Human Resources for Health and Philippine Policy Options

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ABSTRACT

The migration "carousel" for health workers – or human resources for health (HRH) – is a phenomenon ripe with opportunities and difficulties for its many stakeholders. With an in-depth literature review, the situation is put into context, in terms of the underlying factors that prompt workers to relocate, as well as the facilitating effects of globalization and worldwide HRH shortages. The possible outcomes are discussed, particularly the externalities that relate to source and recipient countries. The actual impact of worker shortages on the delivery of health care is further clarified. Policy options for modulating HRH flows and enhancing HRH stocks are thereafter drawn. Individual as well as country interests are taken into consideration in deriving a range of applicable policy instruments. Managed migration schemes for HRH flows appear to provide the greatest flexibility for most concerned parties. The application of the derived policy framework in a leading HRH "donor" country, the Philippines, is presented.

Key Words: health resources, migration, Philippines

Introduction

"Brain drain" entered the lexicon in the 1960's in reference to the migration of British scholars to the US.[1] In 1965, concerns regarding the migration of health workers in particular were raised at the Edinburgh Commonwealth Medical Conference.[2] More than a decade thereafter, a World Health Organization (WHO) study on the matter was undertaken as the "anxiety evoked by migration had reached a peak in both major donor and recipient countries".[3] The so-called "Mejia report" looked into the apparent inequity in the stocks and flows of physicians and nurses in 40 countries. But as the health manpower situation did not seem to worsen in the succeeding years, the importance of the study waned over time.

But the tide of health manpower – or "human resources for health" (HRH) – migration did insidiously continue to rise. It has now reached levels and areas way beyond those of the incipient WHO report.[4] There is also a growing impression that the health "brain drain" has crippled the manpower backbone of many health systems, with consequent worsening of the health status of the poor and under-served populations.

The migration scenario has been succinctly called a "medical carousel", referring initially to physicians sequentially moving onwards to positions with better conditions.[5] As it now exists, the carousel runs across many more countries, and involves non-physician health workers more prominently. The ride ends in the US and other developed countries, and never comes full circle to bring back health workers to less developed countries.[6] On a national or local level, the international transfers also exacerbates "internal" migration, as rural or public posts are abandoned by health professionals as they "move up" to the positions vacated by those who have gone abroad.[1]

HRH migration can be viewed as either providing better opportunities for all those involved or as being a bane of health care systems. There is therefore a need to better understand the basic concerns underlying the phenomenon, if only to be better guided in drawing up effective policy alternatives. It is the objective of this paper to elucidate the essential issues of relevance to the HRH migration as well as to set down circumstance-appropriate policy options. The possible application of such a policy array on a leading HRH "donor" country, the Philippines, is briefly examined. Being a policy paper, this work utilizes an extensive review of pertinent and current literature.

HRH Migration in Context

That the HRH situation has not subsided over the interim can be attributed to the persistence if not intensification of the migration "push" and "pull" forces acting on individual workers. The effects of these have been accentuated by two developments: a worldwide shortage of health personnel as well as the increasing influence of globalization.

Push and Pull Factors

As gleaned from various studies, several adverse conditions known or perceived to exist in a setting or country can be the implicit "push" factors that drive health workers away.[6-10] The staggering workload for health workers from the spread of HIV/AIDS in sub-Saharan Africa was confounded by the loss of significant numbers of their coworkers from the disease – providing added migration incentives for those remaining.[11] The inverse of these may exist elsewhere and serve as the "pull" factors that induce workers to relocate to these places. The improved economic situation in Chile encouraged more of its physicians to

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practice in the private sector, providing municipal openings for migrant health workers from nearby countries.[4] A "migration mentality" may prevail in some quarters - often linked to thriving diaspora communities – which may make it even a prestigious option for health workers to work abroad.[12] Often overlooked though just as important are those variables that restrain worker movements.[2, 10]

These sets of factors, listed in Table 1, are not mutually exclusive. For instance, the desire to obtain higher incomes or provide better opportunities for their families may make migration an attractive option for workers. However, the anticipated emotional hardship of being away from their families may deter them from leaving. Gender issues are also relevant, as HRH migration involves female workers for the most part.[12, 13] While migration may expose females to exploitation risks, this may also provide greater personal autonomy for the workers and higher remittances for their families.

