Philippine Medical Association (PMA) in 2000, specialty distribution was determined as follows: 14.8% of the respondents were in Family Medicine, 11.8% in Pediatrics, 11.2% in Internal Medicine, 6.9% in Surgery and 6.8% in Obstetrics and Gynecology. The leading preferences for specialization among male doctors were surgery, family medicine, internal medicine, pediatrics and anesthesia, while it was pediatrics, family medicine, internal medicine, obstetrics and gynecology and dermatology for female doctors. Most doctors are in private practice although in 2006, 38.8% were reported to be government employed. This explains the tendency for doctors to gravitate to urban areas.

Nurses

In 2008, nurses in the Philippines were found to be more than enough based on the reported nurse to population ratio of 545 per 100,000. Again there is serious maldistribution of Filipino nurses. Based on the study of Corcega et al, PRC data and updated data as of June 2009, ever registered nurses were estimated to be 578,312. When adjusted for retirement and death of nurses, the cumulative stock of nurses was calculated to be 544,967. Data on supply of nurses showed an alarming increase of nurses over the last 8 decades (1919-2000).

Almost half of all nurses or 43.61% (252,198) were produced and registered in the last decade (2001 to 2009). Specifically, only 1.25% (7,229) were registered from 1919 to 1950, while 55.14% (318,885) were reported to be registered in the next 4 decades (1951- 2000). Significantly, the increase of nurses in the last decade was more substantial than changes noted in the first 7 decades. The increase from 2001 to 2009 can be attributed to nursing becoming one of the most popular college courses due to employment opportunities overseas. Most nurses are employed in hospitals whether government or private. Based on the 1998 study on local employment of nurses, the government is still the biggest employer of nurses with an estimated 9.86% of all nursing positions in the country, while the private sector employs 4.23%. However because the government official positions as well as hospital positions have not changed over the years, the preponderance of nurses have been reported to be working abroad (85%) (Table 1). Due to lack of current actual nursing positions in government and private hospitals, the Department of Health-Bureau of Health Facilities and Services (DOH-BHFS) created the staffing standards based on bed capacity for government and private hospitals. Based on these standards, it is estimated that about 32,944 nursing positions should be made available across government hospitals (15,184 nursing positions) and private hospitals (15,874 nursing positions) as of 2009. This gives rise to an estimated 91,149 nurse surplus in 2009 who are either underemployed or unemployed. Nurses in the Philippines are mostly females and predominantly young.

Table 1: Distribution of Employed Nurses by Work Setting, 1998

WORK SETTING	NUMBER	PERCENTAGE
A. Local/ National	27,160	15.25%
- Service Government Agencies	17,547	9.86%
- Service private Agencies	7,535	4.23%
- Education	2,078	1.16%
B. International	150,885	84.75%
Grand Total	178,045	100%

Source: Lorenzo, et al, 2002

Midwives

The greater preponderance of midwives are employed by the government to promote mostly maternal and child health. In addition, they also provide basic health services such as immunizations and consultations for simple health problems such as cough and colds especially in far flung areas. The supply of midwives are adequate considering a 164 per 100,000 midwife to population ratio. Recently, more midwives have been observed to venture into private practice, setting up group practices around birthing clinics. Most midwives are female and this may be because of the nature of their profession, where the core of midwifery practice centers on maternal and child health. Majority of the midwives are 31-40 years old (32%). However, there are those that still practice at the age of 61 (1%) and over. This implies that the profession provides for quite a range of practice that can cover 4-5 decades. The practice focuses on normal childbirth and

delivery such that midwife practitioners get to hone their skills in a very short time depending on the number of patients that they see. Perhaps due to the culture sensitivity surrounding maternal and child care and childbirth, the demand for Philippine midwives abroad are almost nil. This may partly explain why the midwives have stayed in their posts especially in the rural areas and have not migrated. A few have been reported to migrate as caregivers.

Dentists

With the decentralization of the DOH, the recruitment and employment of local government unit dentists became the responsibility of municipal mayors. This created many variations in the way government dentists were hired and employed by local government units. In 2005, only 2,598 government dentists were employed across the country out of the 13,313 active members of the Philippine Dental Association, national organization of registered dentists, dental hygienists, and dental technologists. This means that about 20% of the country's dentists work in public institutions, while 80% are private practitioners. The ratio of dentists to population is 57 per 100,000. Dentists do not migrate much and therefore does not contribute significantly to health professional mobility to EU countries.

Pharmacists

The Pharmacy Licensure Examination (PLE) started in 1903 and since then until the year 2009, a total of 56,665 licensed pharmacists were recorded. Of the total number ever-registered, it is estimated that only about 70.8% or 40,155 pharmacists maybe actively involved in service. At present, there are no records on the actual number of pharmacists per region which makes it difficult to ascertain that there is at least one pharmacist per retail outlet or drug distributor. While there is no standard pharmacist to population ratio for the country, the present ratio is obviously low which could present concerns on the provision of accessible, safe and quality medicines to Filipinos. Also, there are no exact data records on the level of professional activity or inactivity among pharmacists although the common identified reasons for inactivity are: to pursue medicine and later on practice as a medical doctor or shift to other careers.

Occupational Therapist (OT)/ Physical Therapist (PT)/ Speech Pathologist (SP)

The occupational therapy (OT) and physical therapy (PT) professions were officially recognized as unique professions when the practice act was enacted in 1969. The highest number of newly-registered OT and PT professionals was observed in 2001 when 318 OTs and 2,341 PTs enlisted under the Professional Regulation Commission (PRC) in just one year. After the 1999 peak of registration, a steady decline in the production of new professionals was observed. Such a trend was brought about by the slowly shifting interest and demand towards nursing profession, and by the perceived decrease in demand and oversupply of OTs and PTs in the country. In terms of the number of health facility positions available for physical therapists and occupational therapists in 2005, it was identified that there are only 130 and 116

