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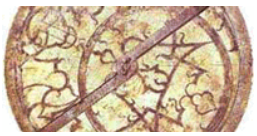

III A TALE OF THREE MARKETS: HOW GOVERNMENT POLICY CREATES WINNERS AND LOSERS IN THE PHILIPPINE HEALTH SECTOR

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Abstract:[1]

For more than half a century the Philippines has been a leading exporter of human capital in the healthcare sector. This paper estimates that remittances from Philippine nurses who worked abroad on a temporary basis netted the country some $0.5-$0.6 billion in 2008 while total remittances from all Philippine nurses working abroad—whether on a temporary or permanent basis—are likely to exceed $1 billion. In the last decade the country's supply of nursing colleges has more than doubled and its annual output of registered nurses has increased fourteen fold. The education, licensing and international recruitment of nurses have become highly lucrative markets. These developments are due to the unintended consequences of shifts in immigration policies, particularly of the United States, as well as negligent education and healthcare policies in the Philippines. The nurses who seek work abroad face stringent re-licensing requirements and a plethora of restrictions, including quantitative limitations, on work permits in rich countries. A detailed analysis of the regulatory requirements in Saudi Arabia, the United Kingdom and the United States reveals that local nurse associations often have a strong influence and effectively can regulate the inflow of foreign nurses.

[1] The author benefited from interviews and consultations with Liberty Casco, Jaime Galvez-Tan, Chang Huh, Matthew Jowett, F. Marilyn E. Lorenzo, Patrick Messerlin, Eufemia F. Octaviano, Ruth Padilla, Gloria Pasadilla, Kenneth Ronquillo, Karima S. Saleh, and Josefina Tuazon.

1. INTRODUCTION

The Philippines has been a leading, if not *the* leading, exporter of human capital in the healthcare sector for more than half a century. The Philippine Government has encouraged exports of registered nurses by maintaining a light regulatory framework for the establishment of private nursing colleges and by establishing institutions that facilitate the movement of the country's nurses to foreign markets. Former President Ferdinand Marcos articulated the country's pragmatic position to nurse migration in 1974 when he announced in a speech that *"…this is a market that we should take advantage of. Instead of stopping the nurses from going abroad why don't we produce more nurses? If they want one thousand nurses we produce a thousand more"* (PJN, 1974).

President Marcos' market-friendly rhetoric was followed up by decisive government action as labour and health departments established mechanisms to enhance the country's capability of sending "globally-competitive" healthcare professionals abroad (Lorenzo, 2005). He went on to invest considerable effort in transforming the image of migrating nurses from "national traitors" to "national heroes" and took a number of initiatives to derive as many benefits as possible from this trade. As an example, the Philippine Government asked the many thousands of nurses who served abroad to deposit their foreign currency earnings in foreign branches of Philippine banks (Choy, 2003).

The deliberate policy to export nurses has been sustained over time. In 1990-2009, the Philippines registered 447,113 new nurses; or more than ten times the number of nurses employed domestically. Philippine nurses view foreign labour markets as natural extensions of the domestic labour market. This process reflects the country's "migration culture" as documented by observers such as Choy (2003), Kingma (2006) and Lorenzo et al. (2007).[2] The most attractive of the foreign labour markets offer salaries that are thirtyfold of what many Philippine nurses earn at home. Despite unpredictable demand and restrictive migration policies abroad, the labour cost arbitrage has led many Philippine lower-middle income and middle income families to invest their savings in nurse education for their daughters.

Today, the Philippine Government seeks to ensure that the country meets the standards of foreign employers and its Technical Education and Skills Development Authority (TESDA) has forged

[2] The Philippine government's deliberate policy of exporting labour has helped it become the largest organized labour exporting country in the world (Agunias and Ruiz, 2007). As of December 2007, the Philippine Overseas Employment Agency (POEA, 2008) estimated that 8,726,520 Philippine citizens were based abroad. Of these, 4,133,970 were temporary workers, 3,692,527 were permanent migrants and 900,023 were irregular migrants (see Annex A). This implies that for every three workers at home, there is one Philippine-born worker serving abroad.

partnerships with countries such as Canada to raise the quality of education of Philippine healthcare workers. Nurses represent a mobile profession in general and Philippine nurses may be more mobile than most: an estimated 85 percent of newly graduated nurses leave the country every year according to the Philippine Health Secretary, Francisco Duque (Duque, 2008). Yet there is no consensus among Philippine policy makers whether this sizeable outflow should be a source of concern or celebration.

The Philippine Overseas Employment Administration (POEA) channels nurses to some thirty countries every year and the government actively seeks to pursue bilateral agreements to increase this number and facilitate the nurses' movement abroad. In many foreign client countries, obtaining a work permit is a time consuming, costly and cumbersome process, notwithstanding abundant demand. Any nurse, independent of nationality, confronts very different incentive structures in prospective client countries. The greater the economic incentives are to serve in a given labour market, the higher the cost of the regulatory barriers faced by the prospective migrant. Consequently, as this paper will illustrate, Philippine students who train to become nurses are taking a substantial risk of not generating a return on their investment in education.

The first part of the title of this paper—'A tale of three markets'—refers to the domestic market for tertiary education of nurses, the domestic healthcare market, and the international healthcare market as viewed from the perspective of Philippine nurses. The continuation of the title—'How government policy creates winners and loser in the Philippine health sector'—refers mainly to the Philippine Government since it has been unsuccessful in living up to its own compensation targets, in raising the working conditions in the Philippine healthcare sector, and in enforcing regulations on minimum quality standards in higher education. This has led many students to invest in poor quality education and has produced an excessive number of nurses with few employment opportunities at home or abroad. However, it also refers to some foreign governments, in particular the U.S. Government, that have manipulated their immigration policies in a way that create potentially huge but at the same time highly uncertain incentives for young students in poor countries like the Philippines to take up nursing.

1.1 Objectives and scope

This paper seeks to achieve three main objectives. The first objective is to shed new light on the international migration process of Philippine nurses and analyse this process from a trade and economic perspective. There is already a significant literature on international migration of healthcare professionals from poor to rich countries but it has focused largely on:

- ✓ ***Social issues*** (motivational factors, behavioural factors, welfare of individuals) – including Saith (1997), Aiken et al (2002), Carlos (2002), Vahey et al. (2004), Waldman et al. (2004) and Opiniano (2008);
- ✓ ***Healthcare-related issues*** (effects on national healthcare systems) – including Martineau et al. (2002), IOM (2005), Adams and Kennedy (2006), Clemens (2007), Buchan (2008), Bhargava and Dcoquier (2008) and Bhargava et al. (2010);
- ✓ ***Labour market and ethical issues*** (brain drain arguments, supply shortages, labour productivity, remuneration effects) – including Glaessel-Brown (1998), Kingma (2001), Thomas-Hope (2002), Stilwell et al. (2003), Bach (2006), IOM (2006), Dovlo (2007), Pettersson and Clemens (2007), Salmon et al. (2007) and Troy et al. (2007);
- ✓ ***Government policy issues*** (reducing North-South hiring, compensating sending countries) – including Findlay (2001), Wickramasekara (2002) and Martin et al. (2004).

Studies of the movement of Philippine healthcare professionals have also focused on current issues, documenting short-term trends rather than studying the issues over time. This is partly a result of limited data sources but also due to the fact that recruitment and international work permit policies change rather frequently in many countries.

The second objective is to analyse the trade and regulatory environment that nurses have to navigate in the labour markets that have absorbed most Philippine nurses in the last two decades; *i.e.* Saudi Arabia, United Kingdom and the United States. This analysis will highlight the different approaches to migration that these high-income countries have adopted to address their domestic shortages of nurses. The third and final objective is to assess some of the trade and economic implications of foreign recruitment on the Philippine nursing market.

The scope of the analysis is mainly limited to *temporary* movement (international trade in services) rather than *permanent* movement (immigration) of nurses. In the case of movement to the United States, it has been temporary or permanent in nature depending on the U.S. immigration policy at the time. The sharpest growth in the number of Philippine nursing graduates is a consequence of U.S. policies to offer permanent work permits to foreign nurses and their family members. The United States has traditionally been the preferred destination for Philippine nurses and countries in the Middle East and Europe have often been used as stepping stones for their quest to obtain employment in the United States. While international movement of nurses covers North-North, North-South, and South-South trade, this paper

focuses on the movement of nurses from the Philippines to high-income countries. References to the experiences of nurses from other countries as well as the international movement of Philippine physicians, midwives and caregivers are occasionally used to illustrate the bigger picture.

The analysis focuses on economic and trade aspects of Philippine nurse migration and largely leaves out the social, ethical, labour market and healthcare-related issues identified above. The underlying premise of this paper is that the migration of Philippine nurses is not a brain drain issue as much as an issue of maximising the gains from trade, in particular since the supply of nurses widely exceeds demand in the Philippines.[3]

Finally, healthcare services can be traded in several ways and the terminology of the World Trade Organisation (WTO) and its General Agreement on Trade in Services (GATS) distinguishes four distinctive modes of supply. Trade in healthcare services covers all four of them: *i.e.* cross-border supply (Mode 1), consumption abroad (Mode 2); commercial presence (Mode 3); and temporary movement of natural persons (Mode 4). The following examples illustrate Mode 1-4 trade in healthcare services:

- Mode 1: A Philippine healthcare professional provides advice by telephone to clients in Singapore;
- Mode 2: A Singaporean patient travels to the Philippine to obtain medical care;
- Mode 3: A Singaporean healthcare clinic establishes itself in the Philippines to treat local patients;
- Mode 4: A Philippine nurse moves to work at a hospital in Singapore on a time-limited contract

Philippine exports of healthcare services are predominantly supplied through the fourth mode. There are no Philippine healthcare clinics established abroad. Telecare—whereby a Philippine healthcare professional provides medical advice to foreign clients—or similar services provided on Internet, do take place and may be growing but from a relatively limited scale. Medical transcription services have grown rapidly, however, and several drop-outs and graduates from nursing colleges move into this field. But medical transcription is a backup plan for nurses who fail to land a job overseas rather than a complement or substitute to Mode 4 trade. Some hospitals in the Philippines, like in Thailand, India and Singapore, treat foreign patients on a commercial basis, and Mode 2 is a business with significant potential. Movement of Philippine nurses to serve temporarily abroad is big business and covers hundreds of thousands of nurses.

[3] Brain drain is an issue in some of the developing countries that host around two-thirds of the world's population and only a fraction, or 15%, of the world's nurses (Choy, 2003).

1.2 Data and structure of paper

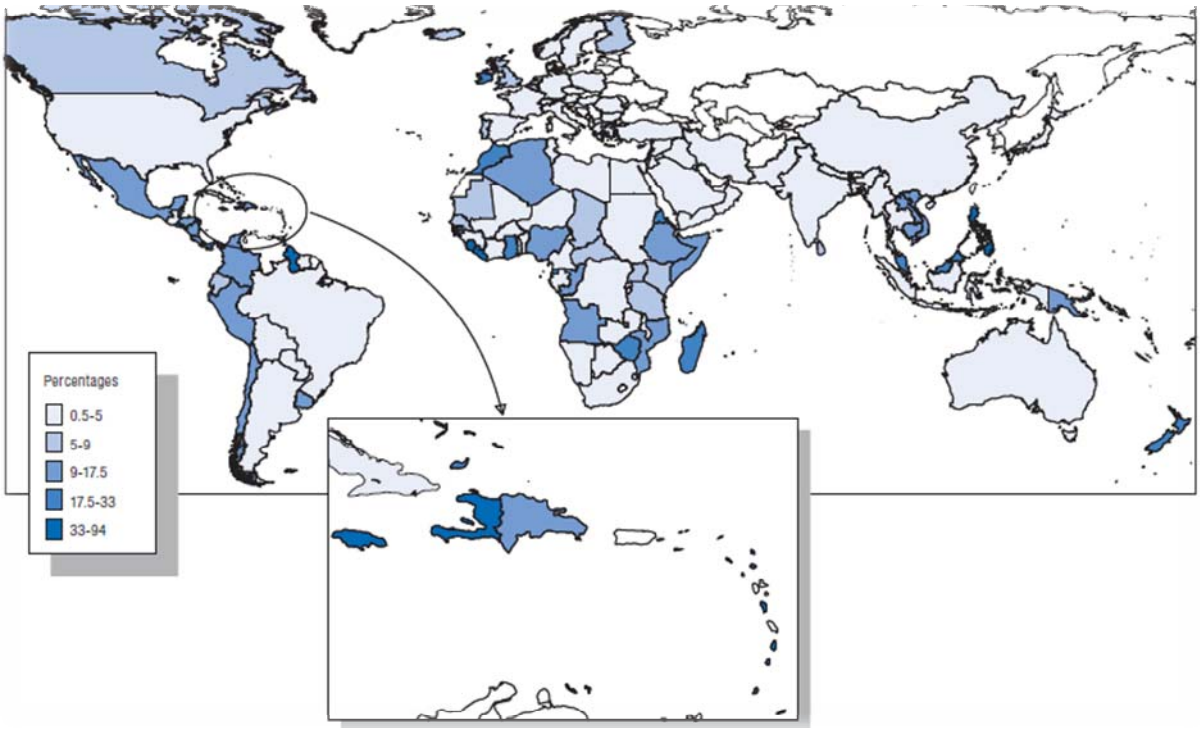
The following analysis draws on information obtained from interviews with health analysts, government officials, nurses and experts on trade and labour migration. The section that focuses on demand and supply of Philippine healthcare services is based on data provided by the Philippine Overseas Employment Administration (POEA), the Professional Regulation Commission (PRC) and the Commission for Higher Education (CHED) in Manila, as well as the National Council of State Boards of Nursing (NCSBN) in the United States and the Nursing and Midwifery Council (NMC) in the United Kingdom. The section that assesses trade and economic policies related to the movement of nurses, including the section on restrictions, is based on a review of public legal documents and draws on input from in-depth interviews conducted in Manila in January 2006 and August 2009.

The paper is organised as follows. The next section examines the economic incentive structure and the recruitment process for temporary migration of nurses. The following section explores demand for and supply of Philippine nurses and highlights the various policies and other forces that have affected Philippines' exports of healthcare services to various client countries. It also investigates the market for private nursing education and estimates its size. The paper then studies the rules and regulations that restrict the flow of Philippine nurses to the three main client countries—the United States, the United Kingdom and Saudi Arabia—and presents a structured inventory of these restrictions and their impact on international movement. The two final sections turn to the economic impact of Philippine exports of nurses, estimates the size of remittances sent by nurses and reviews some negative externalities of this trade, before concluding with some proposals for how the Philippines can enhance the gains from its export-oriented healthcare sector.

2. TEMPORARY MIGRATION OF PHILIPPINE NURSES

There are approximately 12 million nurses worldwide (Kingma, 2006). The total healthcare workforce covers roughly 24 million medical doctors, nurses and midwives, and more than three times as many informal, traditional, community and allied healthcare workers (Chen et al., 2004). The distribution of the healthcare professionals is heavily skewed towards high-income countries: for example Europe hosts ten times as many nurses and physicians as Sub-Saharan Africa; and Italy has fifty times as many healthcare professionals as Ethiopia. Nevertheless, there are chronic shortages in the supply of nurses not only in most low-income countries but also in many high-income countries. These shortages have persisted due to the relatively low return on investment from nursing degrees, the often challenging work environment, and the low social status of the profession in many countries. The relatively low remuneration of nurses may be explained by several factors: hospitals have monopsony power in some areas, most nurses work in the public sector, and the occupation is largely dominated by women.

Map: Expatriation rates for nurses by country of origin, circa 2000



Source: Dumont and Zurn (2007).

Nursing is a fairly mobile profession notwithstanding the often strict rules and regulations that affect it. Nurses are moving from low-income countries to high-income countries as well as between high-income countries and between low-income countries. For example, the United States recruits many British nurses; the United Kingdom recruits many Australian and South African nurses; Australia recruits nurses from the Philippines; and South Africa recruits nurses from neighbouring African countries and Cuba. A study by Kilne (2003) found that Australia, Canada, the Philippines, South Africa and the United Kingdom are primary sending countries while Australia, Canada, Ireland, the United Kingdom and the United States are primary receiving countries (see Table 1).

Thus, three out of the five top countries are both major importers and exporters of nurses, which highlight the mobility of the profession. In addition, there is significant movement of nurses from one client country to another client country. For example, 40 percent of the Philippine nurses working in the United Kingdom have previously worked in Southeast Asia or the Middle East (Kingma, 2006). And when former President Nelson Mandela of South Africa requested the United Kingdom to stop recruiting nurses from South Africa, it was noted that 78 percent of rural physicians in South Africa were foreign nationals (Martineau et al., 2002).

Table 1. Major sending and receiving countries of nurses

Receiving countries	Australia	Canada	Ireland	UK	USA
Sending countries	China	*Ireland*	*Australia*	*Australia*	*Canada*
	Germany	**Philippines**	**Philippines**	*Canada*	Hong Kong, China
	Hong Kong, China	*UK*	South Africa	Finland	Japan
	India		*UK*	Germany	India
	Ireland			Ghana	Mexico
	Malaysia			*Ireland*	Nigeria
	New Zealand			India	**Philippines**
	Philippines			Kenya	South Korea
	South Africa			New Zealand	*UK*
	Sri Lanka			Nigeria	Vietnam
	UK			Pakistan	
				Philippines	
				South Africa	
				Sweden	
				USA	
				West Indies	
				Zambia	
				Zimbabwe	

Source: Kline (2003).

The income elasticity of demand for professional healthcare services is greater than one and sustained economic growth in high-income and low-income countries alike has led to a rapid growth in demand for nurses worldwide. In many low-income countries, population growth and the double burden of disease (*i.e.* the prevalence of disease linked both to poverty, *e.g.* malaria, tuberculosis, and to affluence, *e.g.*

diabetes, heart disease) have also had a positive effect on demand (Jowett, 2006). In high-income countries, rising longevity and the resulting greying of populations have led to more demand for various healthcare services. Some countries, like those in the GCC region, with sparse human capital but abundant economic resources, import tens of thousands of nurses to help staff new hospitals and healthcare clinics where indigenous women are restricted to serve.

Several countries have responded to these confluent forces and sought to alleviate labour shortages by hiring foreign nurses with adequate language skills. The Philippines is the country that has most vigorously sought to capitalise on this demand. According to the Philippine Nurses Association (PNA), the country employed some 36,000 nurses domestically in 2006 (Ceuto, 2006) while the country in the last twenty years produced 447,113 registered nurses. Only in 2008, 153,108 candidates took the country's Nursing Licensure Examination (NLE) administered by the Professional Regulation Commission (PRC): 67,220 of those candidates passed the exam and became registered nurses. As late as 2002, there were 9,453 examinees of which 4,228 passed the NLE. This latest boom in nurse education is not a result of domestic demand: as the following section will show, it is entirely due to employment possibilities abroad, in particular in the United States.

There are few professional incentives for Philippine nurses to return home after serving abroad. It is widely acknowledged within the profession that returnees have few, if any middle or higher nurse positions to take up. Returnees have to start all over at the bottom of the national healthcare hierarchy. Promotion is based on loyalty rather than merit (Alvarez, 2005). There is plenty of anecdotal evidence that many of those who return pursue careers in sectors other than healthcare—many returnees invest their savings in land, a business or real estate; others return for family reasons. Yet the return rate of nurses is higher than the return rate of physicians, partly reflecting that many nurses leave spouses, children and dependents behind in the Philippines (Padarath et al., 2003; Kingma, 2006).

The time that a nurse serves abroad is closely linked to the labour regulation in the client country. Thus, Philippine nurses tend to serve two to three years in East Asia and the Middle East before they return—often to seek a new opportunity to serve abroad. To some extent in Europe and to a large extent in the United States, Philippine nurses stay on for as long as they can. This often implies that they settle permanently in those countries. However, many of the nurses who graduated in the last 4-5 years will never get a chance to work abroad given their sheer number and the limited number of foreign jobs and work permits available. Many nurses are forced out of economic necessity to take up lesser paid jobs as nursing aides, caregivers or domestic helpers abroad.

2.1 The economic incentive structure

The economic lure of serving abroad can be illustrated with a thought experiment. How many U.S. nurses would be willing to serve abroad in an attractive work environment if they were offered an annual gross salary of $2.1 million? A four-year contract offering an aggregate gross pay package exceeding $10 million with some overtime and evening, night and weekend shifts would probably entice quite a few U.S. nurses to accept the offer even if the new destination was far from home. Many U.S. nurses might even go to great length and invest quite some time and money to qualify for the journey to land such "once-in-a-lifetime" contract. Many Philippine students and nurses must ask themselves a similar question given that the increase in their annual income—by the same factor of thirty[4]—could yield $69,000 in Chicago instead of $2,200 in Manila. Many Philippine households consequently encourage girls to take up nursing in order to gain employment abroad and thereby spread risk and enhance household income.

Serving abroad—whether temporarily or permanently—offers Philippine nurses a highly attractive income proposition. In addition to the financial incentives, Philippine nurses often face a safer, better equipped and less stressful work environment. Developed country healthcare facilities may also offer more clearly defined career paths and more training opportunities. Another motivation for migration is the high degree of nepotism, cronyism and poor governance that afflict the country at large and obstruct the economic advancement of the aspiring middle class to which most nurses belong. If nurses migrate for reasons similar to physicians, survey findings indicate that these are associated to their desire for increased income, greater access to enhanced technology, an atmosphere of general security and stability, and improved prospects for one's children (Astor et al., 2005). To attract more nurses and physicians to stay, the Philippine Government would need to close some of these gaps.

Table 1 presents the monthly salaries of Philippine nurses who moved abroad on temporary, POEA-approved contracts in 2008. This data have not been published and must be qualified. First, the data show the average income and not the distribution within different countries. Thus, if a country mainly recruited registered nurses with specialised expertise, the income would naturally be higher than for a country mainly recruiting fresh nurse graduates. Second, some of the countries in the table recruited only a small

[4] This differential is derived below in this section. The salary differential has widened in the last generation. Joyce and Hunt (1982) reported that the monthly salaries for nurses around 1980 were $800-$1,500 in the United States and $70-$140 in the Iloilo island in the Philippines (*i.e.* the U.S. salary was 11 times the Philippine salary).

number of nurses. For example, the data for Trinidad and Tobago are based on contracts for three individuals. Finally, the average income approved for Australia-bound nurses is surprisingly high and it is unclear how many nurses the calculation of this average was based on. Australia has recruited very few Philippine nurses through POEA over the years and this income should be interpreted with caution.

Some general observations can be made from Table 2 and Figure 1.[5] The monthly income data approved by POEA in 2008 help explain why the United States remains such an attractive destination for Philippine nurses: the income is superior to that of any other country in purchasing power terms. Potential savings in the United States belittle the savings in almost any other country, including those countries with higher GDP per capita than the United States. Next to the United States, other OECD countries like Australia (90 percent of US income, PPP), Canada (62 percent), New Zealand (50 percent), as well as most of those in

Table 2. POEA-approved average gross monthly income (PPP and nominal) of nurses in 2008

[5] Many Philippine nurses choose to work at unattractive hours (weekends and evenings) to increase their income. There are also surveys of Philippine nurses that indicate that many of them work double shifts in order to maximise their income.

Destination	POEA-approved average monthly income (PPP)	Share of U.S. income (PPP)	POEA-approved average monthly income (nominal)	Share of U.S. income (nominal)
USA	$5,722	100%	$5,722	100%
Australia	$5,173	90%	$6,561	115%
Canada	$3,560	62%	$4,105	72%
New Zealand*	$2,883	50%	$3,197	56%
Norway	$2,047	36%	$3,595	63%
Ireland	$2,018	35%	$2,900	51%
Denmark*	$1,879	33%	$3,128	55%
Brunei	$1,859	32%	$1,372	24%
Malaysia	$1,632	29%	$941	16%
UK*	$1,614	28%	$1,942	34%
Egypt	$1,539	27%	$564	10%
Trinidad & Tobago	$1,421	25%	$1,389	24%
Cyprus	$1,178	21%	$1,293	23%
Singapore	$1,141	20%	$868	15%
Oman	$1,140	20%	$1,000	17%
Bahrain	$1,067	19%	$839	15%
Taiwan	$1,000	17%	$550	10%
Jordan	$840	15%	$550	10%
UAE	$822	14%	$1,163	20%
Libya	$819	14%	$835	15%
Qatar	$790	14%	$856	15%
Saudi Arabia	$773	14%	$612	11%
Maldives	$725	13%	$533	9%
Kuwait	$695	12%	$800	14%
Saipan	n.a.	n.a.	$792	14%

Note: * 2007.

Source: Data obtained from Liberty T. Casco, Director at the POEA; IMF Balance of Payments Data (2010), author's calculations.

Northern Europe: Norway (36 percent), Ireland (35 percent), Denmark (33 percent) and the United Kingdom (28 percent) offer relatively attractive salaries although there are significant differences between the countries. In particular the United Kingdom lagged its neighbours in 2008.[6] South-East Asian countries like Brunei (32 percent), Malaysia (29 percent) and Singapore (20 percent) offer income packages that are almost as attractive as those in Northern Europe. In the Philippines, the average monthly salary for a nurse is $180-$220 in nominal terms (or 3.5 percent of US levels) and $370-$452 in PPP terms (or 7.2 percent of US levels).