Table 1a. Matrix of factors that favor HRH migration

	Origin "Push Forward" Factors	Destination "Pull Forward" Factors
Work Conditions	• Inadequate compensation •Poor working conditions (including ill-equipped and poorly supplied facilities; exposure to hazards) •Undervalued work contribution •Overload from staff shortage (including demoralization with migration of co-workers)	•Better compensation •Improved working conditions •Work contribution better appreciated •More manageable workload •Greater career opportunities • More training opportunities, including centers of excellence
Professional Development	•Lack of career opportunities / Limited advancement •Limited training opportunities	•Better over-all quality of life •Stable socio-political situation/ Personal security
Socioeconomic Circumstances	•Poor over-all quality of life •Socio-political uncertainty/ Personal insecurity	•More opportunities/ facilities for family •Diaspora communities
Family Situation	•Lack of opportunities/ facilities for family	
Others	•Social desirability of emigration	

Table 1b. Matrix of factors that restrain HRH migration

	Origin "Pull Backward" Factors	Destination "Push Backward" Factors
Sociocultural Concerns	• Family ties	•Cultural differences
Professional Status	•Professional / Institutional pride	•Lower-rung position •Comparatively lower wages
Migration Process	•High transaction costs •Recruitment agency exploitation •Exit restrictions	•Prohibitive relocation costs •Employment maltreatment •Entry Restrictions
Uncertainty	•Risks more familiar	•Risks less familiar

HRH Shortage

An appraisal of the global health workforce was provided in 2004 by the Joint Learning Institute (JLI).[13] It estimated that there are currently about 100 million health workers worldwide – inclusive of 9 million physicians, 15 million nurses and midwives, and the remainder being allied as well as informal health workers. The worldwide HRH shortage is estimated to be at least four million workers. Shortages exist, to varying degrees, in most countries. And these shortages are further aggravated by regional or local maldistribution as well as skills imbalances ("technical maldistribution").

There is a large variance in the worldwide HRH distribution. Europe and North America combined have 20% of the world's population. Taken together, however, these regions have 50% of the global stock of physicians and 60% of the world's nurses. The United States, in absolute terms, has the second highest tally of physicians (following China, which has a fifth of the U.S. physician density) and, with the rest of its HRH pool factored in, is classified as a "high density, low mortality" country.[13] Yet, the US is projected to have a shortfall of a million health workers within the coming 15 years. The same magnitude of HRH shortage presently exists in sub-Saharan Africa.[14]

Shortfalls exist both when HRH stocks are scarce (proportionate to essential population health needs) – and hereby called "low density" shortages – as well as when the workforce quantities are substantial – whereby these are designated as "high density" shortages. The shortfalls are usually periodic in "high density" settings (mostly from demand-driven variations), while these are often protracted in "low density" cases.[8] While simplistic, the grouping nevertheless puts HRH shortages into better perspective. The classification is shown in Table 2, inclusive of the various reported specific shortage causes.[1,2,8-11,15-17]

Table 2. Possible causes of HRH deficits

"LOW DENSITY" SHORTAGE	"HIGH DENSITY" SHORTAGE
•Inadequate Production •Limited training capacity •Poor health infrastructure •Prohibitive costs •High Attrition •Crisis situations, including HIV/ AIDS •Migration	•High Demand •Geographic Maldistribution •Technical Maldistribution •Insufficient Positions •Limited Caseload •Waning Interest •Other careers more attractive •Low regard for health professions •High personal risks, including malpractice •High direct and opportunity costs of training •Imposed Quotas

"Low density" shortages can be more adverse, as these can lead to HRH deficits so grave that the provision of even the most basic services are severely hampered. The lack of medical and nursing schools coupled by the attrition of health workers from HIV/AIDS have undoubtedly contributed to the glaring HRH shortage in Africa.[11] The threshold HRH density for the delivery of essential health services has been estimated at 2.5 workers per 1,000 population.[13] While developing countries are more likely to have "low density" shortages, this is not always the case. And while HRH stocks may be substantive in some, the local demand may not be commensurate – giving rise to high HRH unemployment or under-employment rates.[10, 13]

Circumstances in developed countries – or privileged enclaves in developing countries – provide a different employment environment. If other career options are more attractive, potential health occupation entrants may opt out and already qualified health workers may retire early. Likewise, prevailing market incentives may discourage HRH involvement in less financially rewarding areas even if the latter have more pronounced medical needs. These result in geographic (e.g., urban rather than rural practice) as well as technical (e.g., more procedural specialists rather than general practitioners) HRH maldistribution – and shortages in the bypassed areas. Erroneously projected surpluses of physicians led to the imposition of limits on medical school enrollment in France and the USA – contributing to recent physician shortages in these countries.[17]