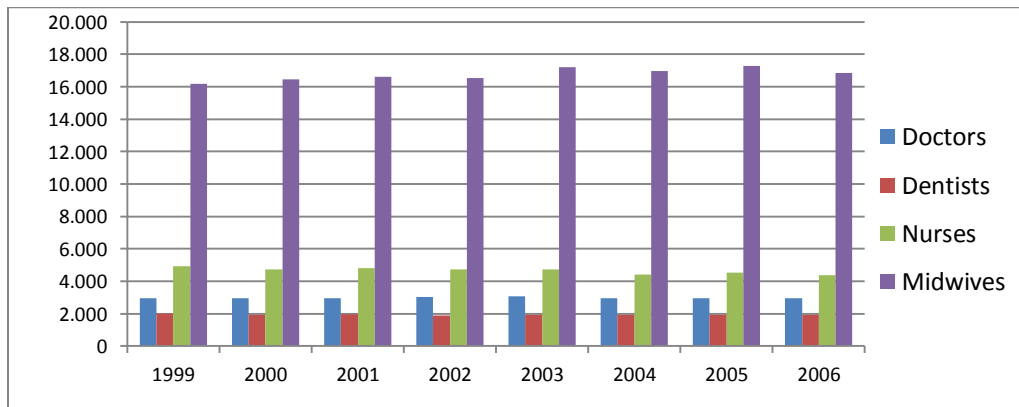
positions for OTs and PTs respectively, in DOH-managed government health facilities. Currently, there are more government positions for physical therapists compared to occupational therapists and none for speech therapists. Due to limited or absent PT and OT positions in government and private hospitals, and health units, private OT, PT, and SP clinics have recently emerged to cater to the needs of the underserved population. There are approximately 145 OT / PT / SP private clinics in the country, majority of which are located in urban areas. Of the 2,258 licensed Filipino physical therapists enlisted under the Philippine Physical Therapy Association (PPTA), nearly 60% of its members are located within the highly-urbanized National Capital Region (NCR) and most are working in the private sector as clinicians and educators. Based on the PRC database, the age range of enlisted PT and OT professionals is 21 – 70 years old and about half of the present OT and PT professional population is aged between 21 and 30 years old.

Figure 1 shows the categories of health professionals in government. Over the years there were minimal changes in the number of positions in government health care facilities. It was difficult to ascertain an accurate estimate of health professionals in private practice. Such data is difficult to obtain as not all private hospitals and facilities submit data to the DOH. Furthermore, based on the different Focus Group Discussions (FGDs), the various problems related to determining and meeting the actual demand for health workers were raised. These include the insufficiency of DBM positions in government health care facilities, data limitations especially on the number of private health care practitioners, absence of data on active health care practitioners as well as outdated health care practitioner to population ratios in the country.

Health Sciences professional education is popular in the Philippines especially among women. Tertiary health sciences professional education is supervised and regulated by the Commission on Higher Education (CHED). Bachelor of Science degrees in Nursing (BSN), Midwifery (BSM), Pharmacy (BS Pharm) and Medical Technology (BSMT) have 4-year curricula while Bachelor of Science degrees in Physical Therapy (BSPT) and Occupational Therapy (BSOT) are accomplished in 5 years. Doctor of Dental Medicine (DDM) is a six-year program while Doctor of Medicine (MD) has a 4 year baccalaureate degree or at least 35 units of health science subjects (pre-med) and National Medical Admission Test to qualify for medical school. In addition, medical education proper curriculum is 5 years.

Of the programs, the BSN follows a competency-based, community-based and value-based curriculum. The steady increase of international demand for nurses resulted to an escalating rate of production since the 1950s. This became more pronounced in the 1990s and early 2000s. Within the ten-year span from 1997-2008, this demand resulted to a cumulative increase of 147% in the number of schools resulting in about 490 schools at present. The quality of nursing schools in the country varies. Largely, CHED data showed the preponderance of substandard schools of nursing. Currently, CHED is in the process of phasing out poorly performing nursing programs.

Fig.1: Number of health professionals employed by government, Philippines, 1999-2006



Source: Department of Health data in NSCB, 2008

Health Policy

Universal Health Care (UHC) is currently the Philippines' flagship program to ensure that the Filipinos attain two specific outcomes: 1) Filipinos are healthy and free from disease as well as illness and that 2) they have access to quality health services. To realize this vision, the Aquino Government and

the UHC program aims to focus on the implementation of the National Health Insurance Program or PhilHealth; construct, rehabilitate and support government health facilities in providing basic health services and achieve the Millennium Development Goals particularly reduce maternal, neonatal and infant mortality and address public health diseases such as tuberculosis, malaria and dengue.

The need for social health insurance in the Philippines was recognized in 1986 when the Philippine Medical Care Plan or Medicare was established. It initially catered to just the employed sector. In 1995, the National Health Insurance Program or PhilHealth superseded the Medicare policy and mandated that all Filipinos be covered by 2015. To date, universal health coverage has yet to be achieved. Government's thrust is to keep the PhilHealth program and its implementation relevant to meet the country's needs by pursuing various reforms. Different insurance reform strategies are underway to ensure that all Filipinos obtain health and financial risk protection. These include reforms in enrolment, health facility accreditation, availment and processing of claims, insurance payments and support value of the insurance's benefit package.

Hospital reforms were also developed to ensure better access to health care. The strategies include upgrading of rural health units, district hospitals, provincial hospitals as well as Department of Health retained hospitals with the help of the private sector through public-private partnerships, promotion of health facility fiscal autonomy and income retention.

At the core of attaining the MDGs targets are human resources for health. Implementation of health financing and health facility reforms were designed to address human resources for health retention issues. The government recognizes that reasonable compensation, adequate health facilities and opportunities for career growth will help health workers to stay in the country. Other strategies to improve health outcomes at the community level include the complementation of existing human resources for health in schools and local government units and the deployment of Community Health Teams to actively assist families within a catchment area with their health needs.

General Migration

Based on UN data and projections, outmigration or emigration is more predominant in the country as indicated by the actual and projected negative migration rates (Table 2). Projections show a declining rate of outmigration based on the UN assumptions on future trends in fertility, mortality and international migration.

Table 2: Net migration rate (per 1,000 population), Philippines, 1995-2030.

Year(s)	Value
1995-2000	-2.4
2000-2005	-2.2
2005-2010	-2
2010-2015	-1.7
2015-2020	-1.7
2020-2025	-1.6
2025-2030	-1.4

Source: UNdata (<http://data.un.org/>)

Immigration and Source Countries

Immigrants to the Philippines are mostly as business investors, expatriates of multi-national corporations located in the country and staff employed by international NGOs. Over the years, the number of immigrants to the country was observed to have increased. In 1997, the number of migrants in the country was reported to be 28,328. The figure increased to 66,545 migrants from the latest available data (2008). In 2008, most immigrants came from countries like China, Japan, Australia, India, US and Canada. Since 1997, there has been a steady inflow of migrants from the European Union. Of the EU immigrants in 2008, most came from the United Kingdom (Fig. 2).