Income earned by Philippine nurses in Arab countries is low relative to other overseas markets. For example in Qatar and Kuwait—two countries with similar or higher nominal GDP per capita to the United States—Philippine nurses earn 14 percent and 12 percent respectively of what their peers earn in the United States. In Saudi Arabia, the largest destination for Philippine nurses who move through POEA-

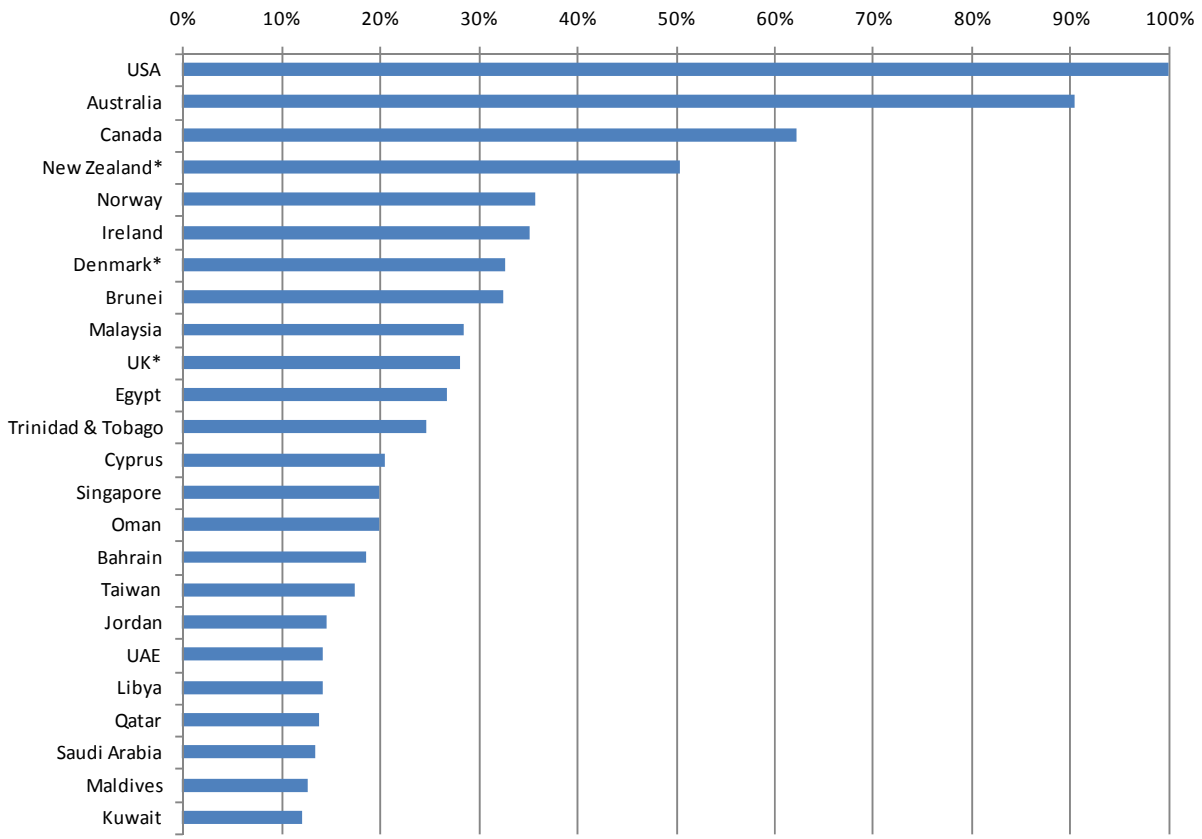
[6] The average salary approved by POEA for UK reflects well the salary rates offered by NHS (see www.nhscareers.nhs.uk/details/Default.aspx?Id=766).

certified channels, average income (PPP) of migrating nurses was 48 percent of the income earned in the United Kingdom and 14 percent of the income in the United States.[7] The difference is somewhat smaller between GCC countries and other countries if the net, or disposable, income is compared since few, if any GCC countries impose an income tax on their nurse expatriates. While these comparisons are far from perfect given the fact that they may reflect nurses with varying degrees of experience and specialised skills, they still provide a good indication of the fiscal incentive structures involved.

The variance in the remuneration of foreign nurses even in countries with similar income levels is significant. Some observers have argued that a government-mandated minimum salary for foreign-employed nurses could help address these disparities. However, the implementation of a minimum salary for Philippine workers has had strongly negative effects in some low-end professions in the past. For example, POEA imposed a $400 monthly minimum wage for domestic helpers in 2007, which led to a sharp drop in the number of domestic helpers sent abroad that year. In 2006, 91,400 Philippine domestic workers moved to work abroad while only 47,900 domestic helpers moved to work abroad in 2007 (see POEA (2008) and Table 7). Traditional client destinations in the Gulf States region turned to domestic helpers from other low-income countries and some Philippine domestic helpers accepted below minimum wage contracts and moved through informal channels.

Figure 1. POEA-approved average monthly gross income (PPP) in 2008 (U.S. income = 100%)

[7] POEA announced on March 7, 2008, that the Ministry of Health in Saudi Arabia had decided to raise the salary for Philippine nurses by 20 percent to 60 percent, depending on specialization, and effective March 19, 2008. This raise would be from the basis of the SR2,250-SR4,000 (or $6,000-$1,070) paid before the change. (see www.poea.gov.ph/news/2008/PR_Mar2008_MOHsalary.pdf)



Note: * 2007.

Source: Data obtained from Liberty T. Casco, Director at the POEA, author's calculations.

The Philippine Nursing Act of 2002 (the Republic Act 9173) stipulates that the minimum monthly salary of a registered nurse serving in the Philippines is P13,300. Yet most young nurses earn less than what the law stipulates: P10,000 per month is regarded as a decent starting salary for a registered nurse in a public hospital; and P8,000-P10,000 in a private hospital.[8] A nurse may earn P12,000-P15,000 per month, depending on the position, after five years of work experience. According to the Bureau of Labor and Employment, in 2006, the average monthly salary of nurses was P8,944 (down from P9,869 in 2002). This was less than half of the income obtained by medical doctors (P18,134) and medical transcriptionists (P19,657) employed in the Philippine business process outsourcing industry (Ronquillo and Balanoba, 2007). Entry point income for nurses in public hospitals was almost 90 percent higher than in private hospitals in 2004. The difference in income paid by private and public sector hospitals was somewhat

[8] Ronquillo and Balanoba (2007) point out that existing policy could have addressed the rights and welfare of the Philippine healthcare workforce but they have not been fully implemented, including the Labour Code, which contains the Workers Statutory Monetary Benefits, the Occupational Safety and Health Standards, and the Magna Carta for Public Health Workers.

lower for medical doctors, paediatricians and midwives. According to Lorenzo (2006), with the exception of Japan, nurse remuneration tends to be higher in the public sector than in the private sector in East Asia.

There are reports of nurses who earn as little as P2,000 per month on the Philippine country side (Makilan, 2005) and given that many foreign clients require a minimum of two years of professional work experience, it is increasingly commonplace that fresh graduates work for free or even pay to work during the first two years. While raising the remuneration for nurses in the Philippines would improve the welfare of the country's nurses, it may not stem the tide of nurses who seek employment abroad. Indeed, in a study of WHO data, Vujicic et al. (2005) found that the wage differential between source and destination countries was so large that small increases in wages in source countries are unlikely to significantly affect the supply of healthcare migrants, suggesting that non-wage instruments might be more effective in altering migration flows.

2.2 The international recruitment process

As the previous section showed, there are strong economic incentives for Philippine nurses to move abroad. Finding a job in a foreign country, however, can be a challenge in particular given the fierce competition for foreign employment. Consequently, there is a sizeable industry that caters to the employment matching process. There are formal and informal employment channels that a nurse can approach to obtain a position in a foreign healthcare facility. The formal recruitment channels are overseen by the POEA and informal recruitment channels bypass the POEA. According to stock estimates from the Commission on Filipinos Overseas (2007), the POEA manages around 47 percent of total migration from the Philippines. Formal recruitment channels include certain forms of media advertisement, certified recruitment agencies and government-to-government contacts while informal recruitment channels include personal networks and institution-to-institution contacts (see Agunias (2008) for an extensive overview).

- ✓ **Government-to-government hiring** involves public health departments in foreign countries directly contacting Philippine government agencies with requests for nurses and international hiring practices. This market channel typically involves inexperienced foreign recruiters who seek advice on respected Philippine recruitment agencies, recruitment best practises, etc. For example, the UK Government hired nurses through the Philippine Ministry of Labour and the POEA in the early 2000s.
- ✓ **Private recruitment agencies** can be based in the Philippines or abroad; many are small and specialised, and they cover everything from the individual uncertified or fly-by-night agent to

large, POEA-certified agents with decades of experience administering large portfolios of prospective candidates. All POEA-certified recruitment agencies are based in the Philippines and there were 1,037 of them for land-based workers in July 2009.[9] 94 percent of all workers channelled abroad through POEA were recruited using private recruitment agencies.

Private recruitment agencies are mainly employed by foreign healthcare facilities with limited experience in recruiting Philippine nurses. Many recruitment agencies screen and register the nurses, assist with the work permit application process, and facilitate transportation. They earn an income by charging service fees to the hiring company—some agencies also charge a placement fees from the nurse. U.S. hospitals often offer sign-on bonuses to foreign recruits as well as fees to the recruitment agent: recruitment agencies may offer $5,000-$10,000 per nurse, which is covered by the hiring healthcare institution (PHR, 2004). In return, nurses contract to work for 2-3 years in the hiring institution (Brush et al., 2004).

The recruitment of nurses in the Philippines is therefore a rather formal and commercial process. Recruitment agencies must obtain a license from the POEA and limit their charges from the nurse to one month worth of salary except in the United States and the United Kingdom where placement fees are prohibited (Bach, 2007). However, some nurses have been charged placement fees of up to £5,000 in the past (Grzincic, 2004). The POEA only approves contracts that pay at least the minimum wage of the destination country. It also requires employers to cover the airfare, the work permit processing fee, the POEA processing fee, and the Overseas Workers Welfare Administration (OWWA) membership fee.

- ✓ **Job advertisements** are frequently issued in print or in online news media by hospitals and other healthcare facilities that target foreign nurses. A newspaper advertisement may for example state that a recruitment team from a particular healthcare facility will visit Manila to interview prospective candidates during a certain period of time with the view of contracting a number of nurses.
- ✓ **Personal networks** cover recruitment through relatives, friends and colleagues, especially through nurses and current overseas workers. For example, a Philippine nurse employed in a U.S. or Saudi hospital may be told by his/her employer that it seeks to recruit a number of nurses and the nurse is encouraged to identify prospective candidates among relatives and friends. The employer may offer financial incentives for successful recruitment. The dean of a Philippine nursing college may

[9] Email communication with Liberty Casco, Director of Marketing at POEA.

also be offered economic incentives to send nurses to foreign healthcare facilities. Lorenzo (2006) estimates that 20-40 percent of all Philippine nurses are recruited through personal networks.

- ✓ **Institution-to-institution contacts** involve Philippine nurses employed abroad who contact their old schools or employers to recruit nurses; as in hospital-to-school and hospital-to-hospital contacts (sometimes partnerships). An example of this informal route is a U.S. hospital that invites a Philippine nurse to visit the United States on a tourist visa to help the nurse process the necessary paper work and pass the board exam. The advantage of this informal channel is that the recruitment time can be cut from a minimum of 18 months for formal hiring through the POEA to 6 months or less.

Informal recruitment channels are common partly because extended family ties are more important than business ties in the Philippines. Informal channels also represent the most expedient route and are generally free or at least less expensive than the formal channels. However, they are also more risky than the formal route as there are frequent reports of Philippine nurses who have been recruited abroad through unlicensed recruitment agencies and get into contractual disputes. This is less of a problem in the formal recruitment channels where immigration lawyers inspect contracts at both sides of the border, and POEA provides advice and offers support services through the OWWA that are based in main client countries.

3. INTERNATIONAL SUPPLY AND DEMAND OF PHILIPPINE NURSES

In 2000, Philippine nurses made up the single largest group of foreign-born nurses serving within the member states of the Organisation for Economic Cooperation and Development (OECD, 2007). The estimated 111,000 Philippine-born nurses surpassed nurses born in the United Kingdom (~45,000), Germany (~32,000), Jamaica (~32,000), Canada (~25,000) and India (23,000). The international movement of Philippine nurses was initiated in 1948 as a result of the U.S. Exchange Visitor Programme (EVP) (see in particular Choy, 2003; Lorenzo, 2005; Kingma, 2006). In the late 1960s and 1970s, active recruitment began in the Middle East and turned more commercial in North America. Nurses venturing to the Middle East eventually returned as specified in their contracts while many North America-bound nurses converted their temporary status to permanent status. In the late 1990s, in the face of widespread global shortages of nurses, recruitment conditions changed, with destination countries such as the United States making more attractive and permanent recruitment offers and the United Kingdom and Ireland hiring tens of thousands of Asian nurses. This has resulted in a booming education sector for nurses.

The Philippine government is supportive of the exports of nurses and has responded by enacting legislation and adopting labour policies to facilitate this process. The government adopted its first international labour migration policy in 1974 as a temporary measure to alleviate pressures of unemployment and on the financial system (Soriano, 2004). The Migrant Workers and Overseas Filipinos Act (Republic Act 8042) of 1995 was instituted to oversee the welfare of overseas Filipino workers (OFWs), specifying procedures for recruitment, deployment, and welfare administration and established a higher standard of protection and promotion of the welfare of migrant workers and their families. The Act established two support institutions: the POEA and the OWWA; that aimed to facilitate the international movement and maximise the welfare of the workers. Other relevant legislation include the Philippine Nursing Law RA 877, first enacted in 1953 and amended by RA 7164, the Philippine Nursing Act of 1991, and its revision, RA 9173 of 2002 (Lorenzo, 2005).

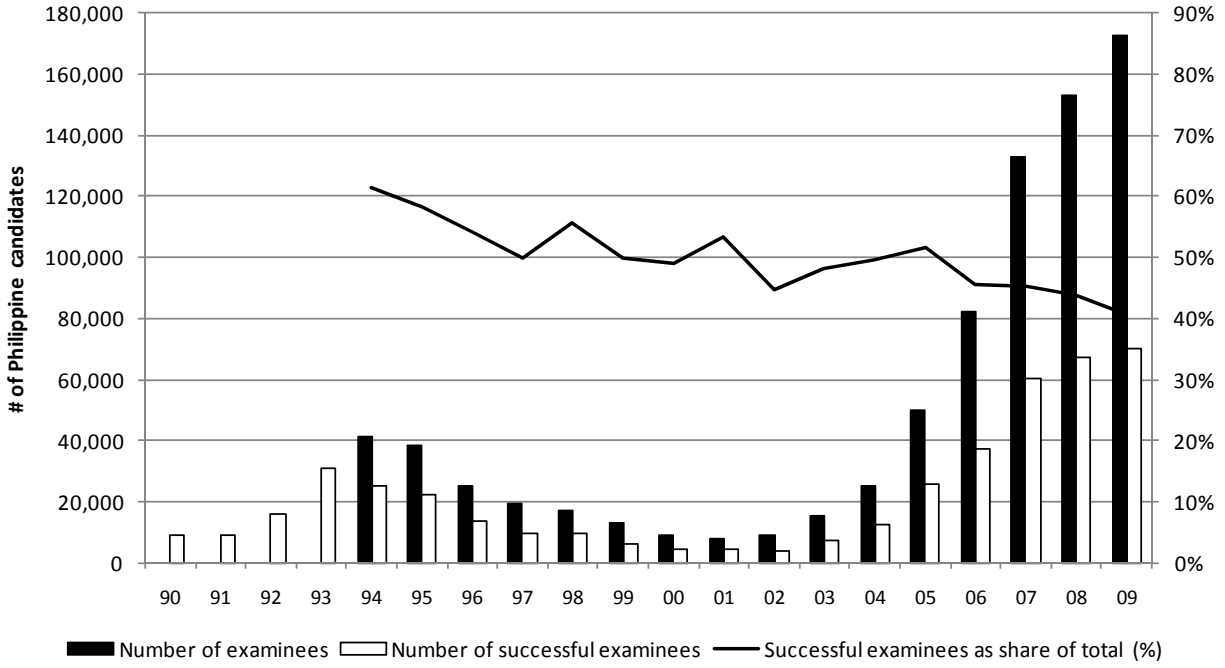
3.1 Supply of nurses in the Philippines

The Philippines is the only country in the world with an explicit export policy for nurses and it is currently the world's leading exporter of nurses (Brush and Sochalski, 2007). Excessive supply of nurses has been the prevailing practice in the Philippines ever since Philippine nurses were first invited by U.S. hospitals through the EVP (Kingma, 2006). Lorenzo et al. (2005) estimated that the Philippines produced 333,581 nurses in 1960-2003 and that approximately 332,000 of those nurses were alive in 2003. 193,000 (58 percent) of the registered nurses were active either in the Philippines or abroad, leaving 139,000 nurses in other jobs or outside the labour market. Of the 193,000 in work, 15 percent were active in the Philippines (10 percent in the public sector, 4 percent in the private sector, and 1 percent in the education sector) and 85 percent were active abroad, *i.e.* in 2003, 164,000 Philippine nurses were active abroad.

Figure 2 illustrates how the supply of registered nurses has been cyclical over time. There was a peak in the number of newly examined nurses in 1993 followed by nine years of decline. In 2002, this downward trend was broken and the number of nurses who took the nursing licensure examination and those who passed it literally exploded. Between 2002 and 2008, the annual number of test takers and the number of successful test takers increased by 1,500 percent. Given that a B.Sc. in Nursing degree takes four years to complete in the Philippines, the decision by the students to take up nursing ought to have peaked around 1989 during the first cycle (the year when United States introduced the H-1A work permit for foreign nurses), and bottomed out around 1997 (when the H-1A finally expired), followed by new impetus starting in 1999 (when the United States introduced the H-1C work permit for foreign nurses, and the United Kingdom and Ireland started hiring to Philippine nurses) and continues to this day (boosted by the U.S. decision to offer green card not only to foreign nurses but also to their immediate family in 2000).

To put the most recent positive trend in perspective: the 333,581 nurses who were registered in 1960-2003 can be compared to the 273,628 nurses who registered in 2004-2009. The number of registered nurses produced in 2009 alone was roughly twice as large as the number of nurses who practice their profession in the Philippines. Many Philippine hospitals are overcrowded with fresh nursing graduates—referred to as trainees—who volunteer to gain valuable but unpaid work experience. In healthcare clinics and hospitals throughout the country the attrition of nurses is so high that administrators are complaining not only about the cost of training new nurses but also about the poor quality of service (Conde, 2004). New nurses often stay for two years to gain the required work experience to move abroad.

Figure 2. Philippine nursing licensure examination results, 1990-2009



Source: PJN (2005) for 1990-93, PRC for 1994-2009.

The number of registered nurses would have been even greater if it was not for the fact that the success rate of NLE examinees dropped during the period for which PRC data are available (see Figure 2). For example, in 1994, 61 percent of the examinees passed the examination. By the first half of 2009, the share had dropped to 42 percent. This decline may not be surprising given the growth in the number of new nursing colleges in the country (more on this below) and the natural decline in marginal interest in nursing among recent students. In addition, only 48 percent of the total number of candidates passed the nursing licensure examination in 1994-2009. This leaves 374,816 failed tests and even though some candidates take the test more than once, a very large number of students end up never passing the exam

and are forced to take up jobs other than nursing. Many seek to move to a high-income country as nursing aides, caregivers and domestic helpers.

3.1.1 Supply of nursing education

A particularly salient characteristic of Philippine nurse migration is the higher education sector's capacity to quickly adjust to shifting demand conditions. This was pointed out already by Meija (1979) who studied the supply of physicians and nurses in the 1960s and 1970s and noted that the budget allocation to education was more than four times as high as the healthcare budget at the same time that most health colleges were private institutes of higher education graduating excessive numbers of nurses. Entrepreneurial activity in the education sector is what sustains the Philippines' prominent role as a leading exporter of labour. The number of nursing colleges was a relatively stable 183-198 in 1998-2001, but had jumped to 251 by June 2003, 310 by October 2003, 370 by April 2004, 450 in 2005, and 460 in 2007 (Corcega et al., 2002; Conde, 2004; Makilan, 2005; Galvez-Tan et al., 2005; Cueto, 2006; Lorenzo et al., 2007).

As a result, according data from the Commission on Higher Education, enrolment in nursing schools increased from 28,095 in the 00/01 academic year, to 292,240 in the 04/05 academic year (Cueto, 2006), and to 453,896 in the 06/07 academic year (CHED, 2009). In the first half of 2009, graduates from 448 nursing colleges took part in the National Licensure Examination (PRC, 2009).[10] This number did not include those colleges that had been in operation for too short time to produce any nurse graduates. And of the 448 nursing colleges, the very great majority were unsubsidised and privately run: *e.g.* in 2004, 92.5 percent of the nursing colleges were private institutions (WHO, 2006).[11]

The proliferation in nursing colleges implies that there is plenty of choice for young Philippine students who seek a career in nursing. There are inexpensive and high-quality public options as well as a plethora of private colleges scattered around the country's many islands offering education of varying quality and tuition fees. However, many colleges offer education of low quality and virtually no future prospects for their students to pass the NLE. The national government sought to address some of the ills of poor schools by enacting the PRC Modernization Act of 2000, which states that PRC should "*...monitor the performance of schools in licensure examinations and publish the results thereof in a newspaper of national circulation"*.

[10] www.scribd.com/doc/12800033/PERFORMANCE-OF-RP-NURSING-SCHOOLS-AS-TO-PERCENTAGE-OF-PASSING-2009.
[11] All registered nurses in the Philippines hold a B.Sc. in Nursing degree. In the United States, less than one third of registered nurses hold such a degree: more than half of U.S. trained RNs hold associate degrees (Aiken et al., 2009).

In the June 2009 NLE, 55.5 percent of the 88,649 examinees failed the test: 10 colleges had a zero passing rate; 21 colleges had a passing rate lower than 10 percent; and 57 colleges had a passing rate lower than 20 percent. In addition, the six colleges with the largest numbers of examinees had passing rates of 31-39 percent. The college with the most number of test takers, Our Lady of Fatima University-Valenzuela, with 3,567 examinees (first time takers and repeat takers) reached 37 percent. A year earlier, in June 2008, one-fifth of all nursing colleges registered a zero passing mark (PRC). Thus for the ten colleges with zero passing rate in June 2009, there may well have been another eighty colleges for which no students took the NLE.

Brush and Sochalski (2007), among others, have argued that several nursing colleges in the Philippines have inadequate curricula and are run by deans who are responsible for multiple colleges and faculty that are seldom, if ever, present to teach the students. The Commission on Higher Education can order the closure of a nursing college if it has achieved less than a 5 percent passing rate for three consecutive years. The Board of Nursing at the PRC wants to raise this minimum level to 10-15 percent (Pascual et al., 2005). Given the poor standard and results of some colleges, in November 2004, the Commission on Higher Education ordered the closure of 23 nursing colleges. Following an appeal by college owners to the government, however, this decision was overruled.

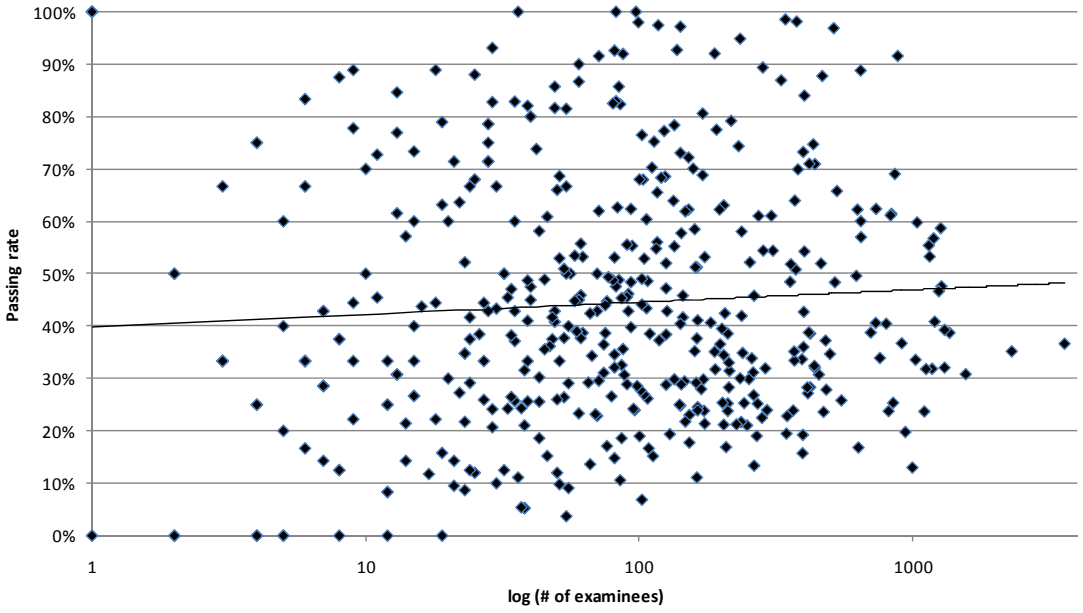
The chair of the Commission on Higher Education also tried to implement tighter screening procedures to reduce the number of "diploma mills"—as for-profit and poor quality colleges are commonly referred to in the Philippines—but owing to political pressure he was forced to resign (Makilan, 2005). This situation was not new: Ortin reported in 1994 that nursing colleges had become such a lucrative business that politicians, business men and even parents of nursing students pressured the Department of Education, Culture and Sports to lift the moratorium on opening new colleges of nursing despite deplorable education conditions that resulted in half of the colleges failing to meet the standards set by the ministry.