The near universal stock shortages translate to ever present work opportunities for health professionals. While providing steam for the health carousel, the enabled transfers are not directed towards areas with more pronounced shortages - as these presumably offer less potential personal benefits for the migrant workers.[7,8,11,16] For most, therefore, the destination is a better-paying facility or a more developed locality – which, due to the enhanced mobility brought about by the forces of globalization - is increasingly found in another country.[1,2,4,6] These HRH flows are illustrated in Figure 1.

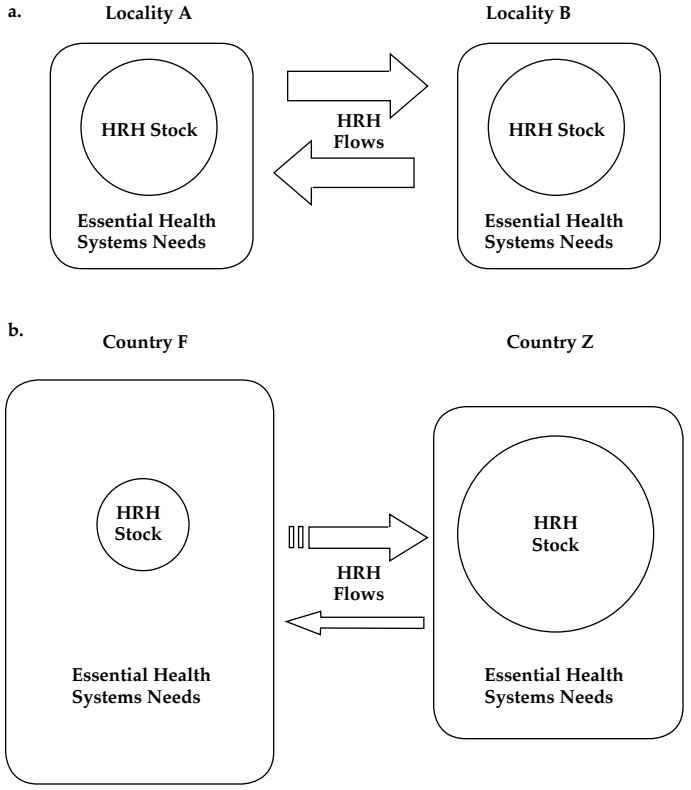

Fig.1. a. Symmetrical HRH flows between two localities of similar workforce densities **b.** HRH flows between two countries of unequal worker density levels (hatched flow arrow represents the "carousel" passage across intermediate countries).

Globalization Milieu

The present-day globalized environment provides the machinery and expanded opportunities that further sustain the health carousel.

Many of the elements of globalization seem inconsequential yet do have a significant bearing on cross-country HRH mobility. The broad adoption of Western curricular models, even the use of English as a medium of instruction, are concrete examples.[18] Improved and more affordable transportation and communication systems have greatly enhanced cross-border information access and employment possibilities.

Globalization has also changed the hierarchy and nature of international health.[19,20] The World Health Organization (WHO) had been the predominant global health body since the 1950's. Presently, the International Monetary Fund (IMF), World Bank, World Trade Organization (WTO) and various unilateral and international bodies have been gaining more ground – swaying health policies and priorities in the process.

In this milieu, the construct of human capital, including HRH, as a commodity that can be traded has taken root. It is in this context that the opening up of international markets for health services is now occurring. The General Agreement on Trade and Services (GATS), under World Trade Organization (WTO) auspices, has attempted to further promote this liberalization ethos. But the contentiousness of some issues – such as "Most Favored Nation" constraints, lack of safeguards particularly for manpower exporting countries, and even the uncertainty of any tangible benefit for a participating country – has dissuaded broad GATS participation in the health sphere.[21,22] Countries have more readily entered into bilateral agreements on HRH transfers outside of GATS.[4,8]

Though they have provided vital development support, some of the ascendant international bodies have adopted policies that have been detrimental to health workers. The International Monetary Fund (IMF) / World Bank restrictions on public expenditures (including those for health services) as well as the "vertical" approaches of some of the international agencies have reportedly contributed to the worsening of local work environments, thereby accentuating the conditions that induce HRH migration.[6,19,23]

Stakeholders and Outcomes

There are three main stakeholders with regards to HRH cross-country transfers: the individual migrant and family, the country of origin, and the destination country. The observed and postulated effects on these have been widely reported and are often country or region specific. These are summarized in Table 3.