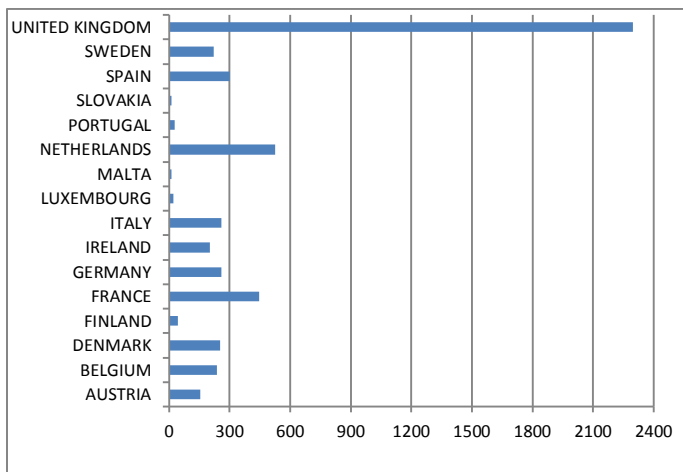
Emigration and Destination Countries

In 2007, an estimated 8.7 million Filipinos were documented to be residing overseas. Based on the total stock estimate in the world, about 3.6 million Filipinos were in the Americas/ Trust Territories, 2.1 million in West Asia and 1.2 million in East and South Asia. The number of Filipinos in the EU in 1997 was around 741,000. This steadily increased to about 950,000 in 2007. And of the European countries, the top three destination countries were the United Kingdom, Italy and Germany. In 2007, an estimated 203,035 Filipinos were residing in the United Kingdom, 120,192 in Italy and 54,336 in Germany.

The Bureau of Labor and Employment Statistics (BLES) division of the Department of Labor and Employment (DOLE) defines a deployed *Overseas Filipino Worker (OFW)* as a recruited worker who leaves for an overseas job with the pre-condition that employment/travel documentation papers are processed by Philippine Overseas Employment Administration (POEA) and his/her departure is recorded at the Labor Assistance Center at the Ninoy Aquino International Airport.

Filipino migrants are classified as either *permanent or temporary*. A *permanent migrant* is defined by CFO as an immigrant or legal permanent resident abroad whose stay in the destination country does not depend on work contracts. A *temporary migrant*, on the other hand, is a person whose stay overseas is employment-related, and who is expected to return at the end of their work contracts. They are commonly called as Overseas Contract Workers. Based on the CFO data, most Filipinos overseas are temporary migrants. In 2007, there were 4.1 million temporary migrants and over 3.6 million permanent migrants. The CFO also documented the number of irregular migrants, i.e. those not properly documented or without valid residence or work permits, or who are overstaying in a foreign country over the 10-year period. Though declining in trend, still, over 900,000 Filipinos were reported to be irregular migrants in 2007. Most of the overseas Filipino workers belong to the 25-29 and 30-34 age bracket. The number of migrant workers who are 45 years old and above has significantly increased from 214 in 2004 to 306 in 2007.

Fig. 2: Immigrants from EU countries, by citizenship, Philippines, 2008



Source: Data Administration Unit, Bureau of Immigration, 2009

Migration of health professionals

Most information about the health professional or health worker migration focused on outflows or emigration. It is unfortunate that data on returning or re-entering Filipino migrants is not available. Based on the 11-year migration data of the POEA and CFO, most categories of health professionals migrate as temporary or permanent workers to various destination countries around the globe.

Emigration and destination countries

The health professionals, except for doctors, generally migrate to seek better employment opportunities overseas. For Filipino doctors, nurses, midwives, physical therapists/ occupational therapists, medical x-ray technicians and dentists and pharmacists and their assistants temporarily working abroad from 1997- 2007, the top destination countries include KSA, USA, UAE, Bahrain and the UK (Table 3). From 1998 to 2008 Filipino health workers permanently migrated to destination countries such as the US, Canada and Australia. The USA seems to be the country of choice for most.

Table 3: Percentage of temporary Filipino health professional migrants in top destination countries, Philippines, 1997-2007

Health Professional / Sub professional Categories	KSA (%)	USA (%)	UAE (%)	UK (%)	Bahrain (%)
Medical doctors	50.3	16.5	0.5	1.6	2.0
Medical x-ray technicians	90.6	1.6	1.1	0.1	0.3
Midwives	92.7	0.0	1.1	1.7	0.1
Nurses	60.9	5.0	4.9	13.9	0.4
PTs/Ots	39.0	42.5	5.0	1.4	1.5
Dentists	94.3	2.9	0.5	0.0	0.0
Dental Assistants*	83.6	0.0	0.6	0.0	0.3
Pharmaceutical assistants	86.4	0.8	2.1	0.0	0.1
Pharmacist	56.1	6.7	3.7	0.3	6.2

Source: POEA 2009

*1997-1st quarter of 2007

Generally, Filipino **doctors** have been migrating to pursue further studies in their fields of specialization. Based on the estimates of the Philippine College of Physicians (PCP), 147 out of the 3,000 fellows of the College are presently working in other countries. From 1997 to 2007, 1,238 doctors left the country as temporary migrants and 2,440 as permanent migrants. By 2009, there were forty (40) doctors who left as permanent migrants for Europe. Most of them went to the UK then Germany, Netherlands, Norway and Austria. According to the interviews with Filipino doctors in Europe, several were pursuing either post-graduate studies (master al or PhD) or research. None were employed as clinicians. Their stay in Europe is perceived to be transitory. They plan to (a) pursue their careers in public health in the Philippines, (b) obtain further studies in another country, or (c) explore the fields of research and development elsewhere.