The transparency clause in the Professional Regulation Commission Modernization Act was aimed at providing information to allow prospective students to make informed decisions of where to apply. There are plenty of anecdotal stories in the nursing community of how some Philippine senators and governors who own private nursing colleges opposed the transparency measure and contest any initiatives to tighten the regulatory oversight and enforcement mechanisms in the sector. The chairman for the Commission for Higher Education announced in October 2009 that 177 nursing schools had failed to make even a single graduate pass the NLE during the last five years and 152 of those schools were warned that they would

have to close down unless they improved in the 2010 NLEs (Ronda, 2009). The 5 percent rule had not been enforced as of early 2010.

Figure 3 depicts a scatter plot of the passing rate and the number of test takers for the 448 nursing colleges that participated in the June 2009 NLE. 44.5 percent of the examinees passed the test and the average passing rate for the colleges was 44.3 percent. There was no link (correlation = 0.006) between the number of examinees per college and the passing rate.

Figure 3. Performance at National Licensure Examination by nursing college, June 2009



Source: Board of Nursing, Professional Regulation Commission (2010), author's calculations.

3.1.2 What is the turnover of the private nursing education sector?

It takes a minimum of four years to obtain a bachelor degree in nursing. The cost of private tuition varies from college to college but experts consulted for this paper indicated that the average tuition fee at a private nursing college is approximately P25,000/semester. Eight semesters entail a rough average of P200,000 (~ $4,300) in tuition fees, which is a significant amount in a country where GDP per capita is less than $2,000. The tuition fee at public institutions is P6,000-P9,000/semester, which offers an opportunity for students from low-income families to obtain a nursing degree. However, the public option is only available to a select few. For the purpose of the following estimation of the value of the private nursing market, assume that public colleges graduate 2,000 nurses per year (*i.e.* 5-6 percent of the number of nurses employed in the country). In addition, according to the nursing leaders consulted for this paper, approximately 50 percent of all students who embark on a nursing degree drop out during the course of

the four-year education; thus assume that the students who eventually drop out on average stay and pay the tuition fee for four semesters.

Given that 66.4 percent of the 153,108 examinees in 2008 were first-time test takers, the annual income in tuition fees generated by the 150,504 (= 1.50 x 0.664 x (153,108-2,000)) private-sector educated students who graduated, or who were supposed to graduate (drop-outs), in 2009, was P7.5 billion (= P50,000 x 150,504). Add P10,000 in education material and the income was P9.0 billion (see Table 3).

Table 3. Estimation of income for private nursing colleges based on NLE data

	2006	**2007**	**2008**	**2009**
Number of first-time NLE examinees educated in private nursing colleges *Assumptions: (i) public nursing colleges produced 2,000 test takers; (ii) 66.4% of test takers were first-time test takers*	53,222 0.664x(82,153-2,000)	86,743 0.664x(132,637-2,000)	100,336 0.664x(153,108-2,000)	113,121 0.664x(172,363-2,000)
Number of dropouts *Assumptions: (i) 50% of students take the NLE; (ii) the average dropout student stay 4 semesters*	26,611 (0.50x53,222)	43,372 (0.50x86,743)	50,168 (0.50x150,336)	56,561 (0.50x113,121)
Average annual tuition fee	P50,000	P50,000	P50,000	P50,000
Annual cost of education material	P10,000	P10,000	P10,000	P10,000
Annual income from final year students	**P4.8 billion** (P60,000x79,833)	**P7.8 billion** (P60,000x130,115)	**P9.0 billion** (P60,000x150,504)	**P10.2 billion** (P60,000x169,682)

Source: Author's assessment.

Another way of estimating the income of private nursing colleges is to make use of the aggregate data of nursing students provided by the Commission of Higher Education as presented above. While there is only data available for three academic years, they still reveal the growth of the private education sector (Table 4). Between 00/01 and 06/07, the income generated by private nursing colleges may have increased from an estimated P1.2 billion to P26.8 billion of which 83 percent was tuition fees. If the 06/07 tuition fees were paid on September 1, 2006, the P26.8 billion equalled $528 million. Add the expenses that nursing students spend on campus lodging, which may be provided by the nursing colleges, and the

market for private nursing education in 06/07 may have been worth P35-P40 billion, or $700-$800 million.[12] This indicates that private nursing education is big business in the Philippines.

Table 4. Estimation of income for private nursing colleges based on CHED data

Academic year	**2000/2001**	**2004/2005**	**2006/2007**
Number of students in private nursing colleges *Assumption: public nursing colleges accepted 2,000 students per academic year*	20,095 28,095-(4x2,000)	284,240 292,240-(4x2,000)	445,896 453,896-(4x2,000)
Average annual tuition fee	P50,000	P50,000	P50,000
Annual cost of education material	P10,000	P10,000	P10,000
Total income from tuition and education material	**P1.2 billion**	**P17.1 billion**	**P26.8 billion**

Source: Author's assessment.

3.2 Supply of Philippine nurses to foreign healthcare markets

Data on the temporary (and permanent) movement of Philippine nurses are fragmented and incomplete. The sources that do exist are of four main kinds: (i) foreign nursing registers; (ii) foreign work permit data at the occupation level; (iii) foreign census/population survey data; and (iv) POEA records of movement through its certified channels.

Data from foreign nursing registers are publicly available information in some countries and often the starting point for tracking the international movement of nurses. However, they are imperfect and the WHO (2003) points out that there are limitations linked to the fact that registration signifies the intent of practicing rather than actual work; some nurses register and enter the country but then drop out and pursue other work; a nurse may register in multiple countries; and in some federated and decentralised countries, there are multiple registers. Foreign work permit data at the occupation level are often not published and the extrapolation of foreign census/population survey data may or may not adequately capture the extent of nurse migration. The following section presents an overview of data from all these sources, including from the POEA, whenever they are available.

[12] According to Galvez-Tan et al. (2005), the estimated total cost of producing a nurse that passes the Philippine nursing licensure examination is $4,000-$7,000, taking into account tuition fees and other school expenses.

3.2.1 Nurse migration in the 1940s-1980s

In 1948, the U.S. Government passed the Information and Education Act, which established the two-year Exchange and Visitor Programme (EVP), with the objective to promote a better understanding of the United States abroad. The Philippines came to dominate participation in the programme and by the late 1960s, 80 percent of exchange participants were Philippine nationals; and nurses comprised the majority of the Philippine exchange visitors (Choy, 2003). In 1956-1969, more than 11,000 Philippine nurses participated in the EVP programme. A study by Ignacio et al. (1967) revealed that between 1952 and 1965, an average of more than 50 percent of 377 graduates from the College of Nursing at the University of the Philippines went abroad. Meija (1979) also noted that in 1964, 43 Philippine nurses entered the United States as immigrants.

The commercial form of labour movement between the Philippines and the United States was initiated in 1965 with the U.S. Immigration Act, which facilitated the movement of nurses (Rockett and Putnam, 1989). It introduced new occupational preferences that enabled Philippine nurses to not only enter the country but also become permanent residents. 3,222 Philippine nurses emigrated between 1966 and 1970, not including nurses who moved through the EVP, and by 1967, the Philippines became the top sending country of nurses to the United States (followed by Canada and the United Kingdom) (Choy, 2003; Quraeshi et al., 1992). Philippine nurses licensed or registered in the United States increased from 9 percent of all licenses or registered foreign nurses in 1965 to 60 percent in 1970. In 1973, the number of Philippine nurse immigrants in the United States reached 1,273 (Meija, 1979). The Philippines was in 1970 the world's leading exporter of nurses, ahead of the United Kingdom, Australia and the Soviet Union. Between 1966 and 1978, 7,495 Philippine exchange visitors adjusted their status to become US permanent residents (Tullao Jr., 1982).

Permanent migration of nurses created imbalances in the Philippine healthcare system: the EVP's objective of knowledge transfers was not achieved as nurses migrated permanently. Thus, in 1972, the Philippine EVP Committee began requiring that nurse graduates served in the country for one year before they could apply to the exchange programme. In 1973, President Marcos issued a presidential decree requiring nurse graduates to work for four months in a rural area as a condition for obtaining licensure. Yet the migration of nurses continued and Hawthorne (1999) estimated that 65,940 Philippine nurses were working overseas in the middle of the 1980s. Many of these nurses were based in the United States as Philippine nurses made up 75 percent of all foreign nurses in the U.S. nurse workforce by the middle of the 1980s. According to Bach (2003), the options for Philippine nurses also increased towards the end of

this period. In the middle of the 1980s, Saudi Arabia accounted for two-thirds of the total of Philippine nurses going abroad (Ball, 1990).

The income differential was substantial. For example in 1971, a Philippine nurse earned approximately twelve times as much in the United States as in the Philippines. In the middle of the 1980s, the average salary for a registered nurse in the United States was about twenty times that in the Philippines (Berkman, 1988) and the average salary in the Middle East was two to three times as high as in the Philippines (Stahl, 1987). Consequently, moving abroad became a trend among Philippine nurses. Before the creation of the POEA, data sources are scarce. According to Ong and Azores (1994), between 1966 and 1985, at least 25,000 Philippine nurses migrated to the United States.

It was not only the United States that recruited Philippine nurses: during the 1960s, Brunei, Germany, Holland, Iran, Laos, the Netherlands and Turkey recruited Philippine nurses to alleviate their nursing shortages. In 1986, Daniel et al (2001) reported that 50 percent of the 30,000 Philippine nationals who were living and working in the United Kingdom were active in the healthcare sector. Most of these healthcare workers emigrated in the late 1960s and 1970s as a result of UK recruitment drives and were employed as ancillary healthcare workers. A significant number, however, also worked as nurses.

3.2.2 Nurse migration in the 1990s and 2000s

Survey results indicate that the United States is the preferred destination for the great majority of Philippine nurses. Van Eyck (2004) found that more than four-fifths of nurses would prefer a job in the United States. The United Kingdom was the second choice followed by Canada and Saudi Arabia. In the 1990s, Philippine nurses started to face increased competition from nurses in other Asian countries like India, China and South Korea. The Philippine share of foreign nurses in the U.S. nurse workforce had dropped to 43 percent by 2000 (Brush et al., 2004). But Philippine nurse migration has always fluctuated in line with U.S. immigration policies. Out of a total of 185,000 CGFNS Qualifying Exam test takers in 1977-2000, 73 percent were from the Philippines (Davis and Nichols, 2002). In 1995, 88 percent were Philippine nationals. The share dropped to 55 percent in 1997-1998 before rising to 71 percent in 2000.

The POEA is assisting the international recruitment process for Philippine overseas workers and it publishes statistics on the number of citizens it has channelled into productive work. Table 5 presents the data for POEA-approved ‘new hires’ of nurses in 1992-2008. The number of Philippine nurses who went abroad was larger, however, as the data in the table fail to capture the extent of the flows. There are three main limitations to the POEA data. First, the data only cover new hires and not those nurses who extend

their stay or move to another foreign employer through the POEA. For example in 2008, 39 percent of land-based workers who moved abroad to work were "new hires" while 61 percent were "rehires" according to the agency. If the same holds for nurses and other years, the POEA may have overseen the outflow of 364,000 rather than 142,005 nurses.

Second, as discussed above, many nurses move through informal, non-POEA-certified channels. In particular movement to the United States is through informal channels and Lorenzo estimates that 20-40 percent of all movement takes place through informal channels.[13] This would involve an additional 28,000-56,000 nurses as extrapolated from the 142,005 POEA-certified nurses. Finally, many nurses move in other roles than nurses, such as caregivers, domestic helpers, nursing aides, etc.

The aggregate data in Table 5 are illustrated in Figure 4, which shows the relatively volatile demand over time. POEA oversaw an increase from roughly 6,000 in 1999 to 14,000 in 2001 before dropping down again below 8,000 in 2005 followed by rapid growth thereafter.

Figure 4. Foreign deployment of Philippine nurses (new hires) by POEA, 1992-2008

Source: POEA, Overseas Employment Statistics 2007, 2008, 2009.

[13] Based on comments made in an interview.

Table 5. Foreign deployment of Philippine nurses (new hires) by POEA, 1992-2008

Destination	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	*Total*	*Share*
Saudi Arabia	3,279	4,202	3,332	3,249	3,071	3,794	4,098	4,031	4,386	5,275	6,068	5,996	5,926	4,886	5,753	6,633	8,848	*82,827*	*58.3%*
UK	0	0	0	1	0	0	63	934	2,628	5,388	3,105	1,544	800	546	145	38	28	*15,220*	*10.7%*
USA	1,767	1,987	2,853	3,690	270	11	5	53	91	304	322	197	373	229	202	933	649	*13,936*	*9.8%*
UAE	271	47	270	94	137	209	279	378	305	249	424	267	250	703	796	616	435	*5,730*	*4.0%*
Singapore	6	47	85	162	549	586	371	214	418	413	338	326	166	149	86	276	667	*4,859*	*3.4%*
Ireland	0	0	0	0	0	0	0	0	127	1,561	930	210	191	297	249	127	35	*3,727*	*2.6%*
Kuwait	320	139	455	59	269	25	143	53	133	192	108	51	408	193	354	393	458	*3,753*	*2.6%*
Libya	269	721	15	380	809	175	89	18	17	9	421	52	10	23	158	na	na	*3,166*	*2.2%*
Qatar	7	7	6	10	6	14	29	12	7	143	213	243	318	133	141	214	245	*1,748*	*1.2%*
Taiwan	2	44	4	1	1	2	8	17	1	9	131	200	6	357	273	174	231	*1,461*	*1.0%*
Oman	48	25	7	87	108	123	79	119	47	3	0	0	7	4	10	na	na	*667*	*0.5%*
Malaysia	1	1	67	80	101	108	34	13	0	2	16	7	1	0	1	na	na	*432*	*0.3%*
Bahrain	24	4	2	17	20	27	42	11	22	7	57	21	46	4	67	na	na	*371*	*0.3%*
Canada	0	0	0	0	0	0	0	0	1	7	51	25	14	21	7	na	na	*126*	*0.1%*
Japan	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	na	na	*1*	*0.0%*
Other destinations	84	84	75	124	136	170	159	119	245	260	151	131	363	223	286	349	1,022	*3,981*	*2.8%*
Total	*6,078*	*7,308*	*7,171*	*7,954*	*5,477*	*5,245*	*5,399*	*5,972*	*8,428*	*13,822*	*12,335*	*9,270*	*8,879*	*7,768*	*8,528*	*9,753*	*12,618*	*142,005*	*100.0%*

Source: POEA, Overseas Employment Statistics 1992 – 2008.

3.2.3 The Gulf Cooperation Council member states

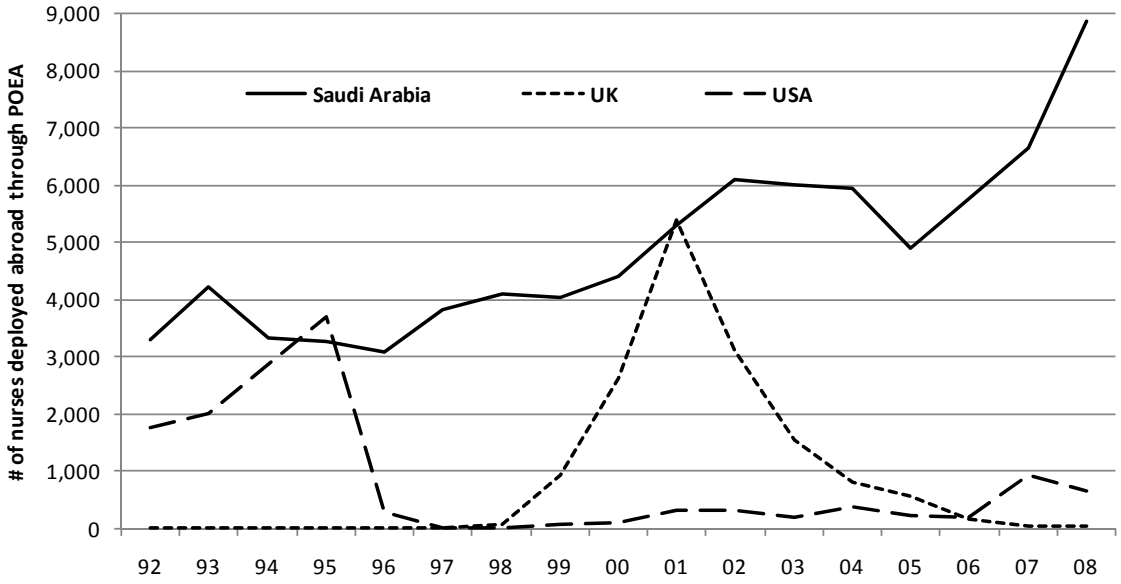
The member states of the Gulf Cooperation Council (GCC)—Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates (UAE)—are particularly dependent on foreign nurses. Nearly 80 percent of all medical professionals in the GCC are expatriate staff (Hediger et al., 2007). Pascual et al. (2005) have argued that the countries in the Middle East started recruiting foreign nurses from countries like the Philippines in 1977. According to Al-Jarallah et al. (2009), in 2007, foreign nurses made up 93.6 percent of the nurse workforce in Kuwait and this share was projected to increase further in the coming decade, from 12,103 in 2007 to 14,850 in 2020.

In 1999, 98 percent of the UAE's 4,417 strong nurse labour force were non-nationals (Iredale, 2001). In the same year, Kingma (2006) cited a WHO study for 1999 that found 84 percent of the nurses employed in Saudi Arabia to be expatriates. Demand for foreign nurses is strong due to the fact that some GCC countries prohibit indigenous women to care for other people, in particular of the opposite sex. Staff turnover rates are high as many nurses from India and the Philippines view their service in the GCC as a stepping stone to more economically attractive positions in Europe and North America. Since the 1970s, GCC constitutes the largest foreign market for Philippine nurses who move on a temporary basis.

In contrast to U.S.-bound nurse migration, most Philippine nurses who seek employment opportunities in the GCC region move through the POEA system. There is significantly less scope for recruitment through informal networks since there are few if any Philippine nurses based in the GCC on a permanent basis. Saudi Arabia recruited 82,827 first-time hires from the Philippines in 1992-2008 (Table 3). Saudi demand increased over time and reached 8,848 nurses in 2008 (Figure 5). Overall, in 1992-2008, Saudi Arabia absorbed 58.3 percent of Philippine nurses moving through POEA-certified channels and two-thirds, or 66.9 percent, moved to the GCC region.

Many foreign healthcare institutions seek to recruit entire teams of foreign nurses. For example 21st Century Manpower Resources—one of the many labour recruitment agencies certified by POEA—advertised 165 nurse positions in Saudi Arabia on August 9, 2009 (Table 4). The positions were for female candidates only and the recruitment agency sought mostly specialist registered nurses, offering monthly salaries from $588-$722 for registered general practitioner nurses and $802-$1,069 for specialised registered nurses.

Figure 5. Top-3 destinations for deployment of Philippine nurses (new hires) through POEA, 1992-2008



Source: POEA, Overseas Employment Statistics 1992-2008.

Table 6. Job advertisements for nurses at 21st Century Manpower Resources, Inc.

Job	# positions	Destination	Salary [SR]	Salary (US$)	Description
Specialist Registered Nurse - CCL	2	Saudi Arabia	3500	935	Female candidates only
Specialist Registered Nurse - CCU	40	Saudi Arabia	4000	1,069	Female candidates only
Specialist Registered Nurse - ICU	20	Saudi Arabia	3500	935	Female candidates only
Specialist Registered Nurse - NICU	25	Saudi Arabia	3500	935	Female candidates only
Specialist Registered Nurse - OR/RR	10	Saudi Arabia	3500	935	Female candidates only
Specialist Registered Nurse - Pediatrics	15	Saudi Arabia	3000	802	Female candidates only
Specialist Registered Nurse - PICU	4	Saudi Arabia	3500	935	Female candidates only
Specialist Registered Nurse - Renal-Dialysis	8	Saudi Arabia	3500	935	Female candidates only
Specialist Registered Nurse - A&E	4	Saudi Arabia	3500	935	Female candidates only
Specialist Registered Nurse - Cardiac - OR	2	Saudi Arabia	3500	935	Female candidates only
Registered Nurse - HSC	10	Saudi Arabia	2200	588	Female candidates only
Registered Nurse 1 - Medical	15	Saudi Arabia	2700	722	Female candidates only
Registered Nurse 1 - Surgical	10	Saudi Arabia	2700	722	Female candidates only

Source: www.21stcmri.com, accessed August 9, 2009.

3.2.4 The United States

Philippine nurses generally move to work in the United States through channels that are not POEA-certified.[14] The large proportion of recruitment through informal channels to the United

[14] The same holds for movement to Canada. In 1992-2008, POEA oversaw a total of 126 placements (*i.e.* first-time hires) in Canada. The real extent of trade was much bigger. Canada hosted 241,342 registered nurses in 2003; 95 percent of whom were female. Some 28 percent of the up to 20,000 nurses that had obtained their nursing graduate degree outside Canada were from the Philippines (Little, 2007). Some

States is probably due to the large permanent population of Philippine nurses who recruit through their personal networks. The informal recruitment channel is less time-consuming and bureaucratic from the employer's point of view than recruitment through formal channels. In 1992-2008, POEA oversaw a total of 13,936 placements (*i.e.* first-time hires) in the United States. This number represented only a fraction of the total flow of Philippine nurses to the United States.

For example in 2001, 304 Philippine nurses were recruited though POEA while the International Union of Nurses noted that nearly 10,000 Philippine nurses were hired by U.S.-based hospitals through job fairs held in the Philippines (Cueto, 2006). In 2004, POEA oversaw 373 nurses moving to the United States while the United States Embassy in Manila noted that 7,944 H-1B and EB-3 work permits had been issued to nurses during the same year (Lorenzo, 2005). And Philippine nurses constitute roughly three-fourths of foreign nurses in the United States according to the World Health Organisation (WHO, 2006). The flow of Philippine nurses to the United States must therefore be sought in professional licensing records, work permit and census data.

3.2.4.1 Professional licensing

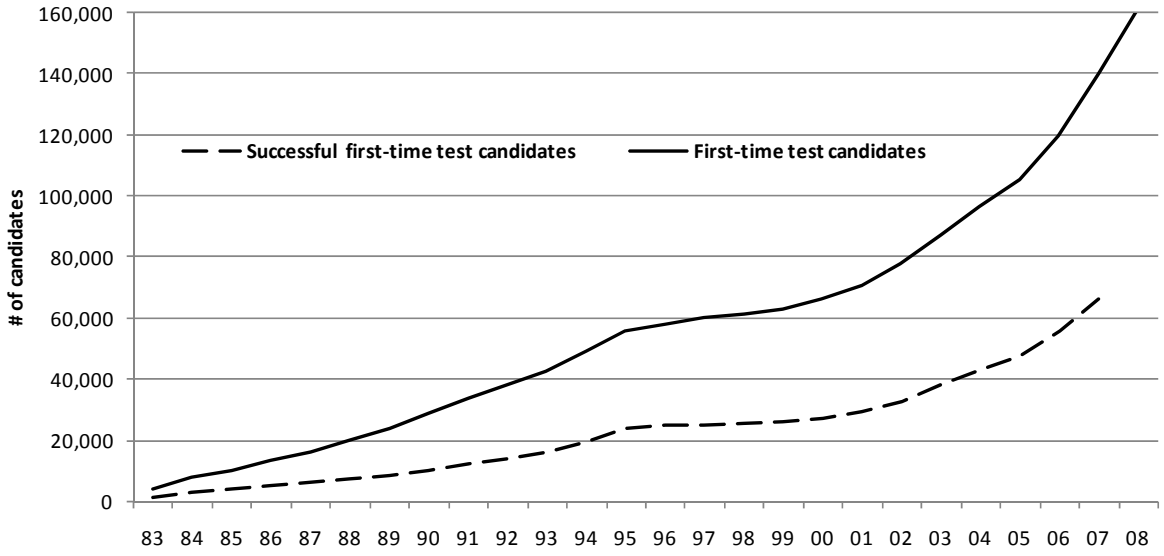
The National Council of State Boards of Nursing (NCSBN) is a U.S. regulatory agency that provides guidance and coordinates the activities of the various state and territorial boards of nursing in the United States. Its mission is to promote safe and effective nursing practices. NCSBN administers two licensure examinations: the National Council Licensure Examination for Practical Nurses (NCLEX-PN) and the National Council Licensure Examination for Registered Nurses (NCLEX-RN). Foreign registered nurses must pass the NCLEX-RN in order to qualify for a professional license and NCSBN publishes data on the number of first-time test takers by nationality.