Table 3. Possible consequences of HRH migration on stakeholders

	BENEFICIAL	ADVERSE
INDIVIDUAL	Higher income Better quality of life Professional development Personal development Cultural enrichment	Disruption of social ties Recruitment or employment exploitation Wages below going rate Low-end or lower skill employment
SOURCE COUNTRY	Remittances from migrant workers Transnational professional networks Improved human capital with returnees Enhanced training opportunities	Lost investments in human capital Aggravates HRH shortage Internal migration Foregone future wage/ income tax revenue Thinning of middle class No incentives for added local positions "Downward spiral" of HRH Population health status
RECIPIENT COUNTRY	Minimal training investment/costs for new workers Minimal time lag in generating staff Acquires personnel more tolerant of conditions unattractive to own workers Competitive advantage	Undermines efforts at developing own as well as other countries' HRH Wage effects

Individual Workers & Families

The effects on individual migrants are as what have been discussed in the previous section concerning "push and pull" factors. It may be assumed that migration decisions have been so deliberated by the individual worker as to optimize personal gains. But while such considerations presumably incorporate both personal benefits and costs, these may be to the exclusion of relevant externalities. Taken in aggregate, HRH migration undoubtedly begets substantial social effects on the countries of origin ("source") and destination ("recipient").

Source Countries

Especially for developing countries, monetary remittances would be a key advantage for exporting their workers. With total remittances amounting to $72.3 billion reaching developing countries in 2001, these funds are undoubtedly significant.[12] Though presumably substantial, the actual magnitude of HRH-specific remittances has not been fully quantified.[24,25,26] Nurses nonetheless have been found to be more reliable sources of remittances than non-health workers.[24] In response to the demand within the source countries themselves, more training facilities, mostly privately-run, have sprung up.[27] The other postulated benefits to the source countries mostly redound to human capital formation.[8,28] These are, however, premised on either continuous contacts with or the eventual return of the expatriate workers.

Undeniably, HRH migration also extracts a substantial toll especially from developing source countries. Public investments in human capital are squandered when the recipients do not stay and work for the direct benefit of those who subsidized their professional education. The opportunity costs of training health workers can be sizable in relation to the limited financial resources in developing countries. Over a recent span of nearly 50 years, India is estimated to have lost $5 billion in training investments due to physician emigration.[2] Though studies suggest that remittances offset the forgone training investments, these may gloss over relevant opportunity costs.[24,25] For Kenya, the economic losses have been estimated to amount to $ 517,931 for every migrating physician and $ 338,868 for each departing nurse.[29] Reductions in the national HRH pool, particularly in "low density" situations, greatly aggravate manpower shortfalls as well as their attendant sequelae.[6,9,29] At its worst, the latter can lead to a "downward spiral", of further HRH migration.[2] The report from a hospital in the capital of Malawi, where one of only two remaining nurses from an initial staff of 500 was to leave for the UK, is but one of the many sad anecdotes that illustrate the point.[8]

The alleged detrimental effect of HRH migration on population health has aroused the most concern.[13] But while deterioration in health services can be intuitively surmised as an expected outcome when health professionals leave, a recent study in Africa suggests otherwise.[30] The reverse relationship, where deteriorated health systems incite HRH migration, has been demonstrated in several surveys.[9, 31] Thus, it seems that HRH migration is largely one of the unfortunate effects, rather a principal cause, of deteriorated public health services. Nevertheless, for "high density" states to source HRH from "low density" countries, and risk making circumstances marginally worse for the latter, borders on the unethical if not unjust.

Recipient Countries

The nearly immediate alleviation of HRH deficits, with little or no prior public investment in the welfare and training of the "imported" personnel, is distinctly advantageous for recipient countries.[2,6,32] For the UK, each qualifying physician costs £200,000 – 250,000 and takes five to six years to train, while foreign staff come at no such cost and time lag.[6] The migrants help fill critical gaps in health services, as they are often more tolerant of work conditions that are shunned by

the domestic staff (e.g., night shift, mental health, rural or inner cities, etc.).[2] All these ultimately make the communities in the recipient countries more competitive, as they are able to enjoy health service amenities at less investment costs.[8] A similar advantage may accrue to diaspora communities, whose members thrive better as their preferences for health professionals from their countries of origin are met.