In the Macro phase of the study, it was found that **nurses** were the largest group of Filipino health professionals that migrate to different countries, including the European region. From 1997

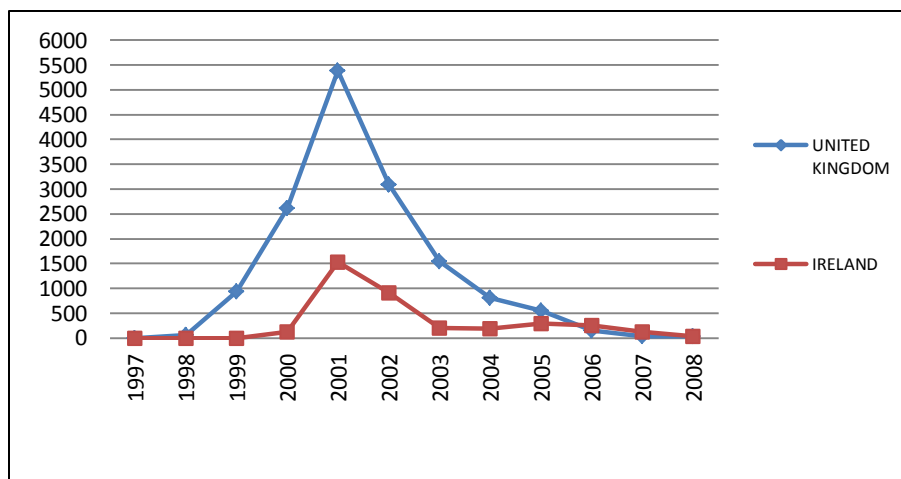
to 2008, a total of 103,629 nurses went to 73 countries as **temporary migrants** and 24,472 nurses to 25 countries as **permanent migrants**. Based on observations in the private sector, nurses who go abroad are mostly aged 22-25 years old. Government hospitals' experiences are similar with those who leave. Those fall within the age range of 20-30 years old. It could also be noted that more female nurses leave the country for better work experiences. Most nurses consider working in other countries after acquiring 2-5 years work experience locally. Also, those with specialty care experience in the Emergency Unit, Intensive Care Unit (ICU), Neonatal ICU and Cardiac Care Unit are more in demand in other countries and are thus most likely to leave for these countries. On the average, the nurse interviewees have been working in their destination country for a period of 8 years. The key destination countries of temporary nurse migrants are the Kingdom of Saudi Arabia (KSA), the United Kingdom (UK), and the United Arab Emirates (UAE). Other countries in top ten countries include Ireland, Singapore, United States, Kuwait, Qatar, Libya and Canada. Year 2001 marked the peak of

recruitment in the UK and Ireland, after this year the recruitment and/or emigration of Filipino nurses decreased (Fig 3). In 2008, only 35 nurses were recruited to the UK and 28 to Ireland.

Migration of **other health professionals** such as physical / occupational therapists started in the 90's. From 1997 to 2008, about 4,206 PTs and OTs left the country as temporary workers for 41 countries but mainly for the US and KSA. And by 2007, 872 PTs and OTs left as permanent migrants for 15 countries and specifically for US and Canada. The PTs and OTs seem to be the next largest group that generally migrate next to nurses. Migration of midwives, on the other hand, was observed in the 70's but the rate was noted to be low but steady. From 1997-2007 data showed that by 2007, 2,016 out of 2,183 midwives left for the KSA as temporary migrants. From 1998-2008, 554 midwives left as permanent migrants primarily for the US then to Canada, Germany and Austria.

In the interviews, it was perceived that Filipino dentists follow a different migration pattern. Apart from exhibiting low migration rates, more leave the country as permanent migrants than temporary. From 1998-2008, 1,515 dentists left for the US, Canada and Australia as compared to those who left as temporary migrants (641 dentists from 1996 to 2007) for the KSA. Pharmacists migration is not a new phenomenon as disclosed by the Philippine Society of Hospital Pharmacists(PSHP) during the FGD. In fact, pharmacists are known to have migrated at the same time as nurses have but to a lesser degree. From 1996 to 2007, 723 pharmacists left for 30 countries (primarily the KSA) as temporary migrants and 938 (to mainly the US, Canada and Australia) as permanent migrants. For medical technologists, migration started in 2000 but migration rate increase was more gradual compared to the nurses.

Fig. 3: Deployed of Filipino Nurses to the United Kingdom and Ireland, Philippines, 1997-2008.



Source: POEA, 2009

Migration to other sectors is not common among health professionals but movement within the sector is. In one of the FGDs, it was perceived that few Filipino doctors work in other countries as doctors. In the recent past, most left as nurses or physical/occupational therapists. This observation showed that there is a change not only in place of practice but also in the choice of profession. The decision to shift to another course is commonly related to better employment opportunities and remuneration as in the case of some doctors who left as nurses (nurse medics) in 2004 and the midwives who leave as caregivers or nursing attendants.

According to the interviews, it seems **training of immigrants** is dependent on the programs set by the institutions where the health professionals will be employed. For Filipino nurses based in the UK, an adaptation or bridging program was prescribed upon their arrival in the country. The program commonly runs for 2 to 3 months while simultaneously working in the assigned area. And during this adjustment period the

new nurse's tasks may be limited until the end of the program. Training may also be in the form of subsidized online continuing education or financial support for professional development as experienced by a few health professionals based in the UK.

Remittances

The Central Bank of the Philippines or the Bangko Sentral ng Pilipinas (BSP) defines remittance as the flow of funds from migrants, both temporary and permanent. Remittances could be in the form of cash, as identified in monthly BSP reports, or goods. In general, the amount of remittance from Filipino migrant workers has improved the country's economic situation. In 2005 and 2008, this amounted to 8.5 and 16.4 billion USD, respectively. From January to June of 2009, the BSP reported a total remittance of 8.5 billion USD and a growth in remittances of 2.9% was noted. About 80-84% of the total annual remittance comes from land-based overseas

workers. From 2003 to 2008 remittance from land-based Filipinos in Europe, increased with the highest remittance from the UK and Italy (Fig. 4). This amounted to USD 660,354 and USD 660,122 respectively.