Figure 6 shows how the aggregate number of Philippine first-time test takers has evolved over time. Between 1983 and the first half of June 2009, 170,683 Philippine nurses took the NCLEX-RN. Up until 2007, 66,281 of the first-time test candidates were successful. The total number of successful test takers (first-time, second-time, etc.) is somewhere in between the 66,281 nurses who succeed the first time and the 170,683 nurses who took the test for the first time.

Philippine nurses working in Canada may have migrated before 1992 and kept their original citizenship and most Philippine nurses moved to Canada through channels that were not POEA-certified. According to Blythe (2008), in 2006, there were 3,114 Philippine nurses employed in the state of Ontairo. The author noted that the 455 Philippine nurses who entered the Ontario workforce in 2004 constituted a peak and a slight majority of the nurses were 45 years or older. Overall, 2,141 Philippine nurses entered the Ontario workforce in 1997-2006. During the same period, POEA channelled 126 nurses to Canada.

Assume that 30-60 percent of those first-time test takers who failed succeeded at a later instance. Assume also that 60-90 percent of those nurses who passed this final qualification hurdle received a job offer and work permit in the United States. This would leave 107,602-138,923 NCLEX-RN holders and 58,561-125,031 potential migrants to the United States in 1983-2007. It should be noted, however, that 20,700 Philippine nurses passed the NCLEX-RN test in 2003-07 and in March 2010, the U.S. consulate was still working on a backlog of applications submitted up until December 15, 2002. Yet if the 7,944 Philippine nurses who moved to the United States in 2004 alone is any guide, it is likely that the total number of nurses who served at least at some point in the United States is in the upper half of the estimated 48,800-96,700.

Figure 6. Aggregate number of Philippines-educated candidates taking the NCLEX-RN examination, 1983-2008

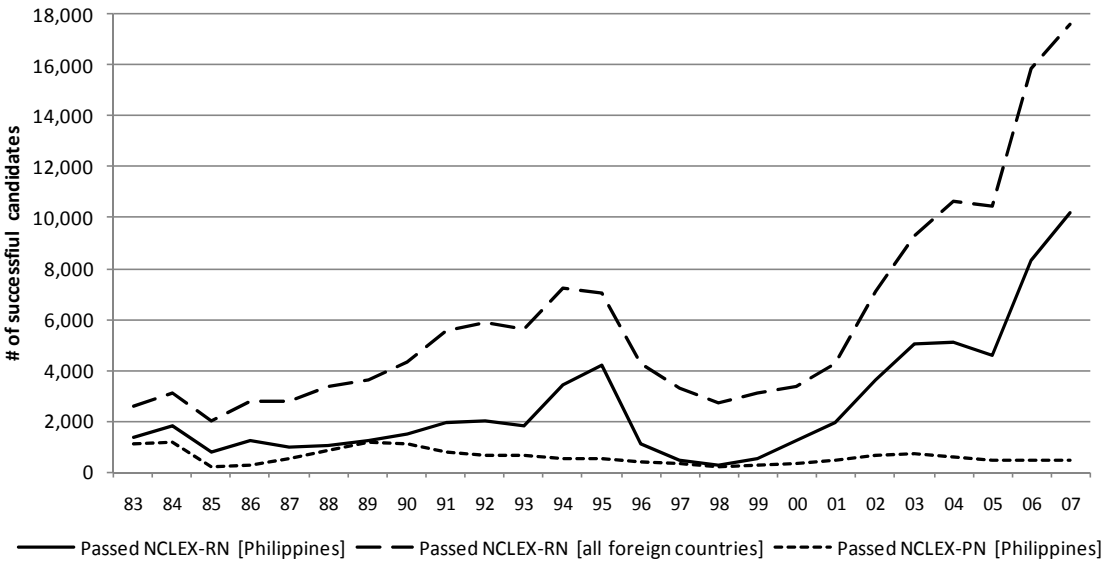


Source: National Council of State Boards of Nursing, Inc. (NCSBN) Annual Reports 1983-2008.

Figure 7 illustrates how the number of first-time test candidates has changed over time. There was a rather steady increase from the middle of the 1980s until 1995 when the number of candidates collapsed. This collapse coincided with the expiration of the H-1A work permit programme (as discussed below). The number of first-time test takers who passed in 1995 exceeded the total number of first-time test takers who succeeded during the following five years. This drop was mostly a reflection of the number of candidates who took the test but also a decline in the passing rate of test takers (Annex B). The passing rate has always fluctuated and the average passing rate during in 1983-2007 was 42 percent for Philippine first-time candidates and 50 percent for all non-U.S. candidates.

The marked decline in the passing rate for 1996-98 happened to coincide with a lengthy lawsuit involving the U.S. Commission on Graduates of Foreign Nursing Schools (CGFNS) and the U.S. Immigration and Naturalization Service about CGFNS's right to require foreign-educated nurses to complete a screening programme to qualify for permanent residence. In 1995, the year before the lawsuit was filed; a record of 64 percent of the Philippine candidates passed the test. In 1997-99, when the lawsuit was ongoing (it settled in 1999), only 26 percent passed on average. NCSBN calibrates its test methodology every third year and may have made a move, conscious or not, to significantly increase the threshold for passing. This is a plausible explanation given the fact that CGFNS and NCSBN control and protect the interests of U.S. nurses as well as public health. Buerhaus et al. (2009) have argued that a shortage of U.S. nurses was identified in 1998 and that demand and supply were fairly balanced in the preceding years. The drastic drop in the passing rate from 1995 until 1998 thus conveniently occurred during a time when competition from foreign nurses was less welcome by U.S. nurses.

Figure 7. First-time candidates taking the NCLEX-RN and NCLEX-PN, 1983-2007

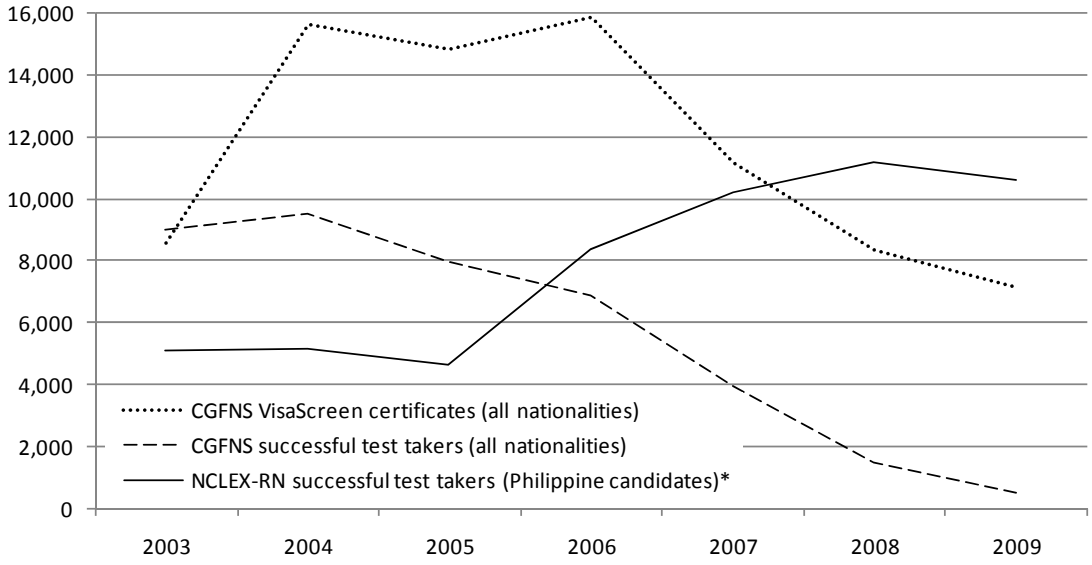


Source: National Council of State Boards of Nursing, Inc. (NCSBN) Annual Reports 1983-2007.

Another source of information that provides some insights to the extent of Philippine nurse migration to the United States is presented in Figure 8. CGFNS issues VisaScreen certificates to nurses who move to work in the United States and although CGFNS does not publish data on nationality, it does publish aggregate data and rank the top five nationalities of VisaScreen certificate holders. The Philippines topped this ranking for all years that the organisation

published information on its website (2003-09). Figure 8 reveals how 15,000-16,000 foreign nurses received a VisaScreen certificate in 2004-06 and that the number had halved by 2008-09. There was also a 94 percent decline in the number of CGFNS[15] test takers (all nationalities) between 2004 and 2009 (discussed in section 4.1.4.1) while the number of successful Philippine NCLEX-RN test takers increased by more than 200 percent. These opposing trends in the issuing of VisaScreen and NCLEX-RN certificates imply that more and more of the Philippine students who went into nursing due to the prospects of migrating to the United States in the 2000s now are left outside the U.S. labour market.

Figure 8. Number of issued CGFNS certificates and NCLEX-RN certificates, 2003-2009



Note: * 2008-2009 are projections based on aggregate data for Philippine test takers achieving a 54 percent success rate.

Source: CGFNS (2010), FCSBC (2010-2003), author's calculations.

3.2.4.2 Temporary and permanent work permits

In the last twenty years, Philippine nurses have been able to move and work in the United States on three types of temporary work permits: the **H-1A** work permit in 1991-1995, the **H-1B** work permit throughout the period, and the **H-1C** work permit in 2000-2009.[16] The H-1A and the H-1C were both uniquely targeting foreign nurses. Philippine nurses have also been able to apply for permanent work permits under the employment-based third preference immigrant programme, *i.e.* the **EB-3** green card programme, whenever nursing has been defined a shortage occupation. The

[15] Galvez Tan et al. (2005) noted that the total number of Philippine-educated applicants to the CGFNS certification programme in 1977-2002 was 184,549 (an average of 7,382/year) and that the total number of successful applicants was 71,051 (an average of 2,842/year).

[16] U.S. authorities and literature refers to the H-1A, H-1B, H-1C and EB-3 as "visas" while they are referred to as "work permits" here.

U.S. authorities do not publish work permit data based on nationality in a systematic way but several inferences can be made from the data that are available and the fragments of information occasionally published on nationality by U.S. authorities.

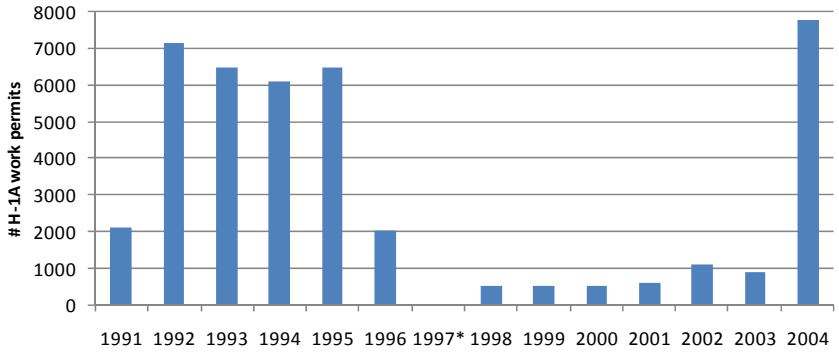
In 1992-95, many Philippine nurses were recruited to the United States on temporary H-1A work permits and many of them are likely to have moved through POEA-certified recruitment channels (see Table 3 and Figure 9). This flow of nurses came to a standstill when the United States stopped issuing new H-1A work permits in late 1995. The temporary H-1C work permit that was issued to foreign nurses between 2000 and 2009 was associated with so many restrictions (analysed below) that only a modest trickle of nurses moved to the United States on this work permit (Figure 10).

While there are no data on the nationality of these work permit holders, Figures 9-10 do reveal that admissions[17] of H-1A work permit holders and the number of H-1C work permits issued were limited in 1996-2008 for all nationalities. In 2004, the only year for which the U.S. Department of Homeland Security published data on nationality, Philippine nurses with H-1A and H-1C work permits entered the country on 59 occasions. Some specialised nurses also serve in the United States on H-1B work permits but the numbers are small: 38 Philippine nurses obtained an H-1B work permit in 2006 and 66 and 136 nurses obtained it in 2007 and 2008 respectively (DHS, 2008a).

Consequently, movement on temporary work permits has not been much of an option in the last decade and a half. Stock estimates based on U.S. census data, however, indicate that approximately 81,000 Philippine-educated nurses[18] were active in the U.S. nurse labour force in 2000 (Aiken, 2007). They represented 37 percent of the 219,000 non-U.S.-educated registered nurses and 3.4 percent of the total stock of U.S. registered nurses. In addition, 65 percent of the Philippine-educated nurses based in the United States had obtained U.S. citizenship, which implied that nurse migration to the United States was largely a permanent phenomenon.[19] Earlier stock estimates also indicate that Philippine nurses have constituted the largest foreign contingency in the United States although their dominance has decreased over time.

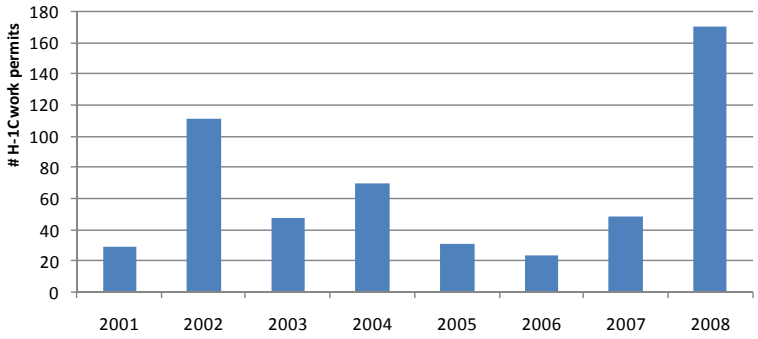
[17] Note that the number of admissions represents the number of times a work permit holder enters the country in a given year. The number of admissions is thus likely to be lower than the number of work permits issued in a given year.
[18] They moved to the United States after their 22nd birthday.
[19] The fact that Philippine nurses constitute the single largest foreign nationality in the U.S. health system is largely the result of the Americanised training and hospital systems in the Philippines (Choy, 2003).

Figure 9. Number of H-1A admissions, all nationalities, 1991-2004[20]



* = not available.
Source: U.S. Department of Homeland Security (2005), Money and Falstrom (2006).

Figure 10. Number of issued H-1C work permits, all nationalities, 2001-2008



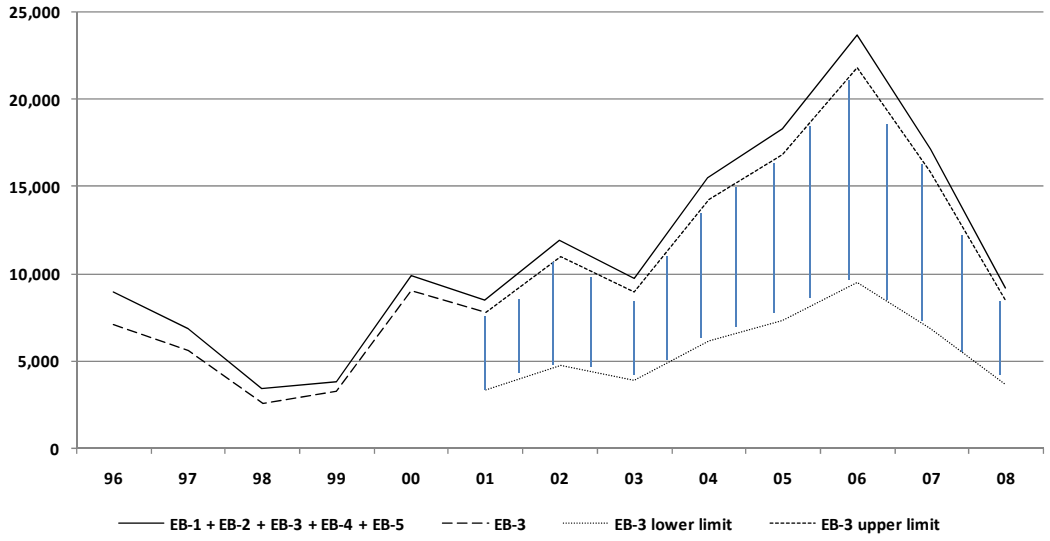
Source: US Department of Homeland Security.

Figure 11 captures the great majority of Philippine nurses who moved to work in the United States in 1996-2008. The number of employment-based third preference immigrant work permits issued to Philippine citizens was only published until 2001 (the "EB-3" line). In 1996-2001, the share of EB-3 work permits to the total number of employment-based immigrant work permits ("EB-1 +...+ EB-5") fluctuated between 75 percent and 92 percent. According to Lorenzo (2005), the United States Embassy in Manila claimed that in 2004, the deployment of Philippine workers to the United States under the H-1B and EB-3 work permits numbered 11,349, of which 7,944 were issued to nurses. It correct, it would imply that POEA captured 4-5 percent out of the 59 H-1C work permit holders and the 7,944 H-1B and EB-3 work permit holders who moved to the United States in 2004.

[20] The H-1A work permit was not issued in 1998-2004 but there are still admissions recorded in the annual statistics of the U.S. Department of Homeland Security. It is unclear to the author why there was a spike in admissions in 2004; some nine years after the work permit programme expired.

The U.S. Department of Homeland Security issued 5,112 H-1B work permits to Philippine citizens in 2004. Consequently, if the 11,349 number provided by the U.S. Embassy in Manila was correct, it would leave 6,237 EB-3 green cards. This would mean that at least 1,700 nurses moved on H-1B work permits in 2004, as compared to the 38 nurses who did so in 2006.[21] It would also imply that the share of EB-3 to all five preferences (EB-1 to EB-5) had dropped to 40 percent by 2004. It could potentially have been the result of the considerable backlog of Philippine EB-3 applications that build up at the start of the 2000s when the U.S. authorities started to issue green cards to the green card holder's immediate family.

Figure 11. Number of Philippine citizens obtaining legal permanent resident status in the United States based on employment-based preferences, 1996-2008



S*ource:* U.S. INS and U.S. DHS Yearbook of Immigration Statistics, 1996-2008, author's calculations.

Figure 11 illustrates the estimates of a lower limit (40 percent) and an upper limit (92 percent) of the number of EB-3 work permits issued to Philippine citizens in 2001-2008. According to the former Health Secretary of the country, Dr Jaime Galvez-Tan, a large proportion of the total number of EB-3 work permits are issued to Philippine registered nurses. These numbers are based on the limited information available and should be interpreted with caution.

[21] The number of H-1A admissions of all nationalities in 2004 was 7,795 and this is also rather surprising given the fact that the U.S. authorities stopped issuing new H-1A work permits in 1995 (see Figure 6). There is seemingly some irregularity for the data in 2004 and the author has not found any convincing explanation for these numbers.

3.2.5 The United Kingdom

National Health Services (NHS) turned to the POEA in 1998 to address its shortage of registered nurses. Following the election victory of New Labour in 1997, the United Kingdom raised its investment in public services in general, and the NHS in particular. In 2000, the 'NHS Plan' for England outlined a strategy to increase the number of nurses by 20,000 between September 2001 and 2004, and by an additional 35,000 nurses, midwives and healthcare visitors by 2008 (Bach, 2007). To achieve these targets, the United Kingdom recruited large numbers of nurses from countries like the Philippines. As Table 3 shows, by 2004, the United Kingdom had recruited some 14,462 Philippine nurses (new hires) through POEA-approved channels. By 2008, recruitment had slowed substantially as an additional 757 Philippine nurses were hired through the POEA. Figure 5 also illustrates how much of this recruitment took place over the span of a few years, peaking in 2001.

Many nurses that are trained outside the United Kingdom are registered to practice in the United Kingdom and work both in the NHS and in the private sector. The Department of Health in England does not collect data on nationality so it is not possible to accurately assess the number of non-UK nurses working in the country (Buchan, 2007). According to an article in the Pinay Nurse Magazine in 2005, there were around 45,000 Filipino nurses working in the United Kingdom, and the great majority of these nurses must have been permanent migrants given the fact that 21 out of 1,389 applications (1.5 percent success rate) by Philippine nurses for initial admission to the UK Nursing and Midwifery Register between April 1991 and March 1998 were granted (Figure 12).

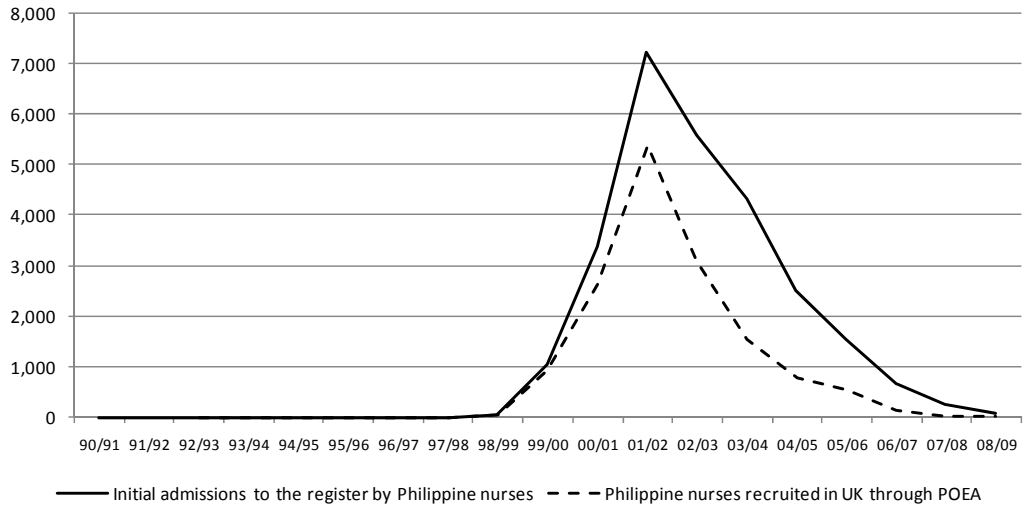
More lately, Philippine nurses constitute the largest group of foreign nurses admitted to the register of the Nursing and Midwifery Council. Initial admissions of Philippine nurses jumped in 99/00 and peaked in 01/02 at 7,235 before declining to 87 in 08/09. As illustrated in Figure 12, most of these new admissions were recruited through POEA-certified channels in the first few years while this share dropped from 01/02 onwards. Some of the nurses who gained admission may have had offers from United States during this time and opted for employment there. Between April 1998 and March 2002, 11,735 Philippine nurses gained initial admission to the register and 39,299 Philippine nurses applied for initial admission (29.9 percent success rate).

The Nursing and Midwifery Council stopped publishing data for the number of applications from April 2002 onwards. It is therefore not possible to say whether the deterioration in the number of

initial admissions was the result of a return to the 1990s when hardly any applicants were admitted or whether demand for Philippine nurses dropped. Yet it is likely that demand dropped as the United Kingdom produced more nurses and as nurses from Eastern European could easily move and work in the United Kingdom from 2004 onwards.

The nurse register provides an indication but not a definitive answer to whether the majority of nurse migration is temporary or permanent in nature. Kingma (2006) has noted that nurses in the United Kingdom are required to renew their registration every three years, but less than half of non-EU foreign registrants in 1995 reregistered in 1998. 85 percent of departures occurred within four years of entry to the United Kingdom, suggesting that more than three-quarters of the foreign nurses registered in 1995 were no longer in active nursing practice in the United Kingdom four years later. All of the registered nurses may not have served in the United Kingdom in the first place but assuming that most of them did would imply that most migrant nurses move on relatively quickly either to another destination country or back home.

Figure 12. Initial admissions to the Nursing and Midwifery Council Register of Philippine nurses and recruitment in the United Kingdom of Philippine nurses



Source: UKCC and NMC annual reports 1990-2008, POEA annual reports, Andy Blake (Records and Archives Officer).

3.2.6 Japan

Japan has been a closed market for Philippine nurses and only one nurse was recruited to Japan through the POEA in 1992-2008. Until recently, the Japanese Nursing Association was successful in blocking market access for foreign nurses by arguing that the country had enough nurses and instead needed caregivers. Trade negotiators and nurse representatives still saw great market potential in the Japanese healthcare sector given their experiences in other sectors. For example, approximately 70 percent of Japanese maritime operations are manned by Philippine sailors and

the Japan Seamen's Union cooperated with the Associated Marine Officers and Seamen's Union of the Philippines to establish local maritime schools and training centres (Samonte, 2009). Given the heightened requirement for client interaction, the natural language barrier may significantly reduce the trade potential for nurses. Yet the Japan-Philippines Economic Partnership Agreement (JPEPA), ratified by the Philippine Senate on October 8, 2008, will allow Philippine nurses to work in Japan for the first time.