The ready availability of imported workers, however, may stymie destination countries from extending additional resources and opportunities for domestic training.[2] For developed countries, recruitment of HRH who were trained at great expense by developing countries may also undermine the effectiveness of their development aid to the same countries. Lastly, the entry of workers amenable to receiving comparatively less benefits may negatively affect the wage and non-wage packages for even the domestic health workers.

Policy Alternatives

HRH migration engenders public policy scrutiny as it involves diverse private and public parties whose interests are often conflicting. Likewise, the optimal levels, if not the actual propriety, of cross-country transfers remain highly controversial. Allowing the status quo may mean the perpetuation of economic inefficiencies as well as the surmised detrimental effects of migration on health systems and disadvantaged populations. Policy initiatives would center on two main areas: actual migration processes ("HRH flows") as well the HRH composition of individual countries ("HRH stocks").

HRH Flows

The policy options for HRH migration would extend from the severely restrictive to the highly permissive. Inevitably, policy preferences would reflect the prevailing, and even the desired, societal attitudes and objectives of the involved countries. These policy options are presented in Table 4a.

A highly tolerant policy on HRH transfers would be consistent with a libertarian approach to the issue. The individual workers, thereby granted free rein, would gain the most in such a regime. Recipient countries would also greatly benefit, as they may then be able to acquire the most number of workers. Hard-pressed source countries would have the potential to lose most, unless, for instance, significant remittances can be generated to somehow offset the resulting losses. With the hesitancy for full GATS commitments as a gauge, however, it would seem that most countries are unwilling to totally liberalize cross-country HRH movements. It may still be in the best interest of individual states to exercise some control over the entry and exit particularly of health professionals (e.g., quality assurance). Some instruments, while putting restrictions in place, may actually streamline transfer processes – such as the bilateral arrangement on nurse recruitment drawn between the UK and the Philippines.[4] The same may be said for mechanisms that help guarantee the upholding of migrant's rights.[33]

Table 4a. Array of policy options on HRH flows

POLICY	SPONSOR	INSTRUMENTS
	Source countries	Full GATS commitment
Permissive	Recipient countries	Incentives for recruitment of foreign HRH
		Full GATS commitment
	Both	Facilitate return migration
		Ensure continued access of migrants to rights
		Bilateral recruitment agreements
	Source countries	Prohibit emigration
Restrictive		Bonding or mandated community service
	Recipient countries	Ban recruitment
	Both	Prohibit cross-country transfers
	Source countries	Demand compensation from professionals themselves with: • exit taxes • cost recovery payment if does not return after overseas training
Intermediate		
	Recipient countries	Lower wages for foreign-trained workers
		Recruitment codes
		Compensation and cost-sharing mechanisms with:
	Both	• hiring institutions • recipient country (including tax payments based on nationality rather than residence)
		Time-bound allowable stay in recipient country by:
		• Predetermined duration of training • Rotation of work opportunities
		Managed overseas employment

A very restrictive approach would follow a utilitarian view, and would redirect health manpower to where it is more effective. While this presumably favors developing countries, a further examination of the possible outcomes indicates otherwise. The most extreme measure, a total ban on HRH transfers, may not only be difficult to enforce but also not be in the best interest of any country. "Recipient" countries would, of course, prefer to have access to more workers. Source countries might lose out on potential benefits (such as, again, remittances). Likewise, these will not necessarily gain workers or have improved health services. In several African countries, the maldistribution as well as low productivity of the (far from over-worked) existing HRH stock – rather than any extant staff shortages (including the comparatively small number lost from migration) – account for the inadequacy of health services.[30] Similarly, the continued prospect of migration can be a principal driver for entry into the health occupations. Taking away the option may thus dissuade future workers (as shown diagrammatically in Fig. 2).[30] Outright bans have thus been the exception and less restrictive means have