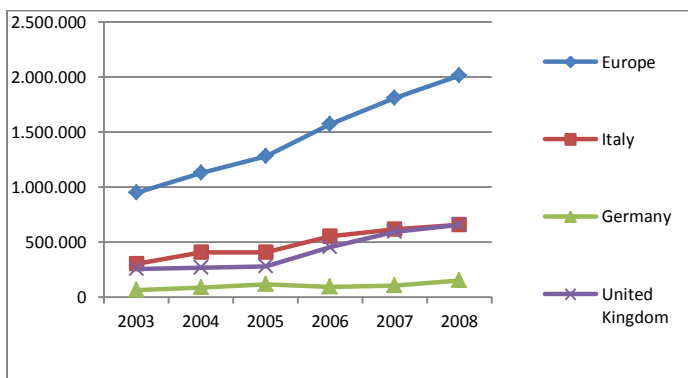
The BSP key informant pointed out that the growth in remittances from Filipinos overseas may be seasonal in nature. Traditionally, the increase in remittances from April to June coincides with the period of school/ university openings and enrollment. The remittance peaks during the months of September to December correspond to the long Christmas season in the country. Filipino migrants, whether permanent or temporary, generally send remittances through formal channels (through banks and remittance centers or money transfer operators that have accounts in banks) or informal channels (through friends, relatives, couriers, and transfer operators). Banks and remittance centers are more pro-active in lowering remittance charges to acceptable levels. This is to encourage migrants to remit through formal channels which are more secure and reliable than informal channels. According to the BSP key informant, a World Bank study revealed that 60-75% of an overseas Filipino worker's income is remitted.

Remittance from Health Professionals

Remittances from health professionals are sent for various reasons. Most send remittances on a regular basis but some do not. Based on the interviews in the Micro phase, it seems that those who left the country for overseas employment remit more and regularly. Those that are overseas for training or post-graduate studies, like the doctors interviewed, remit as necessary (e.g. during family emergencies or to pay for personal expenses in the Philippines).

Families of the doctors interviewed were described as economically stable thus regular remittance is not obligatory. For the other health professionals, such as the nurses interviewed, the amount of remittance sent on a regular basis is less than 50% of the monthly salary.

Fig. 4: Europe land-based overseas Filipinos remittances, in thousand USD, 2003-2008



Source: Department of Economic Statistics, BSP, 2009

The potential nurse migrants, on the other hand, planned to remit 25 to 70% of their foreseen salaries. For physical and

occupational therapists interviewed, 10 % to 35 % of their salaries are remitted regularly to their immediate families in Philippines. According to interviewees, remittances are usually sent or used to fund daily and household expenses; provide educational support to older or younger siblings; as presents to family members; support parents, siblings, and extended families; help establish a business for the family; improve the house and purchase of properties; and support family members with health problems and emergencies.

Return Migration

Circular migration is a phenomenon or process that should allow immigrants to come, go and come back again, with few restrictions and making use of contemporary transnational networks. It is unfortunate that no data is available on returning health professionals. Vignettes instead are common. There also is no formal program for circular migration in the country.

Based on the FGDs, circular migration and return migration happens whether the the health professional left as a temporary or permanent migrant but how often these happen is not documented. Some nurses temporarily employed in the Middle East return to the Philippines at the end of their initial contract to be reinstated in a government or private hospital or academic institution while waiting for the next contract. Somerender lectures in academic institutions or conferences while visiting family members in the Philippines. Return migration may also arise as Filipino migrants desire to retire in the Philippines. More personal reasons could also be cited as motivations for Filipino migrants to return to the Philippines on a more long-term basis, such as the family's preference to come home, and the desire (or need) to take care of sick or aging parents.

Migration Policies

General

Philippine immigration and emigration activities are guided by several Philippine policies. Some of these policies include the Philippine Immigration Act (Commonwealth Act 613), Philippine Passport Act (RA 8239), Foreign Service Act (RA 7157), Rules on Dual Citizenship (RA 9225 and AO 91 series of 2004), The Alien Social Integration Act 1995 (RA 7919) the Administrative Naturalization Law (RA 9139), and Migrant Workers and Overseas Filipinos Act (RA 8042). Generally, all Filipinos need a visa to travel to and from the European region.

Immigration and Emigration

With the Department of Foreign Affairs (DFA), implementation of immigration policies is ensured by the Bureau of Immigration whose mandate is to undertake the administration and enforcement of immigration and citizenship laws and the admission of foreigners to the Philippines including the enforcement of alien registration laws, and the exclusion, deportation and repatriation of aliens.

The system for overseas welfare and employment is fully developed in the country as evidenced by the presence of relevant policies, structures and programs. Key agencies with

emigration functions include the BOI, DFA, CFO, Department of Labor and Employment (DOLE) and POEA. Republic Act No. 8042 otherwise known as the “Migrant Workers and Overseas Filipinos Act of 1995” instituted the policies of overseas employment and established a higher standard of protection and promotion of the welfare of migrant workers, their families and overseas Filipinos in distress, and for other purposes. This policy and the Provisions on Overseas Employment derived from the Labor Code serve as guides to the POEA in providing labor protection and promoting welfare to overseas workers and their families. As the lead and attached agency of the DOLE in overseas welfare and employment, the POEA is primarily tasked to regulate private sector participation in the recruitment and overseas placement of workers through a licensing and registration system. Under RA 8042 it provides a system for promoting and monitoring the temporary overseas employment of Filipino workers by taking into consideration their welfare and the domestic human resource requirements. Another attached agency of the DOLE is the Overseas Workers Welfare Administration (OWWA) established to promote and protect the welfare of overseas workers and their dependents. Its mandate includes 1) the delivery of welfare services and benefits (including insurance, social work assistance, legal assistance, cultural services, and remittance services); and 2) to ensure capital build-up and fund viability to its members. Another government agency created to serve and prioritize Filipino emigrants is the Commission on Filipinos Overseas (CFO). It is tasked to formulate policies and guidelines regarding Filipinos overseas particularly on the migration process and welfare of Filipino permanent migrants.

Republic Act No. 8042, otherwise known as the “Migrant Workers and Overseas Filipinos Act of 1995”, instituted the policies for overseas employment and established a higher standard of protection and promotion of the welfare for migrant workers, their families and overseas Filipinos in distress, and for other purposes. This Republic Act is the basis for policies relating to all migrant workers and overseas workers, including healthcare professionals. It declares that the State shall afford full protection to labor, specifically for Filipinos working abroad. Although it states that the Philippine Government does not promote overseas employment as a means to sustain economic growth and for achieving national development, it will support the deployment of Filipino workers to other countries. There is a pending legislation on the amendment of the Migrant Workers Act. Amendments will ensure a stricter policy on deployment such that it will only occur when at least one of the following is satisfied:

- Presence of a bilateral agreement between host and sending country
- Host country is a signatory in multilateral agreements
- Presence of a protective legislation of the host country for migrant workers

Since the inception of the overseas employment program of the government in 1974, the Philippines has signed several bilateral labor agreements (BLA) with foreign governments on the mobilization of Filipino manpower. Since the early years of the Philippine overseas employment program in the 1970’s bilateral agreements were pursued as part of the aggressive employment strategy to open new labor markets for OFWs and

since the passage of the Migrant Workers and Overseas Filipinos Act, BLAs have also been used to address problems affecting the deployment of OFWs.

