This month a test of the developed world’s sincerity towards solving the global health-worker crisis comes before the WHO’s Executive Board (Jan 19–27).

The innocuous sounding Global Code on International Recruitment of Health Personnel aims to curb the looting of developing country health systems by developed countries hungry for health workers to manage their expanding geriatric populations.

In the time it has taken for the code to be developed, via the Migration Global Policy Advisory Council (following a World Health Assembly resolution in 2004), drafted and then discussed online for a month last September, the issues surrounding health-worker migration have become increasingly complex.

For during those years, while the code went from discussion to document, migrant health workers have gone from a drain on national resources to a major export industry. Nurses, in particular, are in such demand that in some nations doctors and other professionals are retraining as nurses in order to secure jobs overseas. Certain countries are also now turning out many more nurses than they are willing or able to employ in their own systems.

Chief among these is the Philippines which signed a trade pact with Japan in 2007—the Japan–Philippines Economic Partnership Agreement (JPEPA)—in which Filipino health workers featured as a resource Japan coveted. “With JPEPA, the Philippine Government is institutionalising the practice of selling off Filipinos as cheap labour”, said Gene Nisperos, of the Manila-based Health Alliance for Democracy (HEAD). “It has made Filipino migrant workers even more vulnerable to discrimination and abuse.”

Although Filipino health workers have become one of the country’s most valuable exports, sending billions of pesos back to the Philippines as remittances and taxes, their exodus is crippling the domestic health system. An attractive offer from a recruiting agency can clean out a ward, a unit, or even an entire provincial hospital. This type of recruitment “where you suck out the workers in busloads and leave their hospitals employeeless” is certainly happening, says Manuel Dayrit, director of the WHO’s Department of Human resources for Health. “And this is tricky because you have free trade in a sense, where you have private recruiters who look at this purely as a business. In some countries the [code] can be seen as impairment of free trade.”

A survey done by HEAD in 2006, found that 80% of doctors working in the Filipino public sector had applied or intended to apply to work overseas and 90% of municipal health officers were set to leave to work abroad. They were planning to leave not as doctors but as nurses, because it is nurses that the major recruiting countries—the USA, the UK, Ireland, Saudi Arabia, and Singapore—are seeking and luring with promises of pay well above a Filipino public doctor’s salary.

Officially, the Philippines does not have a nurse shortage. “We are not as hard up as Africa...In absolute numbers we have an oversupply”, says Kenneth Ronquillo, Director of the Health Human Resources Development Bureau of the Philippines’ Department of Health.

The Philippine Government is even encouraging medical tourism—private sector plastic surgery, renal transplantation, dialysis, and other services more expensive or unavailable in neighbouring Asian and Pacific nations.

But it is their best and brightest—from specialist doctors and nurses, nursing educators, to even engineers and teachers—who are leaving to work as nurses overseas. And nurse training schools have mushroomed. In the past decade, the number of institutions offering nursing training courses has risen from 170 in the 1990s to

The printed journal includes an image merely for illustration
471 providing full nursing courses of which 45 provide abridged courses for doctors wishing to become nurses.

Of the nursing schools, 60% are focusing on “second-timers”—people with professional training who wish to become nurses in order to get work overseas. At the same time, the number of nursing graduates passing the nurse licensure exams is falling. In the 1970s and 80s, 80–90% passed but in the past few years the passing rate has been 40–50%. Those passing tend to come from specific institutions as well. As far back as 2002, 63% of nursing schools got fewer than 50% of their graduates through the licensing exams. More recently at least 20 nursing schools failed to get a single student through.

“Even though there’s a mushrooming of schools there’s a shortage of faculty”, said Kathleen Fritsch, regional adviser in nursing for the WHO’s Western Pacific Regional Office. “That’s a constant problem and needs to be addressed.”

Although the nature of the Filipino health-worker exodus is different from that decimating the health systems of sub-Saharan Africa, the effects are similar. It has been estimated that seven out of ten Filipinos die without receiving medical care. “Why let your health personnel leave or encourage medical tourism if seven out of ten are dying without receiving medical attention?” said Nisperos.

Ronquillo says the Philippine Government is managing the shortage by developing a “human resources for health masterplan” but that funding for nursing positions are often controlled by local governments.

“We’ve looked at the gaps—compensation and wages. We’re looking at working conditions and so now we’re rationalising facilities so we can provide better working conditions...we’re sharing all our ideas, with the academic institutions, looking at the production side and also involving people at the exit side, overseas...We’re identifying what should be done and how you connect from production to workforce to exit.”

Ronquillo said the government is even considering ways to fill the gaps with volunteers. “We’re also looking at how volunteerism can be part of a solution—how volunteers can be compensated, if at all.”

Given that the Philippines is one of the world’s major exporters of health-care worker, it is fitting that Manuel Dayrit, the man tasked with bringing the Global Code on International Recruitment of Health Personnel to fruition, was the Minister of Health for the Philippines in 2001–05. It was during this period that the steady stream of Filipino health workers who had been leaving to work in North America and Europe for decades swelled into a torrent.

According to Dayrit, it was the recognition by US policy makers that their nursing staff were ageing, retiring or changing professions, and not being effectively replaced by a new generation, that opened the floodgates. Nisperos agrees that the opportunities in the USA turned the existing desire to work overseas into a national industry.

“In the 70s most of my colleagues would go to the USA to do their residency. At that time it wasn’t so easy for nurses to go to the USA. It took a different turn in 2003. The USA and other countries realised they had a big geriatric population. And in the USA a lot of nurses did not want to work with HIV/AIDS. Filipino nurses wouldn’t know much about that—they just go there to work.”

“In 2003 US politicians said we need 200 000 new nurses per year. It was a clarion call to Filipino nurses: we need you and you will get a visa.”

At the same time a promised salary raise for all nurses—though made law by the Philippines National Congress in 2004—has yet to be implemented. “It’s in the law, the nursing law, but it’s yet to be implemented”, said Ronquillo. “We are pushing for it to be implemented.”

But the Philippines’ Department of Health’s budget hovers around 0.3 of gross national product. There is no spare money for an across the board salary raise or the creation of more nursing positions.

Although the African countries driving the development of the code on health-worker migration want to stop their health workers leaving, this is not its primary purpose, says Dayrit. Migration “is a human right—there’s a delicate balance here”. If passed by the WHO Executive Board for presentation and adoption at the World Health Assembly in May, the aim is that the code will achieve “ethical recruitment”. This practice involves recruiting countries accepting the need to protect the rights of overseas health workers and to find ways to minimise the damage done to the health systems of the provider countries.

Dayrit is also careful to point out that the code is non-binding. “The code is a tricky term because it does connote a binding instrument...It is an instrument which lays out ethical principals governing international recruitment, which include, among others, the right to leave countries in search of work elsewhere.”

“The litmus test here is what countries do. They can adopt it but what are they doing internally? Otherwise it’s all lip service.”

Margaret Harris Cheng