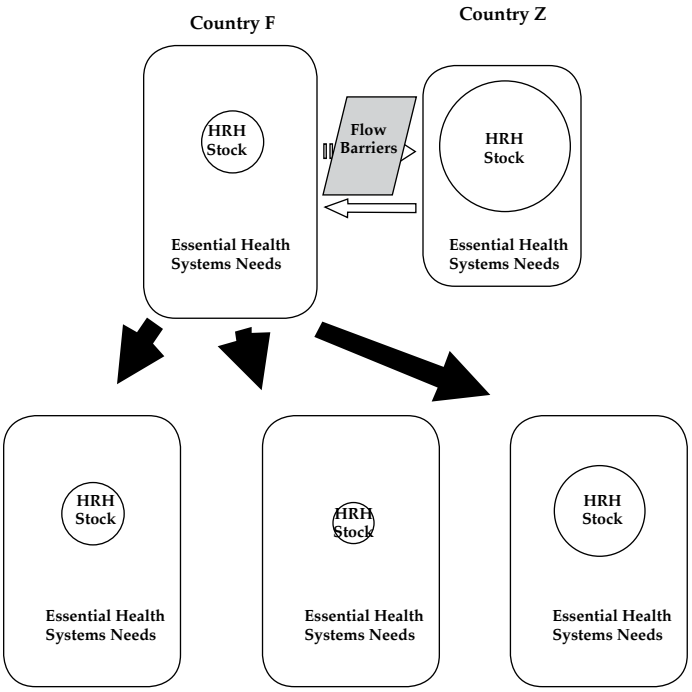

Fig. 2. The possible outcomes of banning HRH outflows from a "low density" country.

been more widely adopted.[34] These have come mostly in the form of "bonding", or mandated community service arrangements.[11] The effectiveness of the latter, however, has often been questioned.[6, 7] Penalties are difficult to impose and buyout options can be availed of .[35] Thailand has had relatively good outcomes when additional incentives were packaged with the bonding scheme.[36]

Intermediate measures allow migration but at a price. Where compensations are to be demanded (effectively rent collections for the Source country), the corollary issues are the burden of payment (whether payable by the migrants, the recruiting institution, or the government of the recipient country) as well as the amounts involved (whether limited to the direct costs of training or inclusive of all relevant opportunity costs).[1,11,17,37] Limitations may be placed on the duration of stay in the host countries.[2,8,34,38] Recruitment codes (primarily from the UK) have been drawn up.[25] While these provide ethical guidelines, these were never designed to restrict HRH migration and have therefore hardly affected actual migration trends.[1,2,6] Migrant wage restrictions, while attractive for receiving institutions, may prove untenable in the long run. These may be to the eventual detriment of the local workers and would also not be compliant with GATS provisions.

Many of the "middle of the road" options have come under the sobriquet of "managed migration". As these intermediate options provide more flexibility for the various stakeholders, policy initiatives in this area would be more mutually acceptable and sustainable. The propensity for partial commitments to GATS as well as tailored bilateral arrangements on HRH transfers highlight the general preference for this policy direction.[4,8,22]

HRH Stocks

Ultimately, individual countries would be most concerned with the status of their own HRH stocks. This would have a bearing on the health systems capabilities as well as the net migration flows for the respective countries.[11,13] The policy options for HRH stocks, in terms of the stakeholder countries, are summarized in Table 4b.

Table 4b. Array of policy options on HRH stocks

SPONSOR	POLICY	INSTRUMENTS
Source Country	Dampen "push forward" factors	Augment incentives and privileges Improve working conditions Modify curriculum to be more locally relevant
	Enhance positive "pull back" factors	Enhance absorptive capacity
	Accelerated replenishment	Recruit foreign health workers Enable auxiliary workers Review manpower regulations
Recipient Country	Increase domestic HRH participation	Increase training subsidies and opportunities Incentives and subsidies to reverse geographic maldistribution Incentives and subsidies to reverse technical maldistribution
Both	Dampen "push and pull forward" factors	Reevaluate systems and priorities Promote status of health professions Promote worker welfare (e.g., increase pay, ensure equality) Better information and management systems

Source Countries

Source countries need to improve the local work environment as well as provide incentives to ensure an adequate and well-motivated domestic HRH stock.[1,11] Though difficult in real terms, a commitment to optimize health systems and facilities has to be made. As additional financial benefits may never match potential foreign earnings and may even be politically resisted by non-health workers, non-wage benefits may be more effective inducements.[39] Allowing "dual" practice for public health workers may help augment their incomes but may lead to conflicts of interest as well as accentuate market failures.[11] The need to modify the HRH training curricula to make these more responsive to local conditions has been repeatedly broached.[1,8] It needs to be pointed out, however, that most health problems do not really respect borders. Also, health professionals may never be satisfied with "limited" training and may therefore even seek further training abroad. The absorptive capacity of source countries needs to be improved to encourage return migration.[7] As it may be difficult to replicate the technical capabilities elsewhere,

countries can at least provide suitable positions for some of the returnees. A pilot "exchange" program that allows US-based nurses temporary positions in a Caribbean hospital has been initiated.[38]