Specific to the European Region, bilateral labor agreements were signed between the Philippines and countries like United Kingdom and Norway. Both agreements specified the process of recruitment of health professionals from the Philippines. In recent years, a more collaborative approach is taken in fulfilling the demand of a destination country for Filipino health professionals. Consensus and agreements between sending and destination countries are drafted in bilateral labor agreements or memorandum of agreements. The Philippines likewise supports and espouses the World Health Organization’s Code of Practice for Ethical Recruitment and Employment’s principles of transparency, fairness and mutual benefit.

A number of policies were identified in an FGD on migration issues that had unintended effects on the migration of Filipino health workforce. These policies include the nationalization policy of the Gulf Cooperation Council (GCC) countries, accession policy of the EU, the reunification policy of the US and the introduction of the NCLEX in the country.

Other policies that have an impact on health professional migration are policies on education, professional practice acts, work or labor policies in government and in the private health care facilities, provision of relevant positions for government based employees and training and development policy and plan for health professionals.

Recruitment

The POEA facilitates and manages the migration of Filipinos overseas. As of the last quarter of 2009, POEA documented 3,334 recruitment agencies accredited with the organization. Private employment agencies are either land-based agencies licensed by the POEA to recruit workers for all land-based jobs for and in behalf of its foreign principal; or manning agencies licensed by the POEA to recruit seafarers to man/board vessels plying international sea lanes and other related maritime activities. Generally, the process starts when a prospective employer interested to hire Filipino workers chooses from the official list of licensed private employment agencies available at the nearest Philippine Embassies and Consulates in their country, or at the POEA website. An employer who has identified a Philippine agent to source his/her human resource requirements must submit the recruitment documents to the nearest Philippine Overseas Labor Office (POLO) at the Philippine Embassy/Consulate for verification. This process ascertains the existence of the company or project; and b) the need for Filipino human resource.

Private land-based recruitment agencies charge service fees from the employers/principals as payment for services rendered in the recruitment and placement of workers. The employers also pay the POEA processing fee amounting to PhP 200.00, US \$25.00 OWWA worker membership fee and visa fee. Private land-based recruitment agencies are also allowed to collect from its hired workers a placement fee

equivalent to one (1) month salary, except in countries where laws prohibit collection of fees from workers as in the case of bilateral labor agreements. The recruitment of Filipino workers is done through a systematic recruitment network where foreign principals must course their manpower requirements through POEA-licensed private employment and manning agencies. The Philippine - licensed agency may advertise the job vacancies in local dailies, create a manpower pool, and conduct preliminary screening and interviews of applicants as part of its services for its foreign principal. The extent to which hospitals and health science education institutions participate in the recruitment of health professionals is not yet apparent. However, there are proposed mediated twinning arrangements that may lead to this.

Based on the interviews, the recruitment experience of health professionals varied when done through direct hire or through a Philippine based recruitment agency. The recruitment process to the UK was perceived as relatively easy and short especially if directly hired since most costs are shouldered by the principal. The process, as experienced by the nurses, only took 5 to 6 months but for the occupational therapists interviewed, it took only 2 to 4 months. Within this period the therapists underwent a series of interviews and an exam. Fees were usually exacted from those recruited through an agency. Those nurses who went to the UK through a recruitment agency, paid a processing fee of about Php 30,000 (£430) although this amount, in practice, vary. Some recruitment agencies require a certificate of funds from any commercial bank with at least Php 600,000 (~£8600) in the account. Other documents required by the principal or local recruitment agency include an English language proficiency examination certificate from the IELTS (International English Language Testing System) and a certification of a 2-year working experience.

Bilateral, Multinational and International Agreements

Since the inception of the overseas employment program of the government in 1974, the Philippines has signed several bilateral labour agreements with foreign governments on the mobilization of Filipino human resource. Since the early years of the Philippine overseas employment program in the 1970's bilateral agreements were pursued as part of the aggressive employment strategy to open new labour markets for OFWs and since the passage of the Migrant Workers and Overseas Filipinos Act, BLAs have also been used to address problems affecting the deployment of OFWs (16). Though the experience of the Philippines on migration has been longstanding, success in forging agreements with governments has been limited. Earlier versions of BLAs are limited in scope and merely included a statement on the objective of the agreement. To date, BLAs go through a more thorough process undertaken by the Philippine government on behalf of the various types of workers including health workers. Particularly for the recruitment of health workers, BLAs have become more comprehensive in scope.

An example is the UK-Philippines labour agreement designed to facilitate the mobility of nurses to the UK through a recruitment process. It aimed to develop close cooperation between countries to respond to the need for health

professionals and provide employment opportunities for Filipino health professionals. It was an operational agreement which described how the recruitment and selection process should be implemented. This government to government agreement implemented a "no placement fee" policy for the recruitment of nurses to the UK. This policy was halted in 2006 due to UK's declaration of non-shortage of nurses. More progressive BLAs or MOUs were signed in the recent years by the Philippines with the governments of Saskatchewan (2006) and Manitoba (2008) in Canada and United Arab Emirates (2007) and Bahrain (2007). For multilateral agreements (MLA), the ASEAN Mutual Recognition Arrangements (MRAs) is based on the ASEAN Framework Agreement for Services (AFAS) which aims to enhance cooperation in services among ASEAN Member Countries to eventually realize free trade in services. The ASEAN MRA on Nursing Services was designed to strengthen professional capabilities by promoting the exchange of information and expertise as well as experience and best practices to suit the needs of ASEAN Member Countries. The MRA involves the recognition of diplomas, qualifications, licenses and certificates, nursing curriculum development and quality assurance training. For the Philippines, the MRAs are in force for several professions such as nurses, doctors, dentists and engineers and implementing guidelines are currently being developed. The Philippines also supports the Codes of Ethical Recruitment and Rural Retention of Health Workers by the World Health Organization.