Trade will be limited, however, as POEA will only be able to deploy up to 200 nurses per year to the Japan (Semonte, 2009). JPEPA states that Philippine nurses are eligible to stay for three years and earn around $1,600-$2,000/month. According to Dalangin-Fernandez (2009), 92 nurses (and 188 caregivers) were hired in various institutions under JPEPA in May 2009. Philippine nurses start off as "candidate nurses" and undergo a six-months training in Japanese before being deployed in their respective institutions. They were to be reclassified as registered nurses if they passed the Japanese licensure examination in February 2010. Overall, nursing and care giving are low-paid, low-status occupations in Japan, and the barriers are substantial—for example foreign nurses need to pass the local nursing board examination in Japanese—thus time will tell if this proves a success in the future.[22] The POEA reported in January 2010 on their website that Japan would only look to hire 60 nurses (and 101 caregivers) in 2010, or 30 percent of the annual quota.[23]

3.2.7 The future of nurse migration

Philippine nurse migration faces an uncertain future. There are hundreds of thousands of Philippine nurses who passed the NLE examination in the last few years with few prospects of finding employment at home and there are well documented shortages of nurses in several OECD economies. As will be analysed in section 4, however, the regulatory barriers are substantial in many countries. Some countries, like the United Kingdom, are expected to close their gaps of registered nurses and the prospect of more opportunities in Japan has opened up as a result of the JPEPA. The U.S. market has been particularly difficult to enter for a number of years and the long-term impact of the economic downturn that started in 2007-08 and the 2010 U.S. healthcare reforms remain unknown.

[22] New Zealand hosted 426 active Philippine nurses in 2001 and the number of Philippine nurses and midwives professionals who received a work permit was 108 in 2002/03, 246 2003/04, 214 in 2004/05, 213 in 2005/06 and 168 in 2006/07 (Zurn and Dumont, 2008). Philippine nurses have also entered the Singaporean health market as shown in Table 3. According to ASEAN – ANU Migration Research Team (2005b), data for 2004 from the Singapore Nursing Board revealed that 11 percent of the country's nursing workforce was made up of Philippine nurses in addition to 12 percent from other countries.

[23] www.poea.gov.ph/news/2010/PR_Jan2010_employment%20prospects.pdf.

In the case of the United Kingdom, demand for nurses is estimated to increase by 25 percent in 2005-2020 and domestic supply is estimated to expand by a similar amount (OECD, 2008). Clark et al. (2006) assessed a number of studies and argued that Australia, Canada (113,000 nurses by 2016) and nearly every European country is experiencing a shortage of nurses. In Saudi Arabia, 46 percent of an estimated 100,000 nurse positions were open in 2004 and the country faced difficulty in adding to its 53,000 foreign and 1,000 domestic employed nurses. In many developing countries the shortage of nurses is even more striking.

According to the U.S. Department of Homeland Security, the lack of supply of U.S. nurses is becoming "increasingly problematic" and may "adversely affect" the country's healthcare sector (DHS, 2008a). The U.S. Department of Health and Human Services estimated in 2007 that the United States will require 1.2 million new registered nurses by 2014 (DHHS, 2007). Approximately 500,000 nurses were expected to exit the labour market and an additional 700,000 nurses would be required to meet a projected rise in demand for healthcare services. HRSA (2004) has also estimated in its baseline projection that the demand for nurses may increase by 31 percent in 2005-20 while domestic supply may decline by 7 percent. The agency also estimated that nurse wages would need to rise by 3 percent per year in 2000-20 and nurse graduates rise by 90 percent over the same period in order for supply and demand to be roughly in balance by 2020.

The increasing population of seniors will play a dominant role in determining the quantity as well as the type of services and personnel required in the coming years (Sochalski, 2002). In 1999, 48 percent of total U.S. hospital inpatient days and 40 percent of all short-stay hospital discharges were linked to care of persons 65 years and older. The nurse workforces are also aging in many OECD economies. The largest nursing groups are in their 50ies and 60ies and as these age groups retire, the pressure to replace them will further increase existing shortages (Buerhaus et al., 2000). The recruitment of foreign nurses is a consequence of this process. The share of foreign nurses in the U.S. nurse workforce increased from 9 percent in 1994 to 16 percent in 2008 (Buerhaus et al., 2009). The authors predict an increased shortage of nurses in the coming decade.

The recent economic downturn may have provided some short-term relief. Nearly a quarter of a million nurses entered the U.S. workforce in 2007-08 (Evans, 2009). This 18 percent surge was the largest two-year increase in more than three decades. Many nurses—in particular those over the age of 50—re-entered the workforce to compensate for a spouse's lost income or health benefits. In 2008, there was a third more working nurses aged 21-34 with children under the age

of 6 than in the previous year. This underlines the supply capacity in times of economic uncertainty.

3.3 Movement of other healthcare professionals

Exports of Philippine healthcare professionals are not limited to registered nurses. Physicians, academic staff, nursing aides and caregivers also move to work abroad. According to Terrazas (2008), based on a study of census data, among the 1,032,199 Philippine-born workers age 16 and older employed in the civilian U.S. labour force, 108,070 were registered nurses, 59,470 other healthcare practitioners, 47,340 healthcare support occupations, and 17,310 physicians.

At the top of the skill ladder is what former Philippine Health Secretary, Dr. Jaime Galvez-Tan, refers to as 'nurse medics', *i.e.* medical doctors who have re-qualified as nurses in order to obtain a green card in the United States. Galvez-Tan et al. (2005) argued that the Philippines lost 3,500 medical doctors who had re-qualified as registered nurses and gone abroad in 2000-2004. An estimated 1,500 medical doctors passed the National Licensure Examination in 2003 and first half of 2004 while another 4,000 medical doctors may have been enrolled in at least 43 nursing colleges offering abbreviated nursing courses tailor-made for medical doctors.

Many nurses who have failed to obtain the registered nurse license at home or abroad move abroad as nursing aides, caregivers and domestic workers. In particular, Taiwan, Israel and Canada have recruited many caregivers—some of whom have a nursing background. Table 5 shows that POEA oversaw almost 100,000 new hires of caregivers in 2001-08 with more than three-fifths working in Taiwan. Working as a caregiver abroad is likely to be the second best option that some nurses may opt for. There is great scope to increase the number of caregivers as the populations of developed countries are greying and two non-Anglophone countries/territories—Taiwan and Israel—are the main recruiters. Nonetheless the hiring of caregivers through POEA dropped by 70 percent between 2004 and 2008. This may have been a result of more caregivers moving outside POEA-certified channels. For example Canada's Live-In Caregiver Program recruited some 12,000 foreign caregivers in 2007 and most of them arrived through informal recruitment channels from the Philippines.[24]

Foreign demand for caregivers has resulted in a booming market for the training of caregivers—just as in nursing (Tullao and Cortez, 2004). In for example Canada, caregivers earned an average

[24] www.cic.gc.ca/english/work/caregiver/index.asp.

monthly salary of $800 for providing care for children, seniors and people with disabilities. As a result of the increase in demand in 2002-2003, training institutes for caregivers grew rapidly in the Philippines. Of the more than 500 training institutes that had applied for accreditation from the Technical Education and Skills Development Authority (TESDA) by April 2003, 150 training institutes had been accepted.

Table 7. Foreign deployment of Philippine caregivers (new hires) through POEA, 2001-2008

Destination	2001	2002	2003	2004	2005	2006	2007	2008	*TOTAL*	*Share*
Taiwan	0	0	14,716	13,928	11,604	8,410	6,346	4,028	*59,032*	*61.5%*
Israel	397	2,908	1,737	3,217	2,535	2,512	2,993	351	*16,650*	*17.3%*
Canada	0	2,152	1,811	2,527	753	1,992	4,170	1,117	*14,522*	*15.1%*
UK	4	253	481	656	732	1,214	521	30	*3,891*	*4.1%*
Saudi Arabia	3	5	0	2	413	3	27	156	*609*	*0.6%*
Kuwait	0	0	3	2	47	74	170	40	*336*	*0.4%*
Spain	0	0	2	7	1	78	49	69	*206*	*0.2%*
Cyprus	0	0	1	3	6	42	54	23	*129*	*0.1%*
New Zealand	0	0	0	0	0	0	14	21	*35*	*0.0%*
Italy	0	0	0	2	6	0	3	22	*33*	*0.0%*
Other destinations	61	65	127	50	49	87	52	35	*526*	*0.5%*
TOTAL	*465*	*5,383*	*18,878*	*20,394*	*16,146*	*14,412*	*14,399*	*5,892*	*95,969*	*100.0%*

Source: POEA, Overseas Employment Statistics 2001-2008.

4. RESTRICTIONS ON THE INTERNATIONAL MOVEMENT OF NURSES

The healthcare sector is heavily regulated in order to ensure patient safety. In many high-income countries, the sector is also largely protected from competition since it is embedded in the public sector and associated with labour unions and powerful interest groups. Foreign nurses and recruiting healthcare facilities must therefore comply with a plethora of rules and regulations. Most of these rules and regulations may be necessary for quality control purposes but as the following section illustrates, the approach to regulation taken by the three main importers of Philippine nurses—the United States, the United Kingdom and Saudi Arabia—varies widely despite the fact that they seek to achieve the same objectives.

A nurse must generally obtain a professional license before he/she can apply for a work permit to practise as a registered nurse in the client country. The nurse must also be able to demonstrate that he/she has adequate language and communication skills and that his/her foreign education and professional registration comply with the requirements of the host country or host state. When these requirements are fulfilled, the nurse can move on to the application process for a work permit. These two somewhat separate procedures—of obtaining a professional license and in securing a work permit—are assessed below for Philippine nurses seeking to enter as registered

nurses in the United States, the United Kingdom and Saudi Arabia. The findings are summarised in tables 9-11 and the economic effects of individual restrictions are discussed in more detail.

4.1 The United States of America

A Philippine nurse who seeks employment as a registered nurse in the United States must first pass the NCLEX-RN to obtain a state license. The nurse must also have his/her education, language and professional credentials verified. The nurse must then obtain a work permit. On a temporary basis, certain skilled categories of nurses may qualify for the H-1B work permit. Until December 20, 2009, registered nurses could also qualify for H-1C work permits that were issued specifically to foreign nurses. As the previous analysis showed, neither the H-1B nor the H-1C work permits have allowed for more than a trickle of foreign nurses to work temporarily in the United States. Since the termination of the H-1A work permit category in 1995, the U.S. authorities have tailored the rules of its EB-3 green card to allow foreign nurses to move and work in the United States on a permanent basis.

4.1.1 Recognition and professional licensing

The economic incentives to enter the U.S. healthcare market are particularly high for foreign nurses. So are the barriers they need to overcome to get there. The U.S. healthcare sector is by far the most time-consuming, costly and burdensome of the labour markets that Philippine nurses often seek to enter. In order to reach the stage at which the nurse can apply for a work permit, he/she must pass an English language proficiency test, pass the National Council Licensure Examination for Registered Nurses and have all his/her credentials verified and approved by the Commission on Graduates of Foreign Nursing Schools. Having reached thus far, the nurse must secure a job offer in order to file an application for a work permit, which is subject to a quota, and may entail 3-8 years of waiting.

4.1.4.1 The Commission on Graduates of Foreign Nursing Schools

CGFNS was established in 1977 as a non-profit organisation co-sponsored by the American Nurses Association and the National League of Nursing (see Choy, 2003; Brush et al., 2004). The CGFNS Certification Program is designed specifically for registered first-level, general nurses educated abroad but eligible to practice as registered nurses in the United States.[25] The programme is comprised of: (i) a credentials review, which includes an evaluation of secondary and nursing education, registration and licensure; (ii) the CGFNS Qualifying Exam, a test of

[25] See the www.cgfns.org website for more details.

nursing knowledge offered three to four times a year at over 50 test sites worldwide; and (iii) an English language proficiency examination.

The CGFNS certificate is required of internationally educated registered nurses by a majority of U.S. states in order to take the NCLEX-RN. CGFNS argues that its certificate holders consistently have a higher rate of success on the NCLEX-RN examination than internationally educated nurses who do not hold the certificate. Davis and Nichols (2002) pointed out that prior to the introduction of the test in the 1970s only 15-20 percent of foreign nurses educated outside the United States passed the NCLEX-RN. In 2000, 85-90 percent of those who passed the CGFNS Qualifying Exam also passed the NCLEX-RN.

CGFNS's role of verifying foreign nurses' academic qualifications, work credentials and language skills may be necessary. The merit of its pre-screening qualifying examination is questionable, however, since it was a mandatory step to take the NCLEX-RN. The CGFNS Qualifying Exam would have been voluntary rather than mandatory and imply no negative consequences if the test taker failed the test if this was a "service". There is considerable risk of collusion and regulatory capture. The CGFNS Qualifying Exam is just another burden for foreign nurses. In 2010, the cost for the certification programme application was $445, including the CGFNS Qualifying Exam, the Official Study Guide for the CGFNS Qualifying Exam, a credentials review and an English language proficiency verification.

Kingma (2006) has pointed out that although CGFNS is a non-profit organisation, it is nonetheless a money making enterprise. CGFNS's revenue increased from $2.5 million in 1996 to $18 million in 2004 and fees are relatively high for Philippine nurses. The high price may be the result of the monopoly that CGFNS has enjoyed for accreditation. According to Kingma (2006), as a prerequisite for taking NCLEX-RN, 40 states have legislation requiring foreign-educated nurses to pass the CGFNS Qualifying Exam. However, new rules issued in September 2003 broke the monopoly that CGFNS had enjoyed since 1977 (Ginsberg, 2004). Successful lobbying by the Philippine Nurses Association led to some Boards of Nursing in states such as Michigan to propose the elimination of the CGFNS Qualifying Exam as a formal requirement.[26] This led to a 94 percent drop in the number of CGFNS test takers between 2004 and 2009.

[26] www.pnaofmichigan.org/NewsltrSpring2006.pdf.

4.1.4.2 National Council Licensure Examination for registered nurses

The National Council of State Boards of Nursing (NCSBN) is a non-profit organisation consisting of the boards of nursing in 50 U.S. states, the District of Columbia, and U.S. territories American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. It acts and counsels on concerns affecting the public health, safety and welfare.[27] Among its core activities, NCSBN develops and administers the NCLEX-RN for the professional licensing of nurses in the United States. The NCLEX-RN is designed to test the knowledge, skills and abilities essential to the safe and effective practice of nursing at the entry-level.

The NCSBN began administering the NCLEX-RN in Manila for the first time in the summer of 2007.[28] All Philippine candidates are required to apply to the board of nursing in the state or territory where they wish to be licensed before registering for the NCLEX-RN. The examination fee is $350 at locations outside the United States.[29] Until the summer of 2007, Philippine nurses had to travel to Guam or Saipan to take the examination. This journey was a significant economic burden for more nurses.

4.1.4.3 English proficiency exam

Philippine nurses must meet certain minimum English language requirements to enter the U.S. market. Foreign nurses may be automatically deemed to have met the English language and/or education comparability requirements if they have graduated from entry-level programmes accredited by the National League for Nursing Accreditation Commission or the Commission on Collegiate Nursing Education, or from programmes in Australia, Canada (except Quebec), Ireland, New Zealand, the United Kingdom and the United States. Very few Philippine nurses graduate from these programmes. All other nurses are required to meet minimum test results in one of the four English language test services that are approved (see Annex C for minimum test scores). According to the academic staff consulted in Manila, Philippine nurses normally perform well in the written test but some struggle with the spoken test. Many nursing colleges therefore offer classes in speech labs to improve the chances of their nurse students to pass the spoken test.

4.1.4.4 Visa Credentials Assessment – the VisaScreen

Registered nurses who are educated outside the United States and who are seeking temporary or permanent occupational work permits are required to obtain a VisaScreen certificate (Visa Credentials Assessment). This document is administered by the International Commission on

[27] www.ncsbn.org/about.htm
[28] www.ncsbn.org/1282.htm
[29] www.ncsbn.org/2010_NCLEX_Candidate_Bulletin.pdf

Healthcare Professions (ICHP), a division of CGFNS International. As part of the VisaScreen assessment, registered nurses applying for an occupational work permit must have a passing score on either the CGFNS Certification Program Qualifying Exam or on the NCLEX-RN. The VisaScreen includes an education analysis, licensure validation, English language proficiency assessment, and in the case of registered nurses, an exam of nursing knowledge.

The VisaScreen was introduced in 1996 by the U.S. Department of Homeland Security (earlier the Immigration and Naturalization Service) for EB-3 applicants. The authority did not issue rules for the implementation of the screening provision until 1999 when the CGFNS won a lawsuit requiring the rules to be issued. The resulting VisaScreen certificate is issued only after a foreign nurse has demonstrated that his/her education, licence and training are equivalent to the education, licensure and training in the United States, and her level of competence in oral and written English are appropriate to practice professional nursing in the United States. CGFNS is currently the only authorized institutions that can issue VisaScreen certificates and CGFNS International charges $540 for its 'VisaScreen: Visa Credentials Assessment'.[30] Since July 26, 2004, the VisaScreen is also required for nurses who apply for temporary work permits.

4.1.2 Temporary nurse migration: the H-1A and H-1C work permits

In 1989, the U.S. Congress passed the Nursing Relief Act, which created the ***H-1A*** 'non-immigrant category' work permit.[31] It allowed nurses with certain non-immigrant work permits (H-1) to adjust their temporary status to permanent resident status. It also created the H-1A pilot programme specifically for the admission of nurses on a temporary basis.[32] Foreign nurses were issued H-1A work permits between October 1990 and September 1995. A committee report issued in 1995 concluded that relatively few nurses were admitted under the pilot programme and that it had no significant impact on wages and working conditions of U.S. nurses. Several organizations, including the American Nurses Association, had a dissenting opinion to the report.

In 1999, the Nursing Relief for Disadvantaged Areas Act created the ***H-1C*** classification as a short-term solution for nursing shortages in a limited number of medically "underserved" areas. The H-1C was a non-immigrant, employer-sponsored work permit for foreign registered nurses valid for up to three years. The legislation included a sunset date (20/09/2004) which the U.S. Congress extended for three years in the Nursing Relief for Disadvantaged Areas Reauthorization

[30] www.cgfns.org/sections/programmes/vs/.
[31] www.uscis.gov/files/nativedocuments/Nonimmigrants_2006.pdf.
[32] See www.uscis.gov/files/nativedocuments/Nonimmigrants_2006.pdf for more details.

Act of 2005. It expired on December 20, 2009.[33] The H-1C work permit was regulated by quotas both at the national and state level: the annual quota at the national level was 500 and the quota for states with populations in excess of nine million was 50 while the quota for states with populations lower than nine million was 25. The annual quota at the national level represented roughly 0.02 percent of the number of nurses employed in the United States at the time.

The H-1C classification was limited to employment with the specific hospital that filed the petition. Petitioning hospitals had to be based in shortage areas as defined by the Department of Health and Human Services, have at least 190 acute care beds, and specified minimum percentages of Medicare (>35 percent) and Medicaid (>28 percent) patients. The application process for an H-1C non-immigrant visa was a long and cumbersome process that involved a number of government agencies. Due to legal interpretation issues, only fourteen hospitals did initially meet the requirements and this number hardly changed over time (DHS, 2008a).[34]

A Philippine nurse could qualify for the H-1C work permit if the candidate possessed a full and unrestricted nursing license in the country where the nursing education was obtained. The nurse also had to: (i) be authorized by the appropriate U.S. State Board of Nursing to practice within the state; (ii) pass the U.S. National Licensure Examination for registered nurses (NCLEX-RN); and (iii) be fully qualified and eligible under the state laws of the state of intended employment to practice as a nurse immediately upon admission to the United States.[35] In addition, the healthcare facility had to have taken significant initiatives to recruit and retain domestic nurses in order to reduce dependence on immigrant nurses. Approved initiatives included the provision of training, career development programmes and other methods of facilitating health care workers to become nurses, and wages that were 5 percent or higher than the prevailing wage in the region. No more than 33 percent of the nurses employed by the facility could be H-1C holders.

The H-1C quota was never reached due to the severe restrictions associated with the work permit. At its peak, in 2008, 170 foreign nurses, or one-third of the annual quota, obtained the work permit. From a cost-benefit perspective, the effort of negotiating, designing, enacting, administering and monitoring the H-1C work permit programme must have far exceeded prospective benefits. In 2001-2008, the H-1C work permit programme provided an average of 1

[33] www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=fd980b89284a3210VgnVCM100000b92ca60aRCRD&vgnextchannel=fd980b89284a3210VgnVCM100000b92ca60aRCRD

[34] www.visalaw.com/07feb3/2feb307.html

[35] www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=fd980b89284a3210VgnVCM100000b92ca60aRCRD&vgnextchannel=fd980b89284a3210VgnVCM100000b92ca60aRCRD.

work permit per U.S. state and year. This outcome must be considered ineffective since tens of thousands of nurse positions remained unfilled during the same time.

4.1.2 Temporary migration: the H-1B work permit

The temporary work permit that is still being issued to Philippine-educated registered nurses is the ***H-1B***, which is a non-immigrant, employer-sponsored work permit offered to non-U.S. guest workers employed in 'specialty occupations'.[36] There is a quantitative limit to the number of H-1B work permits that can be issued each year and a minimum salary required for H-1B holders. Applicants must possess a bachelor's degree or its equivalent as a minimum and the work permit is valid for an initial three years. It can then be extended for another three years. H-1B petitioning employers must: a) prove that they do not lay off U.S. workers for foreign workers; b) post a notice to hire H-1Bs for at least ten days in the workplace; c) place a job order with the local employment office; and d) advertise in a publication for at least three days.

According to the USCIS, registered nurses who are not specialised or do not possess a higher degree do not qualify for the H-1B work permit. However, certain specialized or advanced practice registered nurse occupations and nurse manager occupations may qualify for the H-1B work permit.[37] The deciding factor is whether the position explicitly requires candidates to hold a bachelor's degree or a higher degree in the state in which the position is open. This is seldom the case in the United States. Qualifying positions may include for example clinical nurse specialists, nurse practitioners, certified registered nurse anaesthetists and certified nurse-midwives. Despite the shortage of registered nurses in the United States, and despite the fact the H-1B is the only option for temporary work; there are few nurses who hold H-1B work permits.

4.1.3 Permanent migration: the EB-3 green card

As the previous sections highlighted, the option of working on a temporary basis as a Philippine nurse in the United States is limited. A permanent option is open because the United States issues ***EB-3*** green cards (a permanent work permit) for employment-based immigration of foreign registered nurses. This is the most common channel for foreign nurses to enter the U.S. market (DHS, 2008a). The EB-3 green card normally requires a permanent, full-time job offer and a Labor Certification from the U.S. Department of Labor. The latter is a form of economic needs

[36] See the Immigration & Nationality Act, section 101(a)(15)(H). A "specialty occupation" requires theoretical and practical application of a body of highly specialized knowledge in a field of human endeavor including, but not limited to, architecture, engineering, mathematics, physical sciences, social sciences, medicine and health, education, law, accounting, business specialties, theology, and the arts.

[37] See www.uscis.gov/files/pressrelease/NurseMemo_112702.pdf.

test (labour market test) and it is waived for registered nurses because the nursing profession is designated as a 'Schedule A' occupation.[38] This designation is a precertification status implying that there is an insufficient number of U.S. nurses who are able, willing, qualified and available, and that the wages and working conditions of U.S. workers similarly employed will not be adversely affected by the employment of foreign nationals.[39]

USCIS requires employers to file forms I-140 and ETA-9089, a wage determination issued by the State Workforce Agency, a copy of the posted notice, copies of all in-house media used for recruitment, a full unrestricted permanent license to practice nursing in the state of intended employment, CGFNS certificate or evidence that the foreign nurse has passed the National Council Licensure Examination for RNs (NCLEX-RN), satisfaction of the English language requirement (US DHS, 2008a) and a filing fee.[40]

On May 12, 2005, the Philippine Overseas Labour Organization (POLO) issued a statement that the U.S. moratorium on the processing of EB-3 work permits in December 2004 had been lifted as part of the American Competitiveness in the 21st Century Act and the recapture of 50,000 unused EB-3 work permits from 2001-2004 for issuance of work permits to 'Schedule A' occupations.[41] Applications from China, India and the Philippines had been targeted as citizens from these nations had large numbers of pending applications. Since 2006 it has become increasingly difficult for nurses to obtain EB-3 work permits as an application backlog has built up as a result of annual quotas being reached (Moira, 2009).

According to the U.S. Department of State's Visa Bulletin for March 2010, the quota for annual employment-based preference immigrants is "at least 140,000". A quota of 40,000, or 28.6 percent of the aggregate level, is dedicated for third preference (EB-3) work permits. Any leftovers from the quota of 80,000 dedicated to first (EB-1) and second (EB-2) preferences may also be issued to the third preference. No more than 7 percent (2,800) of the 40,000 EB-3 work

[38] On the "Schedule A" list RNs are defined as follows: Professional Nurses - the alien (i) has a Commission on Graduates in Foreign Nursing Schools (CGFNS) Certificate, (ii) the alien has passed the National Council Licensure Examination for Registered Nurses (NCLEX—RN) exam, or (iii) the alien holds a full and unrestricted (permanent) license to practice nursing in the state of intended employment.
[39] This pre-certification is limited to "Professional Nurses". "Schedule A" is not available to Licensed Practical Nurses, Nurse Assistants, or other nursing aides. Professional Nursing is defined as a course of study in professional nursing resulting in a diploma, certificate, baccalaureate degree, or associate degree.
[40] www.uscis.gov and Permanent Workers/Employment-Based Immigration: Third Preference EB-3.
[41] POEA Market Update (2005), "Recruitment of Filipino Nurses Under EB-3 Resumes", No.13, Series of 2005.

permits may be issued to nationals of any one country, however, and the quota is an effective limitation on permanent migration.