For countries with critical HRH shortages, timely stock replenishment can be afforded by the entry of foreign health professionals and by auxiliary workers.[11,36,40] Foreign workers, if publicly financed, may mean an additional drain on limited local resources.[6] While auxiliary workers may provide crucial support, their employment may be associated with several risks – including the disaffection of some health professionals.[36,39] Also, the "limited" training of such workers will not disqualify them from seeking even menial but still health-related jobs abroad.[6]

Recipient Countries

Particularly for "high density" recipient countries, the most strategic policy would be to increase their own citizens' numbers in the health professions. This would not only help alleviate existing shortages but may also be the definitive solution to the health carousel challenge.

Recent developments in the US, the penultimate destination of the migration carousel, are in line with this. The American Association of Medical Colleges (AAMC) has announced its plan to increase the number of US medical students by 30% over a decade.[41] The Council on Graduate Medical Education (CGME) advocates a modest 12.5% increase in residency positions over the same period.[42] Relevant conditions would also need to be taken into consideration. The amount of debt that the average US medical student acquires (to finance medical education) may reach unbearable levels in the near future.[43] Domestic practitioners, though increased in numbers, may have the same practice preferences and thereby perpetuate existing technical and distributional shortages.[44] Foreign-trained physicians may therefore still have to be relied on to attend under-served areas, such as America's inner cities.[45] US policy considerations should therefore extend to providing more incentives (such as subsidies) for the training and directed practice of its citizens. Likewise, issues such as retirement and work schedules also need to be reassessed. A greater utilization of less expensive complementary workers is another alternative worth considering.[46]

Still and all, it is also not only the US, much less its physician market, which faces a shortage – and draws migrant HRH. Similar policies have to be adopted in other fields and countries, lest these open new channels for worker transfers. The scores of Philippine physicians have already retrained to be employed in the US as nurses illustrate the latter possibility.[13]

Both Sets of Countries

All countries concerned with apparent shortages in their HRH stocks need to reevaluate their over-all health objectives, the capacities of their systems and thereafter determine their appropriate HRH requirements. The quantity and quality measures of HRH stocks, while important by themselves, should not be taken in isolation of the other health system components, much less what these have been set up to accomplish. Thus, while much has been made about the apparent US physician shortage, it has also been pointed out that "superior care" has been provided in other countries – and even in some parts of the US - utilizing far fewer physicians.[44] Improved management practices as well as information processes need to put in place if health systems are to be optimized.

Combined efforts on promoting HRH welfare are daunting but would be of utmost importance.[2, 33] Likewise, measures have to be undertaken to promote, if not refurbish, the status and qualifications of health professionals - either through changes in the educational process, or by more general programs. These will, in the long run, ensure continued public support for and restore personal worth among health professionals – thereby helping guarantee a steady HRH supply.

Philippine Policy Options

Having a culture that tolerates and even encourages migration, coupled with an official policy that implicitly promotes it, the Philippines has earned "a central role in the political economy of migration".[4] The Philippine contribution to HRH migration flows has been substantial. By one estimate, with a little over 18,000 Philippine-trained doctors working overseas, the country is currently the second leading exporter of physicians.[47] This figure, however, is dwarfed by the more than 150,000 Filipino nurses, representing 85% of its trained pool, who have migrated.[4] Up to 15,000 nurses leave each year, and more than 4,000 Filipino doctors have retrained as nurses to join their ranks.[48] Till recently, the rate of overseas deployment even exceeded the increased nurse training capacity of the country. This state of affairs has been blamed for the closure of inadequately staffed hospitals and declines in immunization rates, among