Data Limitations and Monitoring

An accurate estimate of active physician stock is difficult to estimate due to the following reasons: (1) the practice of medicine requires only a license and no other indicator can determine whether physicians are actively in practice or are licensed but working in a different sector or as a different profession, (2) the attrition rate considers age of retirement at 65 years, however, there are physicians in active practice who are beyond retirement age, and (3) physicians practicing outside the country are able to return to the Philippines and renew their professional license. As of yet, the country has not installed a system that accurately determines the supply of physicians in active practice especially in the private sector.

There are no records on the actual number of pharmacists per region which makes it difficult to ascertain that there is at least one pharmacist per retail outlet or drug distributor. There is no standard pharmacist to population ratio for the country.

Presently, no official government data exists that readily categorizes the OT and PT professional populations as to age, gender, regional distribution, urban/rural distribution, and public/private professional practice.

Presently, there is no system in place to determine or segregate the amount of remittances from health professionals. The form used by any migrant when remitting only requires the name of remitter, amount to be remitted, country, and name of beneficiary. Type of profession or occupation and demographics are not included. Because of these limitations, assumptions can only be made in explaining changes in remittance trends from land-based work.

Table 4: Push/ Pull/ Stick/ Stay factors

<p><i>Push factors</i></p> <ul style="list-style-type: none"> • Unstable socio-economic and political condition (sudden changes in the political landscape brings about uncertainty and fear); corruption • Poor priorities in health; Poor living conditions; unsatisfying quality of life • Limited opportunities for employment in country • Lack of competitive compensation package and attractive benefits/ incentives • Heavy workload, especially for those working in hospitals (due to staffing shortages) • Restrictive professional practice; limited continuing education / lifelong learning opportunities • Profession is still highly misunderstood and underutilized • Lack of technology and equipment • Easy access to US NCLEX review and examination in the Philippines • Presence of POEA and recruitment agencies that facilitate and ensure overseas employment and safety • Presence of government-to-government labor agreements • Knowledge of the English language or language of the destination country 	<p><i>Pull factors</i></p> <ul style="list-style-type: none"> • More socio-economic -political stability; • Better quality of life and future of the children in terms of education and career opportunities • Better compensation and benefits i.e. free education, better access to healthcare services, retirement benefits; • Enhanced professional recognition; Gain personal enhancement/prestige • High demand for health professionals • Autonomous system of practice • Better working conditions due to advances in technology and diagnostics (e.g. automation) • More professional growth/career advancement opportunities; availability of a wide range of subspecialties, abundance of training and teaching facilities, opportunities to be trained and work with known experts; and the prospect to be successful in chosen field • Opportunity to travel to other places • Opportunity to migrate with the family • Presence of relatives and friends who are already working and residing in the destination country
<p><i>Stick factors</i></p> <ul style="list-style-type: none"> • Close family ties; desire to take care of ageing parents and/or younger family members; Assured family and social support • Better quality of life especially for the retirees/elderly • Nationalism • Fear of loss of national identity; different socio-cultural environment; Inability to adjust to foreign culture • Entrepreneurial opportunities that are present locally • Contented/satisfied with working in the country • Competitive salary/already established successful professional practice in the country • Good relationship/camaraderie in work environment; less workload • Continuing education; career development • High/positive regard attributed to health workers by patients/clients • Passion and commitment; love for work; High job satisfaction • Stringent requirements imposed by destination countries on foreign graduates • Cannot afford expenses related to traveling to another country • The destination country of choice is not open for hiring 	<p><i>Stay factors</i></p> <ul style="list-style-type: none"> • Possibility of petitioning other family member to gain citizenship in country of destination • Migration of the whole family to destination county • Better living conditions and sociopolitical environment • Fear of losing the quality of life one is already accustomed to; Difficulties of re-adjusting to another environment • Inability to leave receiving country due to insufficient resources • Good working conditions • Marketability as a professional may decline when they return leading to less lucrative opportunities; difficulty in re- establishing his/her practice in the Philippines • Better career growth and work opportunities • Availability of equipment, facilities and other updated technological advancements • Better salary and benefits/incentive packages • High regard for the profession by patients/clients • Established/stable professional practice • Immigrant visa • Opportunity to bring family to destination country

Conclusions/ Recommendations

Based on the study, the following conclusions are made:

- **Professional health worker migration can become mutually beneficial for source and destination countries.** The Philippine health care system will benefit from effective migration management. Health system strengthening will be a direct benefit to the country. The health professional migrant will be helped by ensuring his right to safe and beneficial work environment, fair wage and career development in the destination country. The destination country can benefit by being assured of the quality and commitment of health workers that are recruited to meet their health care needs.
- There are **different reasons for Filipino health professional migration.** Doctors, migrate mostly for post graduate training and to pursue clinical or other education. The majority of nurses on the other hand migrate for economic advancement. Therapists go abroad to further career prospects – to learn new skills and practices.
- Patterns of decision-making to migrate or not are likewise varied. **Nurses consider migration in their decision to pursue nursing. Doctors and PT/OT consider migration after their training.** Unfortunately return migration is negligible and undocumented. But many of the nurse migrants engage in circular migration where they come back after their contracts are finished and leave again for another country if they are not absorbed back into the Philippine nursing workforce.
- **Migration markets are dynamic and evolving** from developed traditional markets to new markets due to economic fluctuations and destination country policy changes. New markets are being explored by the country. Migration is encouraged to address massive unemployment and underemployment.
- The **magnitude of health workers who migrate has been decreasing** recently due to international competition and migration or health system policy changes in destination countries. However, there seems to be recurring patterns of increase and decrease due to the persistence of need for professional health workers in destination countries and their inability to develop and maintain sufficient health professionals to support aging populations.
- There are **significant health professional labor effects.** There is now a surplus of Filipino nurse production. The effects are felt in the consequence of their unemployment and underemployment within the country especially now that foreign markets are readjusting.

- **Bilateral agreements seem to be promising tools forged within new and traditional markets to better manage migration.** Bilateral agreements provide opportunities for investments and quality management, rationalize numbers of migrants among others.
- **Remittances are important for nurses-** no data specific to nurses and health care professionals; national data shows that of remittances sent 90% of remittances are sent to savings accounts while pick-up agencies such as Western Union service 25% of all remittances.

Recommendations to the EU and other parties are offered based on the findings of the present study emphasizing the need for ensuring mutual benefit for both source and destination countries in the mobility of health professionals.