USCIS approved 343 I-140 'Schedule A' nurse petitions in FY2005, 6,834 in FY2006, and 2,559 in FY2007, which reflected the changing priorities by the U.S. authorities (DHS, 2008a). USCIS noted on March 13, 2009, that the processing time for Schedule A petitions was approximately 15 months but that the waiting time for an EB-3 work permit to become available was 3-7 years. At that time, only Philippine petitions submitted on or before May 1, 2005, were being processed.[42] In March 2010, the Philippines in addition to Mexico, China and India belonged to a group of countries whose nationals had oversubscribed for the EB-3 work permit and the U.S. Department of State was only issuing EB-3 work permits to Philippine applicants whose priority date was December 15, 2002 or earlier. The delay was hardly unique: in January 2005, the U.S. State Department announced that EB-3 work permits would only be available to those nurses whose applications had a priority date of December 31, 2001, or earlier.[43]

In summary: Very few Philippine nurses have been able to move to the United States on a temporary work permit since the expiration of the H-1A work permit in 1995. Movement is predominantly permanent in nature as green cards are issued to Shortage A occupations such as nursing. The ten-year H-1C work permit pilot did not result in any real market access for foreign nurses and only benefited a handful of hospitals. The regulatory restrictions, including work permit quotas and economic needs tests, made it too costly and burdensome to fill any function. Quotas impeded market access for Philippine nurses both for temporary and permanent migration in the United States. The backlog of Philippine applications by nurses for the EB-3 green card has resulted in delays of many years. On the positive side, obtaining a licensure to work as a registered nurse in a U.S. state has become somewhat less burdensome as CGFNS's lost its monopoly to require foreign nurses to pass its pre-screening examination in 2003. It still imposes a costly credentials verification procedures amounting to 2-3 months' gross salary of Philippine nurses. The administration of the NCLEX-RN in Manila has reduced the cost of licensure.

[42] See USCIS (2009), "Memorandum: Response to Recommendation 36, Improving the Processing of "Schedule A" Nurse Visas", March 13, 2009.
[43] www.cgfns.org/files/pdf/hs/2005/hs_winter_05.pdf.

4.2 The United Kingdom

Any nurse wishing to practice in the United Kingdom must be registered at the Nursing and Midwifery Council (NMC).[44] Foreign nurses also need to obtain a work permit and those who are educated outside the European Economic Area (EEA) are required to undertake the Overseas Nursing Programme (ONP). The ONP, which came into effect on September 1, 2005, includes a compulsory 20-day period of protected learning, and when deemed appropriate, a period of supervised practice. The ONP comes with restrictions that in effect impose a quota on the number of nurses educated outside the EEA that can practice in the United Kingdom.

4.2.1 Recognition and professional licensing

The Nursing and Midwifery Council (NMC) regulates the activities of all nurses working in the United Kingdom. NMC's objective is to safeguard the health and wellbeing of the public by maintaining high professional standards of education and conduct for nurses. Foreign nurses can apply for registration at NMC from abroad for a fee of £140. If the NMC rules that the applicant's education and professional credentials meet its minimum standards, the applicant is allowed to apply to the Overseas Nurses Programme (ONP), which assesses the nurse's ability to practise in the UK healthcare sector. Each applicant is assessed on an individual basis, taking into account the applicant's training.

The education and professional credentials required to join the register cover education, practice and language. On education, the nurse must have successfully completed at least ten years of school education before starting a post-secondary education nursing programme, leading to registration in the home country, as a first level registered nurse. On practice, the nurse must have practised as a registered nurse for at least 12 months and also have practised for at least 450 hours in the previous three years if employed for more than 12 months. On language, the nurse must demonstrate sufficient English proficiency by scoring 7 out of 9 on the listening and reading section and 7 out of 9 on the writing and speaking section of the International English Language Test (IELTS).

The mandatory ONP then consists of two core components: a 20-day learning module and a 3-12 months adaptation period of supervised practice (clinical placement). The learning module is focusing on the practice of nursing in the United Kingdom, covering classes on the structure of the UK healthcare system, the legal system, health and safety issues, record-keeping, drugs

[44] See www.nmc-uk.org/aDisplayDocument.aspx?documentID=4649 and www.rcn.org.uk/__data/assets/pdf_file/0006/163509/UKemp.January.2010.pdf

administration, and the NMC Code of Professional Conduct. The NMC sets standards for the length and content of the programme. Foreign nurses with education and practice experiences that closely match UK requirements for entry to the Register may only have to take the 20-day learning module. Most Philippine nurses, however, are also required to take part in 3-6 months of supervised practice. Those nurses who successfully complete the ONP and meet the NMC requirements of good health and good character are then allowed to join the NMC register.[45]

The 3-12 months of clinical placement has to be evaluated and certified by a higher education institution delivering pre-registration and post-registration programmes. The ratio of nurses to supervisors in these clinical placements must not exceed a pre-determined maximum. According to Kingma (2006), clinical placements and adaptation programmes are in short supply and this shortage has led to a market where independent agencies identify a clinical placement programme to foreign nurses for a fee. If an adaptation period is required, nurses have two years to undertake the supervised clinical placement and get the supervisor's approval. The foreign nurses work as lower paid nursing auxiliaries until they get registered by NMC.

NMC's decisions indirectly influence the number of foreign nurses that can work in the United Kingdom (Bach, 2007). For example, in 2004-05, NMC received 37,063 applications but registered less than one-third of this number. The most frequent decision was that the applicant had to undertake 3-6 months of clinical placement. The time-consuming process resulting from backlogs in registration is discouraging. Bach (2007) referred to estimates indicating that only 1,500 ONP-accredited clinical placements are made available each year and the Recruitment and Employment Confederation, a trade association of the private sector recruitment industry, criticised the establishment of the ONP and argued that it would *"have an enormous impact on nurse recruitment from overseas"*. Indeed, as Figure 12 showed, the recruitment of Philippine nurses through POEA-certified channels has collapsed. The data on initial admissions of Philippine nurses to the NMC register also indicate that overall movement collapsed.

4.2.2 Temporary migration: the Tier 2 work permit

Foreign nurses, once registered with the NMC, need to meet the conditions set by Work Permits UK in order to secure a work permit. Foreign nurses enter the United Kingdom under the 'Tier 2

[45] Registration is renewed every three years and on each occasion, evidence of continued professional development must be provided. This standard requires the applicant to demonstrate 450 hours of practice activity and undertake a minimum of 35 hours of learning activity relevant to the practice during the three years prior to the renewal of registration. This continuing professional development is known as 'post-registration education and practice' and is the professional standard set by the NMC.

General' category of the Points Based System implemented on November 26, 2008. This Tier 2 General work permit is for external transferees entering the United Kingdom with a skilled job offer to "fill a gap in the workforce that cannot be filled by a settled worker". According to the Royal College of Nursing, a UK employer wishing to employ a registered nurse from the Philippines needs to be licensed as a Sponsor of Overseas Workers with the UK Border Agency.[46] The fee for the application is £270 for applications from the Philippines and £470-£730 for applications from within the United Kingdom.[47]

The restrictiveness of the rules that cover the recruitment depends on whether the nurse's professional background is classified as a shortage occupation or not. Some nurse specialisations are listed on the government-approved 'UK National Shortage Occupation List'.[48] On March 1, 2010, this list included nurses working in operating theatres, operating department practitioners and specialist nurses working in neonatal intensive care units.[49] Employers can offer a job to foreign nurses on the shortage occupation list without having first to fulfil the 'resident labour market test'. Employers who seek to sponsor a nurse whose expertise is not part of the shortage list must comply with the test by demonstrating that it advertised the job at home but failed to find a suitable settled worker. The employer can then offer a foreign nurse a certificate of sponsorship.

Next to the job offer from a sponsoring employer, the nurse is assessed by the UK authorities and awarded points. These points are based on qualifications, future expected earnings, sponsorship, English language skills (unless the stay is for three years or less) and available maintenance (funds). External transferees are allowed to work in the UK for a maximum time of three years plus one month (extendable up to two years). A nurse, or skilled worker, must score a minimum total of 70 points under the terms of Tier 2 General.[50] They must first meet the maintenance requirements (worth 10 points) and the English language requirement (worth 10 points) in addition to scoring 50 points from a possible total of 85 for the other attributes.

- ✓ ***Maintenance:*** the nurse either need the sponsor to be A-rated and certify that it will maintain and accommodate the nurse if necessary for the first month of employment or

[46] www.rcn.org.uk/__data/assets/pdf_file/0006/163509/ukemp.january.2010.pdf
[47] www.ukba.homeoffice.gov.uk/workingintheuk/tier2/general/cost/
[48] www.ukba.homeoffice.gov.uk/employers/points/sponsoringmigrants/employingmigrants/shortageoccupationlist/.
[49] www.ukba.homeoffice.gov.uk/sitecontent/documents/employersandsponsors/pointsbasedsystem/sectionqcodeofpractice.pdf
[50] www.workpermit.com/uk/uk-immigration-tier-system/tier-2-skilled-migrants-test.htm

the nurse must provide documents showing that he/she had at least £800 in a private account at all times over the three-month period before the application (10 points);

- ✓ ***English language:*** the nurse needs to either pass an English language exam or have a degree that was taught in English and approved by UK authorities (10 points);
- ✓ ***Sponsorship:*** the nurse needs to have a job offer and a valid Certificate of Sponsorship from the prospective employer. The nurse gets 50 points if the job is on the Shortage Occupation List and 30 points if the job is not on the Shortage Occupation List;
- ✓ ***Academic qualifications:*** The nurse gets 15 points for a PhD, 10 points for a Bachelor or Master degrees, and 5 points for GCE A level or equivalent. Philippine nurses hold B.Sc. in Nursing degrees and therefore obtain 10 points;
- ✓ ***Prospective Earnings:*** The nurse gets 20 points if the annual earnings specified in the Certificate of Sponsorship equals >£32,000, 15 points for £28,000-£31,999, 10 points for £24,000-£27,999, and 5 points for £20,000-£23,999. According to the NHS Pay Rates[51] of April 1, 2010, less experienced nurses would score 5 points and more experienced would score 10 points. Specialised nurses normally score 10-15 points.

Assuming that the nurse holds a B.Sc. in Nursing from an approved academic institution, has received a job offer from a UK hospital, has passed the English language test and either has £800 of savings since three months or has the employer covering the maintenance requirement, the points qualification hinges on the prospective earnings. This requirement is in effect a form of minimum wage for foreign nurses. Since November 26, 2008, a nurse needs to have an offer of a minimum monthly wage of £2,000 to score 10 points and reach the minimum total of 50 points (unless it is a shortage occupation).

The average wage information provided by POEA for UK-bound nurses in 2007 indicates that the average POEA-certified contract ($1,942/month) was quite some way from this level—in particular as the US$ has been weak compared to the GB£ for some time. The new Points Based System is therefore likely to have raised the minimum qualification levels of Philippine nurses. While the decline in Philippine exports of nurses to the United Kingdom started long before the new system was implemented, the data for 2008-09 (Figure 12) illustrate how this system effectively put an end to this trade flow. The cause and effect is not clear but the analysis of the

[51] www.nhscareers.nhs.uk/details/Default.aspx?Id=766

requirements above show that even if demand were to increase in the future, only highly experienced Philippine nurses would qualify for a Tier 2 General work permit.

In summary: The UK market may not be as difficult to enter as the U.S. market from a licensing and work permit point of view, but neither are the economic incentives to work there as high. The Overseas Nurses Programme with supervised clinical placement is less of a direct barrier than the requirement for foreign nurses to pass a host country licensure exam. It puts faith, however, in an objective assessment by a domestic nurse of the performance of a foreign nurse. This leaves a lot of discretion in the process because a domestic supervisor who may be indirectly competing for the same position can effectively block the entrance of the foreign nurse. There are also indications that the system has capacity limitations to assess foreign nurses. The Points Based System that qualifies skilled workers for temporary work permits is setting a high minimum wage rate that is an effective barrier to younger nurses or nurses without specialised skills.

4.3 Saudi Arabia

Saudi Arabia is by far the largest importer of Philippine nurses through POEA-certified recruitment channels. The financial incentives are not as big as in most other client countries but Philippine nurses keep moving to the GCC area in general and Saudi Arabia in particular due to high demand and the relative ease with which they can enter these healthcare markets. It is often the first stop for Philippine nurses who seek to move up the international value chain.

A foreign nurse who seeks employment in Saudi Arabia must comply with a number of requirements.[52] Before arriving in Saudi Arabia, the nurse needs to obtain a work contract from an employer. The legal advice offered by the POEA is important here since only work contracts written in Arabic are considered as legally binding. The nurse also needs a work permit which can be issued by the Labour Offices at the Ministry of Labour if the nurse: (i) has entered the country legally; (ii) has contracted with a Saudi employer or with an authorized non-Saudi employer under the Investment Law; (iii) holds education qualifications required by the state; (iv) holds a valid passport for at least six months; and (v) is physically fit and not suffering from any diseases as proven by a medical report. The nurse then needs to obtain a resident permit from the Directorate General for Passports.

[52] See www.saudiembassy.net/files/PDF/Information_for_Migrant_coming_to_work_in_Saudi_Arabia.pdf.

Finally, while Saudi authorities until recently required Philippine nurses to have completed a B.Sc. in Nursing degree and passed the NLE in order to work in the country[53], the Saudi Commission for Health Specialties (SCFHS) now mandates all non-Saudi nurses to pass the Saudi Licensing Examination for Health Specialties before working in the country (as announced by POEA on November 22, 2009).[54] The exam is administered four days per week. The certificate is issued by the accredited testing centres of Prometric Testing Center and the fee for the certificate is $90. The merits of the Prometric examination are not clear since the licensure examination will be similar to the Philippine licensure examination according to the POEA.

Job announcements posted on the POEA website for employment opportunities in Saudi Arabia generally require applicants to have three years of relevant work experience. Nurses face a probation period of three months from the date they start working. Work is only allowed for the recruiting employer unless formal procedures are followed and nurses are not allowed to engage in any profession other than the one registered in the work permit. The employer is required to cover the costs of medical care for the nurse according to the Labour Law and the rules of the Ministry of Labour.

In addition, work permits are issued for one or two years and they are renewable. The employer is obligated to cover the fees for nurse's entry visa in addition to the fees for resident permit, work permit and transferring the worker's services in relation to work. The employer must also cover the fees for issuing an exit and return visa. Saudi recruitment agencies can charge a service fees to employers but are by law not allowed to demand any recruitment fee from foreign nurses.

In summary: The Saudi market has traditionally been the easiest to enter for Philippine nurses. The economic incentives have also been rather low compared to many other foreign client countries. Up until the end of 2009, Philippine nurses would fulfil minimum criteria to work in Saudi Arabia as long as they passed the NLE in the Philippines. Many hospitals also demanded a few years of work experience although this was not a strict requirement. The effect of the new Saudi Licensing Examination for Health Specialties on Philippine nurse migration to Saudi Arabia is not yet clear but initial indications are that the test will be inexpensive, frequently administered and not too different from what is required from the NLE. This could potentially

[53] Muslim nurses in particular from Mindanao are not always required to have passed the NLE due to labour shortages and preferences for Muslim guest workers. See www.poea.gov.ph/news/2007/PR-Jul2007_nurses_moh.pdf.
[54] www.poea.gov.ph/advisory/adv2009.htm

change in future but there are no indications that Saudi Arabia would seek to make it unnecessarily difficult for foreign nurses to work in the country.

4.4 Inventory of regulatory restrictions impeding nurse migration

The previous sections provided a detailed overview of the regulations and restrictions that affect the migration of Philippine registered nurses to the United States, the United Kingdom and Saudi Arabia. Tables 9-11 summarises these restrictions in an inventory for the various work permit channels available to nurses who seek temporary work abroad. It is based on the taxonomy developed in Engman (2009) and adjusted to include the restrictions associated with the nurse profession. It includes issues that were raised in the literature and during interviews with trade, labour and migration experts in the Philippines. The columns in the tables are divided into the type of restriction, the type of work permit used (for the United States), an assessment of the restrictiveness of the measure, and the direct effect of the measure.

The restrictions are divided into: (i) quantitative restrictions and prohibitions, including work permit quotas and economic needs test requirements; (ii) work permit/visa regulation, covering the criteria that a work permit applicant and the sending company must fulfil, and the rules and regulations they must conform to in the host country; and (iii) consular and visa processing services, covering issues that a service provider faces at the consulate or public authority of the host country. The issues are mainly related to the capacity, transparency, professionalism and efficiency of the consulates or public authorities offering business and work visa services.

The assessment of the 'restrictiveness' is a measure of the degree of concern based on the author's interpretation of current legislation and its implementation as well as objective performance criteria and input by experts. It includes minor (non-critical issue), moderate (potentially a critical issue) and major (frequently a critical issue). The 'effect' identifies the impact that the restriction has on the recruiting client and the migrating nurse. The effects are divided into productivity implications (adversely affecting the allocation of human capital by the employer); cost implications (raises the cost of service delivery); remuneration implications (lowering the prospective income of the transferee); and risk implications (raising uncertainty about the transaction). While these effects are not necessarily mutually exclusive since they do not identify the cause and the effect, they still identify the immediate effect and are therefore useful for the way we may think about the restrictions.

Quantitative restrictions and prohibitions

The tables and preceding analysis show that United States maintains a stringent quota system for the issuing of temporary (and permanent) work permits. It effectively impedes healthcare institutions from filling open positions with foreign nurses. It is also a cause of uncertainty in the application process since the quotas are operated either on a first-come-first-served basis (EB-3) or through a lottery (H-1B). The economic needs test has a similar effect: if authorities deem that a healthcare institution cannot convincingly document that they were unable to recruit domestic nurses, they do not issue a work permit. If nursing is listed as a shortage occupation—as in the United States and for some specialisations in the United Kingdom—this process is waived, reducing documentation and time. The quantitative restrictions and prohibitions make it particularly challenging for hospitals and healthcare clinics to plan ahead and effectively allocate their human resources, thereby reducing labour productivity.

Work permit/visa regulations

The nurse profession is highly regulated. All three client countries require that foreign nurses first obtain a license to practice as a registered nurse in the client country. The licensing procedure covers potential issues of non-recognition of qualifications, accreditation of work experience and communication skills, and written or practical licensure examinations. Registered nurses in the Philippines all hold B.Sc. degrees that are recognised in all main Anglophone client countries. Many countries do not require its registered nurses to hold a Bachelor degree and this is a comparative advantage of Philippine nurses.

In the United States and Saudi Arabia, foreign nurses must pass the national nurse licensure examination. The licensure exam is an objective measure that is required by nationals as well as non-nationals. The Saudi licensure exam is inexpensive, conveniently organised four times per week, and reputedly not very different from the Philippine licensure exam. In the United States, the licensure exam is costlier, administered infrequently and only valid in a single state. The U.S. accreditation process and pre-screening exam for foreign nurses is administered by an external regulatory body. The pre-screening test, when mandatory, was an unnecessary and costly barrier that effectively shut out many foreign candidates. In the United Kingdom, the licensing process is often lengthy and is based on supervised practice rather than a written test. There are concerns about the discretion of the individual supervisor who act as gatekeeper and the stringent rules affecting the capacity of the country to offer clinical placements. The latter may have the effect of an indirect quota limitation.

Many of the other work permit/visa regulations are rather straightforward to comply with and do not directly impede market entry. Some impose unnecessary costs (social security contributions, minimum wage requirements) while others impose unnecessary rigidities (limitations on mobility, spatial restrictions). The UK points based system that regulates temporary movement of nurses is a transparent if yet restrictive qualification system since the required minimum earnings effectively prohibits less experienced nurses without specialisation. The U.S. system in which states generally do not require nurses to hold a B.Sc. degree effectively shuts out most registered nurses from the Philippines to work in the country on a temporary (H-1B) basis.

Consular and visa processing services

While the consular and visa processing services in Saudi Arabia and the UK are rather efficient—none of the nursing representatives in the Philippines raised any concerns about the consular services in these countries—the consular and visa processing services in the United States are prohibitively slow. The time-consuming process can partly be explained by the work permit quotas that are imposed and the backlogs these tend to generate. It may also be a reflection of the somewhat ambivalent attitude that U.S. authorities have adapted towards labour migration, with frequent modifications in particular to addressing shortages of nurses. For example, the latest initiative, the proposed new Nurse Relief Act introduced in the House of Representatives – HR 1001, would introduce a new non-immigrant W work permit category for nurses with an annual quota of 50,000. The chances of the proposed Act being enacted is seemingly slim.

The delays and the unpredictable nature of the processing of the work permit can have severe productivity implications for the employer. The recruitment of Philippine nurses is largely a result of domestic shortages of nurses and a lengthy and uncertain recruitment process result in labour allocation inefficiencies and high recruitment costs. It also reduces the capacity of hospitals and healthcare clinics in particular in rural areas and inner cities with economically disadvantaged groups. By extension, it also lowers the quality of healthcare.

Table 9. U.S. restrictions to inward movement of registered nurses from the Philippines

TYPE OF RESTRICTION	H-1B RESTRICTIVENESS	H-1C RESTRICTIVNESS	EB-3 RESTRIVENESS	EFFECT: ON CLIENT	EFFECT: ON TRANSFEREE
I. QUANTITATIVE RESTRICTIONS AND PROHIBITIONS					
- Work permit quota	Major	Major	Major	Productivity & risk implications	Risk implications
- Economic needs test	n.a.*	Major	None**	Productivity implications	Risk implications
II. WORK PERMIT/VISA REGULATION					
- Licensing requirement	Major	Major	Major	..	Cost and risk implications
- Accreditation requirement	Moderate	Moderate	Moderate	..	Cost and risk implications
- Minimum wages / wage parity requirement	Minor	Minor	Minor	Cost implications	Remuneration implications
- Spatial restrictions	n.a.	Major	n.a.	Productivity implications	..
- Transferability and mobility	Minor	Minor	n.a.	..	Remuneration implications
- Discriminatory tax treatment	Minor	Minor	n.a.	..	Remuneration implications
- Limitation on duration of stay	Minor	Minor	n.a.	Productivity implications	..
- Education/work experience requirement	Major	Minor	Minor	..	..
III. CONSULAR AND VISA PROCESSING SERVICES					
- Documentation requirement	Moderate	Moderate	Moderate	Cost implications	Cost implications
- Processing time	Major	Major	Major	Productivity implications	Risk implications
- Transparency and predictability	Major	Major	Major	Productivity & risk implications	Risk implications
- Application and issuance fees	Moderate	Moderate	Moderate	Cost applications	Cost implications

Note: n.a. = not applicable; * = Economic needs test only holds for companies classified as H-1B dependent and very few nurses more on H-1B, ** Nurses are designated as a "Schedule A" occupation and the econ

Source: U.S. Department of Homeland Security, input from nurse experts in the Philippines, author's assessment.

TYPE OF RESTRICTION	RESTRICTIVENESS	EFFECT: ON CLIENT COMPANY	EFFECT: ON TRANSFEREE
I. WORK PERMIT/VISA REGULATION			
- Licensing requirement	Minor / Moderate*	..	Cost and risk implications
- Minimum wages / wage parity requirement	Minor	Cost implications	Remuneration implications
- Transferability and mobility	Minor	..	Remuneration implications
- Limitation on duration of stay	Minor	Productivity implications	..
- Education/work experience requirement	Minor	..	..

Table 10. Saudi restrictions to temporary inward movement of registered nurses from the Philippines

II. CONSULAR AND VISA PROCESSING SERVICES			
- Documentation requirement	Minor	Cost implications	Cost implications
- Processing time	Minor	Productivity implications	Risk implications
- Transparency and predictability	Minor	Productivity & risk implications	Risk implications
- Application and issuance fees	Minor	Cost applications	Cost implications

Note: n.a. = not applicable, * the Saudi licensing requirement was announced in December 2009. First impression by POEA was that it would not be much of a barrier.

Source: Saudi Embassy communication, interviews with nurse experts, author's assessment.