Table 5. HRH policy options for the Philippines

POLICY	INSTRUMENT	POINTS
Managed Migration	Bilateral agreements	establishment/legislation ensure both quantity and quality bypass non-official recruiters
	Wage tax collection	amount/proportion duration
Channeled Compensation	HRH fund coordinating body	establishment/ legislation
Strengthened Social Health Insurance	PHIC financing	establishment/legislation augment HRH incomes promote efficiency
Investment in Education/ Training	Basic education subsidies	promote national development
	Health professions training subsidies	improve quality of services competitive advantage
Training for Foreigners	Official authorization	recognition/legislation enhance capacities retain HRH mentors

others.[48] While these trends appear alarming, these should also be weighed against other findings. With manpower export being officially sanctioned by the government, the country is considered a legitimate focus of international HRH recruitment efforts – a situation that many countries reportedly crave.[8, 16] Remittances are undoubtedly a big draw for HRH migration. A key study which showed that migrant physician's remittances made up for their foregone training costs (with some qualifications) was based on Philippine data.[26] The latest overseas developments, with less nursing positions available in the US and UK, may lead to a sizeable over-supply of nurses locally.[49] It remains to be seen, however, if such will translate to nurses being gainfully employed locally, or high unemployment and underemployment levels will persist – particularly as wages may be dampened.

It is apparent, therefore, that the Philippines both gains and loses from HRH migration. And while local health services may have already been hampered, it is nonetheless not in the country's interest to abruptly stem HRH migration (as neither the nation nor its workers benefit when other nationals rush in to fill the void). Rather, it should take advantage of its current leading position in the area, but only to further the greater objective of improving its own health system if not promoting over-all national development.

To effect such a transformation, several policy initiatives may be adopted (as outlined in Table 5). A managed migration program needs to be put in place. To this end, bilateral/multilateral agreements with recipient countries may be effected that would also control for the quantity and quality of HRH stocks and flows. The Philippine Overseas Employment Agency (POEA) has had extensive experience for such arrangements and can take the lead in the scaling up of HRH placements.[4] Professional recruitment agencies, common sources of migrant exploitation, may also thereby be bypassed.[2] To better address the particular circumstances of health workers, a distinct office – whether under the auspices of the POEA or an altogether autonomous public entity – may need to be created. Such an office may serve to coordinate the thrusts and activities of the POEA, the various health professional regulations and accreditation bodies, training institutions, and the Department of Health, among others.

The POEA, or the proposed HRH coordinating body, should develop the corresponding bilateral instruments and systems that will compel and enable recipient countries to relinquish, in whole or in part, the wage taxes from the contracted workers in favor of the Philippines. Such tax collections are to be distinct from worker wages/remittances as well as social service fees for the host countries. These arrangements may be time-bound or open-ended. These should apply to all Filipino HRH, as placement distortions may result otherwise. Likewise, arrangements will have to be made with the national budget and finance bodies to identify (or establish) the appropriate offices to handle such an expatriate HRH-derived fund.

The bulk of the HRH revenues should be channeled primarily to the Philippine Health Insurance Corporation (PHIC) to further strengthen the country's social health insurance program. The PHIC, while being a government corporation, enjoys not only the autonomy but also the wide public support needed for it to effectively serve as the fund's conduit.[50,51] The PHIC, for its part, should use the additional financing to increase benefit payments, but should leverage this against both quantity and quality service improvements among health service providers. An augmentation of health worker incomes can thereby be achieved without arousing the inequity concerns previously brought about by mandated sector-limited wage increases.[39] Increased PHIC benefit payments may thus blunt some of the "push forward" factors.

A proportion of the funds should be directed at supporting both basic-level as well as health professional education, to provide the additional human capital investments needed for sustained national growth and development. Better funding particularly for health professional training is critical, inasmuch as the proposed expatriate taxes will make Filipino HRH more costly. Better training is therefore doubly important, to ensure both the better delivery of care locally as well as to maintain the Philippines' comparative advantage in the international HRH market.

Additionally, the country's well-developed health training capacities may be utilized to train foreigners. This would not only be added fund sources, but also help retain the more experienced workers and mentors. Likewise, service gaps may be addressed with the "on-the-job-training" nature of some of the placements (such as residency training positions). The latter, while currently utilized by a few hospitals in the country, has not gained official acknowledgement by the national professional regulatory nor specialist accrediting bodies. The Professional Regulations Commission, in coordination with the various health professional organizations and training institutions, will have to review and recommend revisions of the relevant policies and guidelines. New legislation may need to be enacted for any proposed revisions to take effect.

The provided recommendations will entail considerable planning, investments, and legislative support. These should also be viewed as medium-term tools that may eventually wean the country's HRH away from the siren song of the health carousel. In the globalized setting, however, the Philippines will have to act strategically – and act soon – if it is to harness the full potential of its human resources for health while promoting the welfare and progress of the country as a whole.

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