The recommendations aim to espouse the attainment of priority policy goals: 1) Equity of health outcomes that will likewise be affected by equity of distribution of health human resources (HRH) across source and destination countries; 2) Effectiveness of implementation of Ethical Recruitment Guidelines; 3) Effectiveness of meeting Millennium Development Goals across source and destination countries.

These recommendations focus on health care system strengthening and migration management.

Health care system

- The **Philippine health care system can be strengthened with effective migration management.** From the study, effective migration management includes ensuring retention of skilled health workers and managing the outflow of professional health workers. Retention mechanisms include providing official positions for health workers instead of hiring contractual workers, ensuring fair wages and providing safe working conditions.
- Country specific measures should be undertaken to **ensure rational production and sustainable deployment of professional health workers in each country.** For both source and destination countries, the goal is to be self-sufficient in terms of professional health workers to meet their country needs. There should not be too much dependence on other countries as source or destination countries for the health professionals that they need. Human resources master planning (strategic plans) should be undertaken for long-term determination of supply, needs and demands of health workers.

Migration of Health Professionals

- **Bilateral agreements** should be encouraged to complement multi-lateral agreements such as the ILO conventions. Bilateral agreements can be more specific and improve implementation of **ethical** recruitment guidelines. Among others, bilateral agreements should include the following provisions;

- **Uphold the rights of migrant workers** by improving access to legal labor channels. These can be done by countries sharing information in order to better match labor supply and demand. Identify stakeholders and involve countries of origin, NGOs as well as international organizations in the selection and recruitment of workers;
- **Enhance and enable temporary labor migration**, including circular and sector-specific migration. Recognize skills and qualifications to facilitate entry into destination labor market. Measures to address irregular migration with arrangements for legal migration opportunities should also be undertaken as an option to restrain irregular movements of people. To enhance temporariness of migration, reintegration and recognition of skills should be facilitated. If possible, provisions should be made for the portability of retirement pensions, social security and health benefits;
- **Monitoring and Evaluation of Employment** should be undertaken. There is a need to Inform workers of legal migration opportunities and of their rights and obligations;
- **Protect migrant workers from recruitment fees and high transportation costs.** Implementation of guarantees for fair work and wage conditions should be undertaken;
- **Improve access to financial systems and enhance financial transfers** in order to improve remittance flows and management. Ensure the same health care and

social security benefits for migrant workers as for local workers. Integrate monitoring and evaluation measures of financial systems access;

- **Improve work skills of migrants and outcomes of migration.** Source and destination countries both have responsibilities in improving outcomes of migration. Source countries should provide pre-departure language training and culture orientation while destination countries can provide culture and technology orientation. Cooperation among countries of origin should be forged to protect migrant workers in countries of destination. Efforts to promote inclusion of migrants in society of destination country. Part of this should be the facilitation of family unification so that families are kept intact even with work abroad; and

Information Systems

- **HRH information should be shared** so that ethical recruitment, long term planning of production and deployment can be made more effectively. Country specific information such as supply, demand or need for health workers, distribution of specialties and special skills should be made available for planning or evaluation purposes.
- In all of these collaboration of countries in exchange will be valuable to ensure that the mobility of health professionals redound to mutual benefits for source and destination countries.

List of Acronyms

AFAS	– ASEAN Framework Agreement for Services
ASEAN	– Association of Southeast Asian Nations
BLA	– Bilateral Labor Agreements
BLES	– Bureau of Labor and Employment Statistics
BOI	– Bureau of Immigration
BSM	– Bachelor of Science in Midwifery
BSMT	– Bachelor of Science in Medical Technology
BSN	– Bachelor of Science in Nursing
BSP	– Bangko Sentral ng Pilipinas
BSPHarm	– Bachelor of Science in Pharmacy
BSPT	– Bachelor of Science in Physical Therapy
BSOT	– Bachelor of Science in Occupational Therapy
CFO	– Commission on Filipinos Overseas
CHED	– Commission on Higher Education
DBM	– Department of Budget and Management
DDM	– Doctor of Dental Medicine
DFA	– Department of Foreign Affairs
DOH	– Department of Health
DOH-BHFS	– Department of Health-Bureau of Health Facilities and Services
DOLE	– Department of Labor and Employment

EU	– European Union
FGD	– Focus Group Discussion
GCC	– Gulf Cooperation Council
GDP	– Gross Domestic Product
GNP	– Gross National Product
HDI	– Human Development Index
HPI-1	– Human Poverty Index-1
HR	– Human Resource
HRH	– Human Resources for Health
ICU	– Intensive Care Unit
IELTS	– International English Language Testing System
KSA	– Kingdom of Saudi Arabia
MD	– Doctor of Medicine
MDG	– Millennium Development Goal
MLA	– Multilateral Agreement
MOU	– Memorandum of Understanding
MRA	– Mutual Recognition Arrangement
NCLEX	– National Council Licensure Examination
NCR	– National Capital Region
NSCB	– National Statistical Coordination Board
OFW	– Overseas Filipino Worker
OT	– Occupational Therapy/Therapist
OWWA	– Overseas Workers Welfare Administration

PCP	– Philippine College of Physicians
PhD	– Doctor of Philosophy
PHIC	– Philippine Health Insurance Corporation
PhP	– Philippine Peso
PLE	– Pharmacy Licensure Examination
PMA	– Philippine Medical Association
POEA	– Philippine Overseas Employment Administration
POLO	– Philippine Overseas Labor Office
PPP	– Purchasing-power-parity
PPTA	– Philippine Physical Therapy Association
PRC	– Professional Regulation Commission
PSHP	– Philippine Society of Hospital Pharmacists
PT	– Physical Therapy/Therapist
RA	– Republic Act
SARS	– Severe Acute Respiratory Syndrome
SEA	– Southeast Asia
SP	– Speech Pathology/Pathologist
UAE	– United Arab Emirates
UHC	– Universal Health Care
UK	– United Kingdom
UN	– United Nations
US	– United States
USA	– United States of America
USD	– United States Dollar
WB	– World Bank

This National Profile was written by Fely Marilyn Lorenzo, Jennifer de la Rosa, Venice Celis, Sharlyn Celino (University of the Philippines Manila) and is based on National Report for PHILIPPINES – available at www.mohprof.eu/PHILIPPINES