Table 11. UK restrictions to temporary inward movement of registered nurses from the Philippines (Skilled worker category: Tier 2 general)

TYPE OF RESTRICTION	RESTRICTIVENESS	EFFECT: ON CLIENT COMPANY	EFFECT: ON TRANSFEREE
I. QUANTITATIVE RESTRICTIONS AND PROHIBITIONS			
PS: Sponsorship (*resident labour market test*)	n.a.* / Moderate	Productivity implications	Risk implications
II. WORK PERMIT/VISA REGULATION			
PS: Qualifications	Minor	..	..
PS: Future expected earnings	Major	Cost implications	Remuneration implications
PS: English language skills	Minor	..	..
PS: Available maintenance	Minor	..	..
- Licensing requirement	Major	..	Cost and risk implications
- Transferability and mobility	Minor	..	Remuneration implications
- Limitation on duration of stay	Minor	Productivity implications	..
III. CONSULAR AND VISA PROCESSING SERVICES			
- Documentation requirement	Minor	Cost implications	Cost implications
- Processing time	Moderate	Productivity implications	Risk implications
- Transparency and predictability	Minor	Productivity & risk implications	Risk implications
- Application and issuance fees	Minor	Cost applications	Cost implications

Note: PS = Points System; n.a. = not applicable., * for those specialisations that are on the shortage list.

Source: UK Home Office (2008a-b), author's assessment.

4.4 Commitments on Mode 4 trade in the General Agreement on Trade in Services

Liberalisation of health services in the GATS has so far been modest. Less than two-fifths of WTO members made any specific commitments on health in the Uruguay Round (Adlung and Carzaniga, 2002). Only education services received less coverage. Health services are subject to government control in most countries and many health ministries and health-related associations have been concerned that trade liberalisation could put the quality of the provision of basic health services at risk. The opportunity that trade liberalisation would entail for reform and the realisation of efficiency gains was generally a secondary consideration during the Uruguay Round negotiations. However, the non-scheduling of a sector or a non-commitment on a particular mode does not imply that the sector is beyond GATS disciplines: basic obligations such as the most-favoured-nation and national treatment principles still apply.

Table 12 provides an overview of the commitments that had been made on health services in the WTO by July 2000. Next to Taiwan, which joined the WTO in 2002, none of the small economies that joined the WTO post-July 2000 imports Philippine nurses. The commitments below are therefore as relevant today as they were in 2000. The sub-sector of 'nurses, midwives, etc' had received commitments by 29 members, which was significantly less than medical and dental services (54 members) and hospital services (44 members). A comparison across all schedules and sectors reveals that trading conditions are considerably more restrictive for Mode 4 than for Modes 1-3. No WTO member undertook full commitments in Mode 4 for any of the sub-sectors and the partial commitments are still subject to limitations that often are highly restrictive.[55]

Of the four modes of supply, Mode 4 received the highest share of partial or limited commitments. Most of these partial or limited commitments are horizontal. Some of the developed countries limited their Mode 3 commitments to natural persons, thus reserving the right to restrict the commercial incorporation of foreign health care providers. Frequent market access limitations scheduled under Mode 4 concern quantitative restrictions, mainly setting a ceiling on numbers of foreign employees or denying access to all persons not considered to be specialist doctors, etc. Typical national treatment limitations under Mode 4 relate to training and language requirements. Economic needs tests have also been frequently referred to under Mode 4 and few members have indicated the relevant criteria underlying such tests. In addition, a

[55] Partial commitments on market access include commitments that carry any of the six limitations specified in Article XVI:2 of GATS as well as commitments subject to limitations in sectoral coverage (e.g. exclusions of small hospitals or public sector entities) or geographical coverage within the member's territory, and any measures scheduled in the relevant column (including domestic regulatory measures for which Article VI might have provided legal cover). Similarly, partial commitments recorded under national treatment include cases overscheduling or misinterpretations.

relatively large number of Mode 4 commitments are limited to trainees or intra-corporate transferees, which also effectively excludes Philippine nurses.

Table 12. Number of WTO members with commitments in health services, July 2000

			Medical & dental services	Nurses, midwives, etc.	Hospital services	Other human health services
TOTAL OF			**54**	**29**	**44**	**17**
MARKET ACCESS	**Mode 1**	Full	16 (-2)	8 (-1)	15	8
		Partial	11	4	0	2
		Unbound	27	17	29	7
	Mode 2	Full	28 (-3)	10 (-1)	38	10
		Partial	24	19	4	6
		Unbound	2	0	2	1
	Mode 3	Full	15 (-7)	6 (-2)	16 (-7)	10 (-4)
		Partial	33	22	26	7
		Unbound	6	1	2	0
	Mode 4	Full	0	0	0	0
		Partial	49	28	41	12
		Unbound	5	1	3	0
NATIONAL TREATMENT	**Mode 1**	Full	19	8 (-1)	18 (-2)	10 (-2)
		Partial	9	4	0	1
		Unbound	26	17	26	6
	Mode 2	Full	28 (-2)	10 (-1)	38 (-3)	11 (-3)
		Partial	22	19	4	5
		Unbound	4	0	2	1
	Mode 3	Full	18 (-1)	9 (-1)	31 (-25)	9 (-6)
		Partial	31	19	10	7
		Unbound	5	1	3	1
	Mode 4	Full	1	0	2 (-1)	0
		Partial	49	28	39	17
		Unbound	4	1	3	0

Note: (i) Figures in parentheses are the reduced number of full commitments if horisontal limitations, which apply to all sectors contained in the individual country schedules, are taken into account. (ii) EU member states are counted individually.

Source: Adlung and Carzaniga (2002).

From an economic development point of view, many developing countries are competitive exporters of health services, in particular through Mode 2 and Mode 4. Concerns have been raised that health services liberalisation may have distributional effects that would need to be addressed to protect the economically disadvantaged. Yet GATS does not impose any constraints on the terms and conditions under which a

potential host country treats foreign patients (Adlung and Carzaniga, 2002). There are no legal impediments in GATS that would affect the ability of governments to discourage qualified staff from seeking employment in the private sector, whether at home or abroad. And Mode 3 liberalisation combined with foreign countries' commitments under Mode 2 may help to create domestic employment opportunities that could help dissuade nurses from moving abroad.

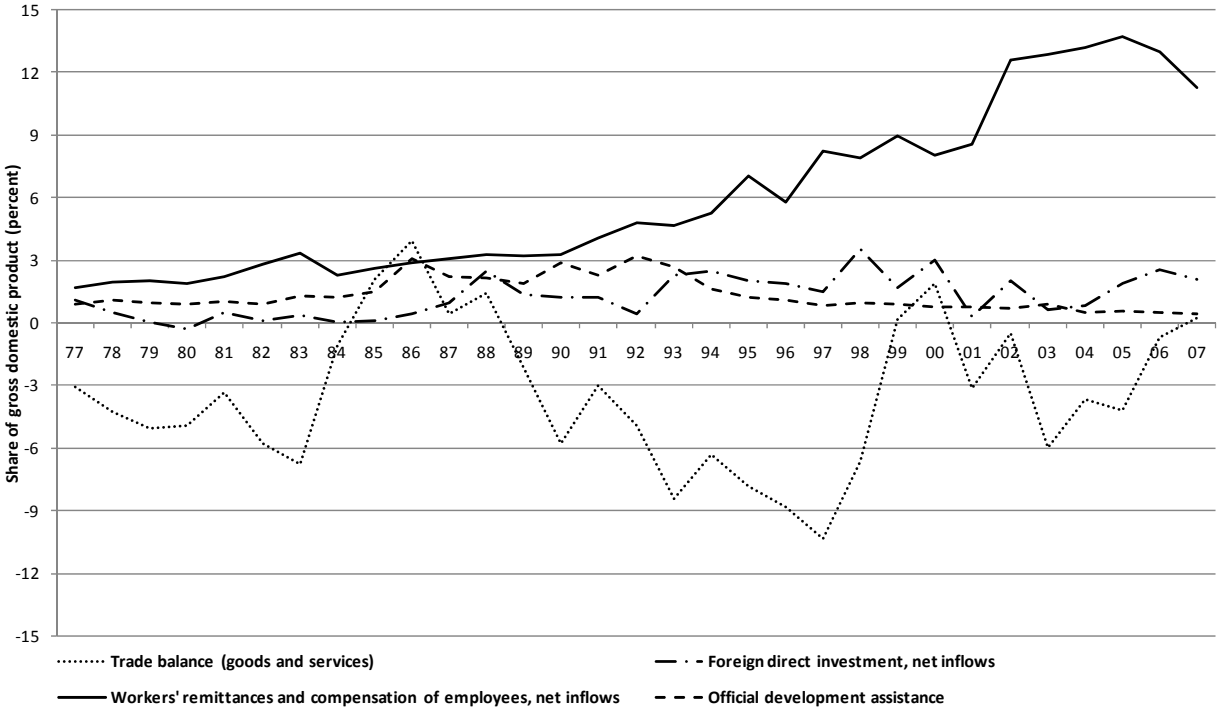
5. THE ECONOMIC IMPACT OF THE EXPORTS OF PHILIPPINE NURSES

The main gains of Mode 4 exports are linked to the remitted savings that are used for consumption and investment in the Philippines. The country's dependency on foreign remittances, including from nurses, has grown rather rapidly as a share of gross domestic product (GDP) in the last thirty years. As Figure 13 illustrates, 'workers' remittances and compensation of employees' (net flows) as a share of GDP increased from less than 2 percent in 1980 to some 13 percent in 2004-2006, before falling back somewhat mainly due to the appreciation of the Philippine Peso.

Dilip Ratha at the World Bank has noted that inflow of remittances to the Philippines increased by nearly 50 percent between 2004 and 2007 and that a big reason for this increase was to preserve the purchasing power of recipients, since the Philippine peso appreciated by 33 percent against the U.S dollar. Remittances dwarf the net inflows of foreign direct investment (FDI) and official development assistance (ODA). Net inflows of FDI as a share of GDP fluctuated between 0 and 3.5 percent in 1977-2007 and averaged 1.6 percent in the 2000s. ODA as a share of GDP has declined steadily since the beginning of the 1990s and reached 0.4 percent in 2007. Remittances help to finance the country's frequent trade deficit and the foreign exchange is used to service the country's foreign debt.

The real amount of remittances is higher than the formal data recorded in the IMF Balance of Payments indicate in Figure 13. Burgess and Haksar (2005) analysed survey data for 1995-2002 and showed that the Philippine remittances that were transferred and reported in the banking system made up only 70 percent of total remittances. Most of the remaining 30 percent were made up of foreign currency carried in person across the border. Some remittances were also brought in kind. If the survey findings by Burgess and Haksar hold at the national level, net inflows of workers' remittances and compensation of employees in 2002-2008, of 11.2 percent to 13.7 percent, may have been between 16.0 percent and 19.6 percent.

Figure 13. Trade, remittances, FDI and overseas development assistance, 1977-2007



Source: World Bank Human Development Indicators (2010), author's calculations.

According to Semyonov and Gorodzeisky (2005), male and female overseas Philippine workers remit an estimated 60 percent and 45 percent respectively of monthly foreign income. A survey of Philippine nurses in London also found that more than 75 percent of the nurses regularly remitted savings to the Philippines (Buchan et al. 2005). Fifty percent of the nurses remitted 26 percent or more of their income. As the earlier section on economic incentives indicated, the average wage for Philippine nurses in the United Kingdom is relatively low and living expenses in London are high. The finding that three-fourths of the nurses regularly remitted savings back home is perhaps surprising given the fact that quite a few Philippine nurses in the United Kingdom have worked in the country for a very long time and can be considered permanent migrants.

In general, foreign workers tend to remit a lower share of their savings the longer they stay abroad, in particular if the worker's family is based in the same location as the worker. It is likely that Philippine nurses who work abroad are among the skilled categories that would have strong incentives to remit a relatively high proportion of their savings. A survey conducted by Van Eyck (2004) found that two-fifths of Philippine nurses were their families' primary breadwinners and three-fifths of them were earning less than the prevailing poverty threshold income in the Philippines. The responsibility was even greater for

Philippine nurses below the age of 40 since more than four-fifths were earning less than the prevailing poverty threshold income at home.

5.1 What is the likely amount of savings that Philippine nurses remit?

Based on the data on recruitment of registered nurses through formal, POEA-certified recruitment agencies, and the average wage data for 2008 on the country level, it is possible to estimate the flow of remittances for 2008. It requires a few basic assumptions. First, the purpose of this paper is to focus on temporary movement and let us concentrate on nurses that moved abroad in the last three years. This ought to be reasonable since most initial contracts are valid for 2-3 years. The two-year contract is most common in the GCC region while the more lucrative contracts in OECD economies—entailing higher potential savings—are generally for three years. Most contracts are renewable for another 2-3 years but let us ignore this group of renewed contracts for the time being.

Second, let us assume that recruitment is taking place evenly throughout the year and that nurses remit their savings on a monthly basis. Since the estimate is for remittances received in 2008, this implies that we are focusing on nurses who moved abroad between January 2005 and December 2008. For example, a nurse who moved abroad and started working in January 2005 could remit the savings from one month's worth of his/her salary in January 2008 before his/her contract expired. In aggregate, this implies that the remittances received from these nurses for 2008 covered half of the nurses who moved abroad in 2005 and 2008, and all of the nurses who moved abroad in 2006 and 2007.

As Table 13 shows, some 28,474 nurses were recruited abroad through formal recruitment channels during this period and the average incomes for 2008 as recorded by the POEA indicate that these nurses earned a total of $371 million in the host countries. The table also includes three different scenarios where the nurses remit 25 percent, 35 percent and 50 percent of their salaries. Empirical research shows that labour migrants in general remit more the shorter time they have stayed abroad. It is therefore reasonable to assume that nurses who work on a temporary basis abroad remit most of their savings after income tax and living expenses. A study of Caribbean nurses found that 83 percent of the nurses sent remittances home to their families and 26 percent were able to transfer more than half of their earnings (Brown, 1997). This would be in line with the findings of Semyonov and Gorodzeisky (2005) mentioned above and imply that nurses working temporarily on POEA-certified contracts may have remitted around $130-$185 million in 2008 (somewhere in between the 35 percent and 50 percent scenarios).

Table 13. Estimates of remittances received from nurses working temporary abroad in 2008

		# nurses on temporary contracts	Average annual salary in 2008	Total income (million)	25% scenario (million)	35% scenario (million)	50% scenario (million)
Formal movement	Saudi Arabia	19,253	$7,343	$141.4	$35.3	$49.5	$70.7
	UK	470	$23,304	$11.0	$2.7	$3.8	$5.5
	USA	1,574	$68,665	$108.1	$27.0	$37.8	$54.0
	UAE	1,981	$13,959	$27.7	$6.9	$9.7	$13.8
	Singapore	770	$10,419	$8.0	$2.0	$2.8	$4.0
	Ireland	542	$34,800	$18.9	$4.7	$6.6	$9.4
	Kuwait	1,073	$9,600	$10.3	$2.6	$3.6	$5.1
	Qatar	544	$10,278	$5.6	$1.4	$2.0	$2.8
	Taiwan	741	$6,596	$4.9	$1.2	$1.7	$2.4
	Other	1,527	$23,016	$35.1	$8.8	$12.3	$17.6
	Total formal	*28,474*	*$13,024*	*$370.9*	*$92.7*	*$129.8*	*$185.4*
Informal movement	UK*	1,711	$23,304	$39.9	$10.0	$14.0	$19.9
	USA*	13,381	$68,665	$918.8	$229.7	$321.6	$459.4
	Other*	13,382	$13,024	$174.3	$43.6	$61.0	$87.1
	Total informal*	*28,474*	*$39,789*	*$1,133.0*	*$283.2*	*$396.5*	*$566.5*

Source: Author's estimates based on POEA data sources and assumptions.

As the previous analysis showed, Philippine nurses move to a large extent through informal, non-POEA certified recruitment channels in particular to countries in North America. For example, in 2004, less than 5 percent of nurses moved to the United States through POEA-certified recruitment channels. The lower part of Table 13 presents estimates of informal movement and it is based on some assumptions. First, it includes all those Philippine nurses who joined the nurse registry of the NMC in the United Kingdom and who did not move through POEA-certified recruitment channels. Second, for the sake of simplicity, it was also assumed that there were as many nurses who moved through formal channels as through informal channels. This assumption is in line with POEA's estimate that around 47 percent of Philippine labour migrants move through formal channels. Finally, it was also assumed that as many nurses moved to the United States as to other countries else than the United States and the United Kingdom.

These assumptions would imply that an additional 28,474 nurses recruited through informal channels and working on a temporary basis earned another $1,133 million in 2008. The significantly higher earnings for the informal channel are due to the significantly higher earning power for nurses in the United States than in the GCC region, and in particular Saudi Arabia. As previously discussed, Philippine nurses who work in the United States have to a very large extent been limited to movement on green cards. These work permits are permanent in nature and the nurse could, if he or she wanted, remain beyond the three years, and bring a spouse and children along. It may therefore be reasonable to assume that the nurse would remit a somewhat lower share of income although the first years of foreign service may be used to

compensate the parents' investment in the nurse's education. Thus, if real remittances are around the 35 percent scenario for the United states and 35-50 percent in the other countries, some $400-$430 million would have been remitted in 2008 from nurses who moved abroad through informal recruitment channels to work temporarily abroad. In total, including formal and informal movement, Philippine nurses working temporarily abroad may have remitted around $530-$615 million in 2008.

The remittances of all Philippine nurses who work abroad is significantly higher since several tens of thousands of nurses are based abroad on a permanent basis or are working abroad on a second, third or fourth contract. Many of these nurses are based in North America where earnings are significantly higher than in the GCC and the EU regions. Permanent migrants tend to remit less than temporary migrants since they are investing in their lives at the new location and therefore send less to their parents, siblings, etc. If, for example, there are an additional 100,000 Philippine registered nurses based abroad—in reality the number is most certainly higher—and they remit on average some $5,000 per year, the resulting inflow for 2008 would be $500 million.

This amount would be significantly less than 10 percent of a nurse salary in the United States but around 30-50 percent in the GCC. Taken together, nurses working on a temporary and permanent basis abroad are likely to remit more than $1 billion annually. A majority of the remittances are most likely obtained from nurses who moved within the last five years. This estimate does not take into account the many nurses or drop-outs from nursing colleges who work abroad in other occupations such as nursing aides and caregivers, etc.

The estimates reveal that the amount of remittances from nurses on temporary assignment more than cover the direct expenses spent on private tuition and education material for the record number of students who are graduating from nursing colleges. An old study of Philippine physicians practicing overseas concluded that the remittances they sent home more than compensated for the economic losses associated with their departure (Goldfarb and Havrylyshyn, 1983). Similarly, another study of remittances from migrant Tongan and Samoan nurses concluded that they exceeded the cost of their training by quite some margin and that they contributed to raising standards of living in those countries (Connell and Brown, 2004). The authors also found that nurses were more likely to remit their saving and also larger amounts than other migrating occupations.

The estimates do not, however, take into account all the costs and benefits of migration. There is for example no counter factual of the economic contributions these nurse graduates could have made if they

instead had opted for another academic degree. Some of the nurses may have had successful careers in engineering, business administration or public administration. The sheer extent of the interest in nursing does indicate that there is a relative dearth of attractive job opportunities for young graduates in the Philippines.

5.2 Negative externalities of nurse migration

The previous section showed that remittances from Philippine nurses are substantial. Migration of Philippine nurses produces positive and negative externalities for the Philippine society. There has been a public debate for many years in the Philippines whether the sum of these externalities is positive or negative and how the country can maximise the gains from the exports of nurses. In general, temporary movement increases the scope for positive externalities and reduces the scope for negative externalities as compared to permanent movement.

Remittances produce positive externalities for example when a rural family can invest in a new irrigation system that allows it to engage in commercial farming and recruit local farm workers. Remittances may also be used to finance the education of siblings, which increases their likelihood to engage in productive rather than criminal activity. A nurse may also gain valuable knowledge that can be shared with colleagues in the local healthcare clinic he/she joins upon return to the country.

There are also negative externalities associated with this trade. The biggest concern is the perceived drainage of the country's specialised nurses. All healthcare experts consulted in the Philippines agreed that the country has produced an excessive number of nurses at the same time as the country's healthcare sector is suffering from a lack of specialised and experiences nurses. It is therefore domestic medical patients, in particular from economically disadvantaged groups, who bear most of the costs of migration. The migrating nurses do not cover these costs directly. At the same time as remittances are used for productive investment and education, many children grow up with relatives and grandparents but receive little parental care, which may negatively affect their upbringing, give rise to criminal activity, etc.

When a negative externality exists in an unregulated market, the producers, or in this case the recruiting healthcare sector in rich countries, do not take responsibility for the external costs. The lower marginal cost of foreign recruitment therefore results in more imports of nurses. This is currently taking place in spite of the barriers erected by various labour groups that represent nurses in countries like the United States and the United Kingdom. It is no coincidence that market entry in the GCC region has remained

open and unrestricted as leaders in these countries have been primarily concerned about public health and enjoyed the relative luxury of not having to face a nurse electorate in democratically contested elections.

The foreign hospitals and healthcare clinics that recruit Philippine nurses—sometimes entire specialised healthcare departments—do not cover any of the costs incurred by Philippine society. There are several reasons: (i) Philippine policy makers argue that the gains from financial remittances exceed the prospective costs of negative externalities; (ii) almost all nurses are educated in private institutions with no public subsidies involved; (iii) international movement is a human right and impeding individuals from realising their ambitions abroad is inherently unfair; and (iv) it is almost impossible for the government to tax foreign employers or the nurses. History shows that employers would turn to nurses from other countries, such India and Mexico, if their recruitment of Philippine nurses was hampered. International recruitment would also migrate to informal recruitment channels.

There are three causes of negative externalities that warrant particular attention. The first issue is the permanent outflows of medical doctors who have re-qualified as registered nurses in order to bring their families to the United States. This phenomenon occurred on a large scale in the 2000s as the U.S. authorities moved to allow dependants of foreign nurses to enter the country on EB-3 green cards (Galvez-Tan et al., 2005). This flow of medical doctors, however, has declined due to the considerable backlog of EB-3 green cards applications. Nevertheless, the migration of thousands of medical doctors (as nurses) came as a shock to the Philippine healthcare system. The number of patients per medical doctor increased in a relatively short period of time. It also had the effect that students preferred to move into nursing rather than medicine, which was reflected in the quality and quantity of new medical students.

Some medical schools had to close down due to a decline in demand for education in medical science (Galvez-Tan et al., 2005). The number of test takers of the National Medical Admission Test in the Philippines dropped from 6,245 in 2000 to 2,912 in 2005. The Philippines Hospital Association estimated that 80 percent of all public sector physicians were either in training to become a nurse or had already retrained as nurses in 2004 (PHA 2005). Galvez-Tan et al. (2005) also reported that the country experienced a decline in the proportion of deaths that were attended by medical staff from 50 percent in 1995 to 30 percent in 2003. This episode in the history of Philippine nurse migration illustrates how sensitive a poor country's healthcare system may be to immigration policies in rich countries. It implies that immigration authorities in rich countries ought to consider the effects of their action beyond the domestic border. It also implies that the Philippine Government should take proper action to prevent a

similar shock from happening in the future and adopt policies that alleviate against the negative effects on the healthcare system.

The second issue is the migration of experienced nurses and nurse specialists. This movement may have an effect similar to the sudden migration of medical doctors. Those nurses who are left behind in the Philippines often have to work longer hours and fresh graduates are asked to care for patients in need of specialised care. The result is that some domestic patients receive worse care than they would have received if the more qualified nurses had stayed. The ultimate outcome on healthcare and quality of life in the 2000s has yet to be measured. Galvez-Tan et al. (2005) raise a number of concerns and argue that the country always had a failed healthcare system. More than 50 percent of the population lack access to healthcare. 40 percent of all births are unattended by health professionals. More than 100 municipalities had no medical doctors and nurses at any time in 1995-2005. An analysis of the effect of migration on public health is rendered difficult given the lack of updated health indicators. New data would be needed to estimate the impact of nurse migration in the last ten years.

The third issue is the opportunity cost of educating such a large number of nurses. Many nurses have scant chances of obtaining a job as a registered nurse at home or abroad. Some nurses end up unemployed and others are forced to take up jobs for which they are overqualified. The country has an abnormal proportion of its tertiary educated population equipped for a job for which there is little demand. In the long-run, the domestic economy may end up suffering from labour shortages in sectors where many of these intelligent individuals would normally have entered. For every nurse among the 447,113 who succeeded in obtaining a license in 1990-2009, there is another student who either dropped out from college or received such a poor education that obtaining a license was always unlikely.

The volatile nature of foreign demand and work permit rules makes the nursing profession a risky option for Philippine students. Many poor families have pooled their resources and taken on loans to educate a single family member with the hope that he or she would one day be able to work abroad and send home savings that would help improve the financial situation of the family. It is often the economically disadvantaged who end up with their sons and daughters in one of the substandard private institutes that prosper without proper regulation. These nursing colleges churn out tens of thousands of poorly trained nurses incapable of passing the national licensure exam and therefore incapable of landing a job at home or abroad. The Philippine Government has failed these families since it has failed to uphold minimum quality standards in these nursing colleges.

6. A REFORM PROPOSAL FOR A MORE EFFECTIVE MODE 4 TRADE POLICY

What should the Philippine Government do to improve the situation for its nurses and the country's healthcare sector? The first and arguably the most important initiative the government could take would be to set its own house in order. The domestic healthcare policy should be strengthened. The nurse education policy is not fulfilling its objectives. The country is highly restrictive to imports of healthcare services. The trade policy is impeding the development of a nascent export-oriented healthcare industry based on foreign direct investment and medical tourism in the Philippines. Finally, the government has been active but fairly unsuccessful in opening up foreign markets for Mode 4 trade though bilateral, regional and multilateral negotiations. The current approach, of protecting citizens abroad, seeking bilateral and regional agreements on recruitment procedures and recognition of academic credentials and licenses, may be the slow but only way forward unless the government's trade policy makers decide to offer greater market access at home in exchange for ensured market access of its nurses in major client countries.

6.1 Getting domestic policy right

The preceding analysis brought to light the relative weaknesses of the country's domestic policies. Three areas of particular concern from an economic point of view emerged. First, in order to gain the moral high ground in seeking significant market access for its nurses in foreign client countries, the Philippines should remove highly restrictive trade policies at home. Second, the government should also invest more effort and resources in addressing the weaknesses of the domestic healthcare market, including by paying the minimum wage that nurses are entitled by law and in adopting a coherent healthcare policy. Third, the proliferation of nursing colleges that fail to live up to even the most rudimentary quality standards is hurting society at large and in particular all the young students and their often poor families who invest in tertiary education. The government ought to not only enforce the mandatory quality requirements established for nursing colleges but also raise these quality requirements.

6.1.1 Adopt a more liberal policy towards imports of healthcare services

The Philippines would have much to gain from opening up its domestic healthcare market. It would not only strengthen the country's arguments for liberalisation abroad but also provide its citizens with more choice in terms of quality and price. It could help alleviate concerns about the manpower shortages of specialised nurses and physicians as voiced by domestic policy makers and result in foreign investment that could improve domestic services, bring in foreign patients, and by extension provide better and higher paying jobs for Philippine healthcare workers at home. The Philippines did not make any specific

commitments in the GATS on '08. Health Related and Social Services' and the healthcare sector is largely closed to foreign exporters and investors (Arunanondchai and Fink, 2007).

For example, the Philippines subjects the entry of foreign medical professionals to economic needs tests. Foreign professionals in some occupations are banned from working in the country. There are numerous requirements for reciprocal treatment of Philippine professionals. Mode 4 imports in the healthcare sector in the Philippines are subject to work permit quotas set annually by the Department of Foreign Affairs. Qualification requirements are strict and foreign medical professionals need to pass the 'state licensure examination' and, additionally, must have permanently resided in the Philippines for at least three years prior to registration. Unsurprisingly, no foreign medical professional had applied for a residence permit by 2007. Citizenship requirements for professional practice are an extreme form of national treatment discrimination (ASEAN–ANU Migration Research Team, 2005b).

A more open domestic market could help attract foreign investment that would create high paying jobs for the domestic nursing workforce. The Philippines has the crucial attributes in place to develop medical tourism into a significant source of revenue. The country does not only graduate a large number of healthcare workers with international credentials—labour is inexpensive, the capital enjoys first-class infrastructure, the climate is pleasant, English is widely used, etc. The Philippines should have the potential to develop exports-oriented medical facilities like Thailand and Singapore. The country would benefit from its relatively lower labour costs and proximity to prospective client countries like Japan and the United States vis-a-vis other South-East Asian countries.

6.1.2 Adopt a coherent policy on nurse migration and enforce existing remuneration rules

As Former Health Secretary Galvez-Tan has argued, there is no unified coherent government policy in the development of human resources in the healthcare sector (Galvez-Tan et al., 2005). The Department of Labour and Employment, the Philippine Overseas Employment Administration, the Department of Finance and the Department of Trade and Industry all promote nurse migration. The Department of Health, the Commission on Higher Education and the Professional Regulatory Commission take the opposite view and encourage nurses to stay and work at home. An incoherent policy on nurse migration creates incentive structures that are non-optimal and potentially costly for the country.

Rather than taking advantage of the excessive supply of nurses, the Philippine healthcare sector would be better off in the long run if the country's nurses were paid a wage on which they can live. A big step forward would be for the public sector to pay the minimum wage stipulated by Philippine law. The survey

results cited above indicated that a large number of nurses are their families' breadwinners and that a high proportion of nurses are living in poverty. Ensuring that those nurses who find employment at home have a wage on which they can live on would reduce one of the leading push factors.

6.1.3. Enforce minimum quality requirements for nursing colleges

The excessive supply of nurses is down to weak regulation of the entry and quality standards of nursing colleges and the lack of enforcement of the existing regulation. There were almost half a million nursing students in the 2006/07 academic year and annual domestic demand is unlikely to exceed more than 1-3 percent of this number. While private nursing colleges are making profits on the dream of Philippine students and their families of landing a high-paying job abroad, many of these colleges are not providing quality education. Many colleges that award B.Sc. degrees in nursing cannot point to a single student who passed the NLE while other colleges produce large numbers of graduates of which only a fraction becomes registered nurses. The ongoing operation of these colleges is wasteful for the society and unfair to the students.

What should the government do? Private risk taking and entrepreneurship in the Philippine tertiary education sector is a significant strength of the country. Introducing numerical limitations on the annual intake of students or the number of colleges allowed to operate would be effective in lowering the number of students and colleges but not necessarily have the optimal results. It could for example impede market entry of new investment in the sector. A policy that: (i) established minimum quality requirements; and (ii) enforced these quality requirements would have a more productive outcome. The Philippines is currently maintaining a particular lax minimum quality requirement and it has not been enforced.

A nursing college that fails to achieve its objective—of educating nurses—should not be allowed to sell its services. A nursing college with a 10 percent success rate at the NLE is not a proper institute for higher education. The exact minimum success rate is difficult to establish but a college that fails three out of four students year after year is neither an asset for the country nor for its students. This author would recommend the establishment of a commission that would determine a minimum success rate—probably around 30-40 percent level—and the automatic cancellation of the license to operate the college if its success rate at the NLE failed to reach the minimum level for three years running, or three years out of five, etc. The focus should be on the quality of the service and the right of the students to be protected from poor services.

6.2 Opening up markets abroad

The Philippines has repeatedly sought to open foreign markets for its workers. The effort to obtain increased market access for its nurses at the multilateral level through GATS trade negotiations has yet to yield results as the member states of the WTO have failed to conclude the Doha Development Round of multilateral trade negotiations. There are no signs that these negotiations will move forward in the near future. A multilateral agreement with real market access would be the best solution. In its absence the Philippine Government has sought to improve market access and improve the conditions for its nurses (and other workers) through bilateral agreements on 'codes of practice' (*e.g.* with United Kingdom), economic partnerships (with Japan) and on mutual recognition of qualifications (*e.g.* with Belgium, Canada, ASEAN). Overall, these negotiations have led to the protection of workers and guidelines of social and ethical recruitment. They have been largely futile in creating new opportunities for nurses to work abroad.

Bilateral agreements and codes of practice

Bilateral agreements have some potential advantages compared to codes of practice. For example, bilateral agreements reduce the need to employ commercial recruitment agencies, which ensures a more predictable and transparent process for both parties, and shift the cost of migration from the individual nurse to the client (Bach, 2006). Bilateral agreements are also flexible policy tools that can include best practice guidance related to induction, training, and so on. Tullao and Cortez (2004), however, have noted that most bilateral agreements negotiated by the Philippines have no implementing guidelines, are not ratified, and cover welfare and social protection rather than the facilitation of movement. The authors refers to the POEA and argue that the Philippine government's policy is to "*seize opportunities* [in the global market], *minimize the costs and the risks, empower and guide the workers in their decision-making, enable stakeholders, engage recruiters, foreign governments, and employers to share responsibilities and mainstream the issues in development planning"*.

The Philippine Government has labour agreements with the Commonwealth of Northern Marianas Islands, Indonesia, Iraq, Jordan, Libya, Norway, Qatar, Kuwait, Papua New Guinea, Norway, United Kingdom and Switzerland (Kingma, 2007). There is also a pilot project with the Netherlands where language training is provided for nursing recruits in the Philippines at the expense of the hiring countries (see ASEAN–ANU Migration Research Team, 2005b). The Philippines have sought similar agreements with the United States and Saudi Arabia but without success given the counterparts lack of interest or policy of not signing such agreements. In 2009, the Philippines and Japan agreed to allow up to 250

Philippine nurses to move and serve in Japan and this market may have great potential for the future. The agreement with Japan is the only agreement which explicitly opens up the market for Philippine nurses.

The Philippines has negotiated a number of bilateral labour agreements with labour importing countries. These agreements generally cover mutually acceptable terms and conditions of employment, recruitment and grievance procedures and social security benefits. Some agreements also cover the exchange of manpower and training. In 2002, the POEA signed a Recruitment Agreement with the United Kingdom and its National Health Service (NHS) that allows POEA to undertake the pre-recruitment for NHS employers by interviewing Philippine candidates.[56] The agreement sets out in detail the requirements placed on the POEA and the NHS, designed to ensure transparency and eliminate potential for abuse (Bach, 2006). NHS employers are requested to cover the cost of the initial application to the NMC, the entry visa, the airfare to the United Kingdom, the POEA processing fee, the Worker's Welfare Fund fee, and a contribution to POEA's Employee's Guarantee Trust Fund. The agreement also includes requirements related to induction and other forms of good practice.

The effectiveness of these types of codes is yet to be demonstrated and the support systems, incentives, sanctions and the means for monitoring their implementation are often weak or nonexistent (WHO, 2006; Willetts and Martineau, 2004). Kingma (2006) has for example noted the narrow content of the UK Code of Practice, which focuses on general principles of ethical recruitment and induction rather than regulating or identifying best practice in terms of remuneration and working conditions. It is voluntary, without legal basis, and with significant loopholes. Go (2004) reported that of the eighteen bilateral agreements proposed by the Philippines with countries in Africa, Asia, Europe and the Middle East, five countries refused to enter into agreements, and other agreements remain inactive. The real breakthrough would be if the Philippine Government would reach an agreement with its trading partners to remove some of the more trade-restrictive measures, such as the economic needs tests, the work permit quotas, the minimum wage requirement or the more protectionist forms of licensing requirements.

[56] The United Kingdom introduced a Code of Practice in 2001 for the international recruitment of nurses in the public healthcare sector. It includes guidance on how to engage recruitment agencies and it provides a list of developing countries that NHS trusts should avoid targeting for recruitment unless the Department of Health has a formal agreement with the country (Bach, 2007). The Philippines is one of the poor countries that the NHS has deemed ethical to recruit from. There are other codes of practice on ethical international recruitment, introduced at national and international levels, including the Commonwealth Code of Practice and the International Council of Nurses (ICN) Position Statement on Ethical Nurse Recruitment (Kingma, 2007).

Mutual recognition of qualifications

The lack of recognition of the education, skills and work experience of nurses is a common trade barrier in many countries (Bach, 2006). The Philippines is a signatory of the mutual recognition agreement (MRA) on nursing of the ASEAN group of countries. This facilitates movement to in particular Singapore through the equivalence of curriculum and accreditations. The Philippine Bachelor degree in nursing was developed along U.S. guidelines and is generally recognised by other countries. Discussions are ongoing with Australia on the recognition of qualifications of Philippine nurses and POEA has reported that it is set to sign a Memorandum of Understanding with South Australia on labour cooperation in 2010.[57]

The Philippine Nurses Association has pushed for the development of global nursing education norms that would facilitate the registration procedures for nurses. The WHO has argued that national norms and standards are essential to respond both to country-specific circumstances and health needs. MRAs with Anglophone countries may be particularly beneficial for Philippine nurses. Kingma (2006) has noted that language is so important for nurses that an MRA involving countries using different languages seldom stimulates trade. The Nursing Directives of the EU was enacted in 1977 to provide free mobility within the union through mutual recognition of nursing qualifications. It has resulted in very limited international migration between EU countries notwithstanding the waiver of re-qualification and work permit requirements. This may partly be due to language barriers but also to non-compliance of the rules.

7. CONCLUSIONS

For more than half a century, the Philippines has been a leading, if not *the* leading, exporter of human capital in the healthcare sector. In the last decade, however, the country's supply of nursing colleges has more than doubled and its annual output of registered nurses has increased fourteen fold. Consequently, the education, licensing and international recruitment of nurses have become highly lucrative markets. These developments are largely attributable to the unintended consequences of shifts in immigration policies, particularly of the United States, as well as negligent education and healthcare policies in the Philippines. Anecdotal evidence reveals that politicians with economic interests in nursing education have ensured that regulation is minimal and seldom, if ever, enforced in the Philippines leaving tens of thousands of students, particularly those from underprivileged families, without any prospect of obtaining employment in the nursing sector.

[57] www.poea.gov.ph/news/2010/pr_jan2010_employment%20prospects.pdf.

Philippine nurse migration is prolific because of strong economic incentives. Data obtained from the POEA for 2008 showed that Philippine nurses earned average monthly salaries from $695 (PPP) in Kuwait to $5,722 (PPP) in the United States. Comparable data for nurses remaining at home were $370-$452 (PPP), indicating that a Philippine nurse can increase his/her earning power by 1,300 percent if the employer is located in Los Angeles rather than Manila. However, an analysis of work permit and licensing data of Philippine nurses abroad revealed that demand in the more lucrative foreign labour markets is highly volatile, especially compared to the GCC member states.

For much of the 1990s, the United Kingdom hardly recruited any Philippine nurses. In 2000-2002, however, it hired more than ten thousand nurses. Demand then dropped rapidly and by 2008 there were virtually no Philippine nurses moving to work in the United Kingdom. The United States has a long history of recruiting Philippine nurses. In 1995, the country phased out its only temporary work permit scheme that provided genuine market access for Philippine nurses. The United States has since then relied on permanent recruitment of nurses on green cards, 2,800 of which can be issued to Philippine nurses every year. The U.S. Government's decision a decade ago to start issuing green cards also to dependants of foreign nurses was an exogenous shock afflicting the Philippine healthcare sector as a significant proportion of the country's nurses and many of its medical doctors re-licensed as registered nurses in the United States. It also provided real impetus for the increase in nursing colleges and students taking up nursing.

The Philippine Government has encouraged an excessive supply of nurses by maintaining a light regulatory framework for private tertiary education and by not enforcing existing rules on quality assurance. The reluctance by Philippine policy makers to address an obvious market failure despite rich evidence that several of the country's nursing colleges fail to offer sufficient training is costing tens of thousands of poor families dearly. Data provided by CHED revealed how enrolment in Philippine nursing colleges increased by 1,500 percent in six years' time, or from 28,000 in the 00/01 academic year to 454,000 in the 06/07 academic year. Consequently, 261,000 new licenses were issued to registered nurses in 2005-2009. This output was around seven times the number of registered nurses practicing in the entire healthcare sector in the Philippines. It also indicates that a large number of fresh nurses will have small chances of obtaining employment abroad since the POEA deployed an annual average of 9,667 nurses abroad in 2005-2008. Their opportunities to join the saturated domestic healthcare sector are small. Many young nurses work for free or even have to pay to work in order to gain valuable work experience often required by foreign recruiters.

The paper presented a number of estimates to provide an overview of the size of markets associated with the nurse exporting industry. First, the income generated by private nursing colleges from private tuition fees and reading material was estimated to have increased from around P1.2 billion in 00/01 to P26.8 billion in 06/07. Including expenses spent on campus lodging put the market value for private nursing education in 06/07 to P35-P40 billion, or $700-$800 million. Second, the Philippines' rather unique export strategy of nurses also brought large inflows of revenue: the paper estimated that savings remitted by Philippine nurses are likely to exceed $1 billion annually. In 2008, Philippine nurses who had moved to work abroad only in the last three years remitted an estimated $530-$615 million.

Finally, the analysis of wage data, work permit data and client country regulations revealed that there are significant risks as well as attractions associated with the exports of nurses. Those nurses who obtain a license to practice as a registered nurse at home and seek work abroad face stringent re-licensing requirements and a plethora of restrictions, including quantitative limitations, on work permits in rich countries. Philippine students who train to become nurses are therefore taking a substantial risk of not generating a return on their investment in education given stiff competition and foreign restrictions.

The procedures for obtaining a professional license and securing a work permit were assessed for Philippine nurses seeking to enter as registered nurses in the United States, the United Kingdom and Saudi Arabia. The analysis revealed that local nurse associations often have a strong influence on trade and can effectively regulate the inflow of foreign nurses.

Next to the obvious benefits of remittances, there are three causes of negative externalities that warrant particular attention: (i) permanent outflows of medical doctors who have re-qualified as registered nurses in order to bring their families to the United States; (ii) migration of experienced nurses and nurse specialists leaving fresh inexperienced nurses behind to work longer hours and care for patients in need of specialised care; and (iii) the opportunity cost of educating a number of nurses that far exceeds domestic and foreign demand. Many nurses have scant chances of obtaining a job as a registered nurse at home or abroad. Some nurses end up unemployed and others are forced to take up jobs for which they are overqualified. Over the long-term, underutilization of a considerable portion of the country's tertiary educated workforce is economically suboptimal and is likely to adversely affect growth.

What should the Philippine Government do to improve the situation for its nurses and the country's healthcare sector? The most important initiative the government could take, arguably, would be to set its own house in order. The domestic healthcare policy needs to be strengthened. The nurse education policy

is not fulfilling its objectives. The country is highly restrictive of imports of healthcare services. The trade policy is impeding the development of a nascent export-oriented healthcare industry based on foreign direct investment and medical tourism. Finally, the government has been active but fairly unsuccessful in opening up foreign markets for Mode 4 trade though bilateral, regional and multilateral negotiations. The current approach, of protecting citizens abroad, seeking bilateral and regional agreements on recruitment procedures and recognition of academic credentials and licenses, may be slow but the only way forward unless the government's trade policy makers decide to offer greater market access at home in exchange for ensured market access of its nurses in major client countries.

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ANNEXES

Annex A. Estimated stock of overseas Filipinos as of December 2007

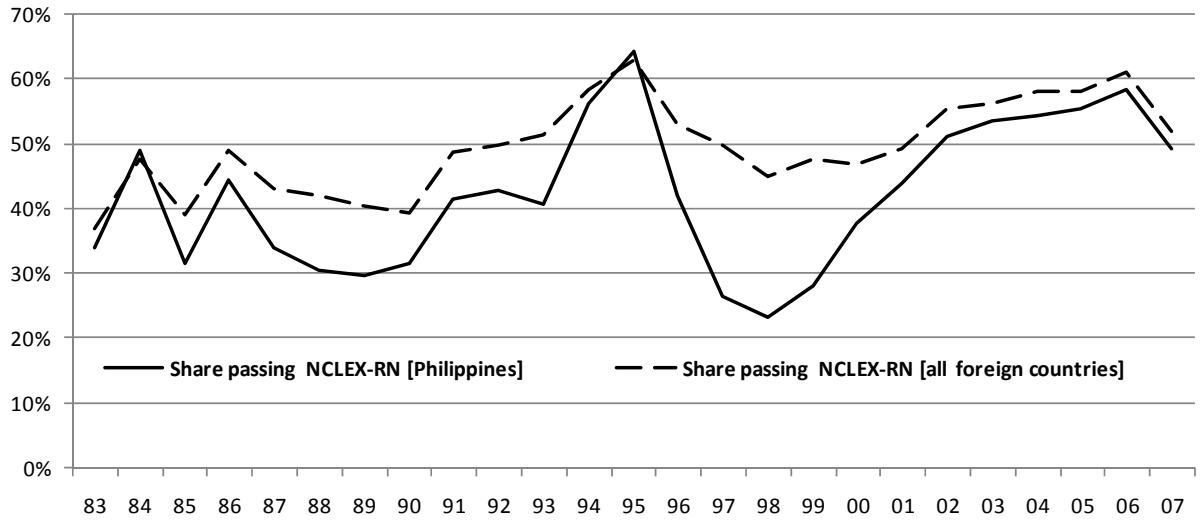
REGION / COUNTRY	PERMANENT	TEMPORARY	IRREGULAR	TOTAL
WORLD TOTAL	**3,692,527**	**4,133,970**	**900,023**	**8,726,520**
AFRICA	**1,983**	**69,880**	**18,540**	**90,403**
Egypt	877	2,302	2,000	5,179
Equatorial Guinea	40	5,812	660	6,512
Libya	75	9,490	680	10,245
Nigeria	280	2,455	700	3,435
Others	711	49,821	14,500	65,032
ASIA, East & South	**213,736**	**747,069**	**258,640**	**1,219,445**
Brunei	50	20,848	440	21,338
Hong Kong	11,471	116,066	3,000	130,537
Japan	133,528	38,329	30,700	202,557
Korea, South	6,187	62,528	12,000	80,715
Macau	56	20,292	3,000	23,348
Malaysia	26,002	90,965	128,000	244,967
Singapore	29,850	70,616	56,000	156,466
Taiwan	2,357	67,153	4,500	74,010
Others	4,235	260,272	21,000	285,507
ASIA, West	**4 082**	**2 055 647**	**121 850**	**2 181 579**
Bahrain	85	40,818	3,800	44,703
Israel	1,001	29,879	6,000	36,880
Jordan	108	14,356	8,000	22,464
Kuwait	94	129,708	10,000	139,802
Lebanon	380	22,138	3,300	25,818
Oman	100	33,164	9,000	42,264
Qatar	15	189,943	5,600	195,558
Saudi Arabia	350	1,046,051	20,000	1,066,401
UAE	703	493,411	35,000	529,114
Others	1,246	56,179	21,150	78,575

REGION / COUNTRY	PERMANENT	TEMPORARY	IRREGULAR	TOTAL
SEABASED WORKERS		**266,553**		**266,553**
EUROPE	**284,987**	**555,542**	**112,990**	**953,519**
Austria	24,252	3,405	2,000	29,657
Belgium	3,960	3,310	2,500	9,770
Denmark	6,493	2,733	0	9,226
France	7,049	1,026	39,000	47,075
Germany	44,130	8,106	2,100	54,336
Greece	92	23,252	6,000	29,344
Ireland	4,860	11,472	500	16,832
Italy	24,598	82,594	13,000	120,192
Netherlands	14,139	3,023	2,000	19,162
Norway	16,561	3,474	0	20,035
Spain	27,537	10,543	3,700	41,780
Sweden	7,811	10,624	0	18,435
Switzerland	8,303	1,739	2,000	12,042
United Kingdom	90,654	102,381	10,000	203,035
Others	4,548	287,860	30,190	322,598
AMERICAS / TRUST TERRITORIES	**2,943,812**	**354,352**	**354,843**	**3,653,007**
Canada	410,626	49,309	3,000	462,935
USA	2,517,833	128,910	155,843	2,802,586
CNMI	1,288	10,979	500	12,767
Guam	12,675	9,392	500	22,567
Others	1,390	155,762	195,000	352,152
OCEANIA	**243,927**	**84,927**	**33,160**	**362,014**
Australia	221,892	19,455	9,000	250,347
New Zealand	21,188	1,715	120	23,023
Palau	5	4,324	400	4,729
Papua New Guinea	770	9,522	2,640	12,932
Others	72	49,911	21,000	70,983

Permanent - Immigrants or legal permanent residents abroad whose stay do not depend on work contracts.
Temporary - Persons whose stay overseas is employment related, and who are expected to return at the end of their work contracts.
Irregular - Those not properly documented or without valid residence or work permits, or who are overstaying in a foreign country.

Source: Philippine Overseas Employment Administration (POEA) (2008), 2007 Overseas Employment Statistics.

Annex B. Share of first-time candidates passing the NCLEX-RN examination, 1983-2007



Source: National Council of State Boards of Nursing, Inc. (NCSBN).

Annex C. Required English language test passing score by profession

	OPTION 1			OPTION2			OPTION 3		OPTION 4	
Healthcare Profession	TOEFL *Test of English as a Foreign Language*	TWE *Test of Written English*	TSE *Test of Spoken English*	TOEIC *Test of English for International Communication*	TWE *Test of Written English*	TSE *Test of Spoken English*	IELTS *IELTS, Inc.*	IELTS *Spoken Band*	TOEFL iBT *Total*	TOEFL iBT *Speaking Section*
Registered Nurse	207 (540 *)	4.0	50	725	4.0	50	6.5 (Academic)	7.0	83	26
Practical/Vocational Nurse (LPN/LVN)	197 (530)	4.0	50	700	4.0	50	6.0 (General)	7.0	79	26
Physical Therapist	220 (560)	4.5	50						89	26
Occupational Therapist	220 (560)	4.5	50						89	26
Speech Language Pathologist	207 (540)	4.0	50	725	4.0	50	6.5 (Academic)	7.0	83	26
Audiologist	207 (540)	4.0	50	725	4.0	50	6.5 (Academic)	7.0	83	26
Clinical Laboratory Scientist (Medical Technologist)	207 (540)	4.0	50	725	4.0	50	6.5 (Academic)	7.0	83	26
Clinical Laboratory Technician (Medical Technician)	197 (530)	4.0	50	700	4.0	50	6.0 (General)	7.0	79	26
Physician Assistant	207 (540)	4.0	50	725	4.0	50	6.5 (Academic)	7.0	83	26

Source: www.cgfns.org/files/pdf/apps/2008%20VS%20Handbook.pdf.