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**AN ASSESSMENT OF THE HEALTH HUMAN RESOURCE  
DEVELOPMENT PROVISIONS OF THE PHILIPPINE NURSING ACT  
OF 2002**

A thesis submitted in partial fulfillment of the requirements  
of Master of Public Policy

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## ABSTRACT

Republic Act No. 9173, or the *Philippine Nursing Act of 2002* enunciates a bevy of incentives under its Health Human Resource Production, Utilization and Development provisions, intended to stem the rising tide of Filipino nurses leaving the country to work overseas. Under Sections 30 to 34 of the Nursing Act, these incentives include the following: (1) upgrading the minimum base salary of nurses from salary grade 10 to 15; (2) establishing a nurse specialty program in government hospitals to upgrade the nurses' skills whereby recipients of the program are required to work in government hospitals for two years; and (3) the provision of other benefits such as scholarship grants, free medical care, etc. These provisions are the government's policy response to mitigate the impact of nurses' migration and retain an adequate supply of skilled Filipino nurses in the country:

This research is a qualitative study that seeks to assess the health human resource development provisions and their implementation and aims to help improve them. This study examines the responsiveness of the provisions to the needs of nurses, and identifies the deficiencies of the provisions by looking into the working conditions of nurses in two Philippine government hospitals. It also examines the processes and the factors affecting the implementation of the provisions.

This study employed a combination of four data collection methods: (1) focus group interviews of nurses working in two Philippine government hospitals, (2) key informant interviews of officials of government agencies and private organizations tasked to implement the health human resource development provisions, (3) document analyses, and (4) researcher's field notes/journal. The researcher conducted five focus group interviews with a total of 15 nurse participants and 12 key informant interviews.

The nurses are working under conditions of low salaries and heavy workload, that is characterized by low nurse-to-patient ratios in the National and LGU Hospitals. The problems of inadequate nurse staffing, large number

of patients and inadequate supplies in the two government hospitals are identified as causes for the heavy workload of nurses. The nurses want a salary increase that is commensurate to their heavy workload, their professional qualifications and long years of service. For the nurses, a salary increase signifies the government's recognition of their dedication, hard work, and commitment to provide health care to Filipinos despite working under dire circumstances. The nurse specialty training program in areas such as oncology, nephrology, critical care, etc. has not been implemented because of the limited capacities of government hospitals to provide this kind of training and the lack of regulatory framework for the practice of nurse specialists in the Philippines. The other benefits have not been implemented as well.

The provisions of the Nursing Act are deficient because they do not address the causes of the heavy workload of nurses. To improve the work conditions of nurses, the Philippine government needs to prioritize to the long-neglected health sector by increasing the budgetary allocation in order to create more nurse positions in government hospitals, to provide adequate supplies and equipment for government hospitals and to improve the facilities for nurses.

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## ACRONYMS

DBM - Department of Budget and Management

DOH – Department of Health

DR – Delivery Room

ER – Emergency Room

EVP – Exchange Visitor Program

FGI - Focus Group Interview

GAA – General Appropriations Act

HHRDB – Health Human Resources Development Bureau

ICN – International Council of Nurses

ICU – Intensive Care Unit

ILO – International Labor Organization

IOM – International Organization for Migration

LGU – Local Government Unit

NLPGN – National League of Philippine Government Nurses

OB-Gyne – Obstetrics-Gynecology

OECD – Organisation for Economic Co-operation and Development

PNA – Philippine Nurses Association

POEA – Philippine Overseas Employment Agency

PRC – Professional Regulation Commission

RA – Republic Act

US – United States

UK – United Kingdom

WHO – World Health Organization

## **Chapter One INTRODUCTION**

### **1.1. Background and Research Problem**

The Philippines is one of the leading sources of nurses to developed nations. Estimates show that around 150,000-250,000 Filipino nurses are presently working abroad and about 15,000 nurses leave the country annually. There is a growing concern about the effect of this large scale migration on the health care system of the Philippines. More specifically, alarm has been raised over the shortage of nurses in the Philippines as a consequence of the continuing migration of nurses. The apprehensions are not baseless as other source countries in Africa and Asia are already experiencing nurse shortages.

Nurses are essential in any health care system because they are involved in all aspects of health care delivery: the promotion of health, prevention of illness and the care of the ill, disabled and dying people. They also form the largest category of health workers and provide direct health care to patients. Their role in public health is increasingly important as countries around the world are confronted with global health challenges, such as TB, Avian flu, SARS, HIV/AIDS, etc. In many developing countries, nurses are the front-line workers who deliver health care services in remote areas. Maintaining an efficient and adequate nursing workforce is crucial to a nation's health care system to ensure the provision of accessible, equitable and quality health care services to its citizens.

The focus of this research is the health human resource development provisions or Sections 30-34 of Republic 9173, the *Philippine Nursing Act of 2002* and their implementation. The *Philippine Nursing Act* is a law that regulates the Philippine nursing profession by setting standards for nursing education and practice in the country. It is a significant piece of legislation because it addresses a pressing issue confronting the Philippine nursing sector – the large-scale international migration of Filipino nurses.

The main objective of the *Philippine Nursing Act*, as articulated in Section 2, the Declaration of Policy, is to improve the nursing profession “through instituting measures that will result in a relevant nursing education, humane working conditions, better career prospects and a dignified existence for Filipino nurses” (Please see Annex A). Recognizing the impact of the international migration of nurses, the *Nursing Act* seeks to guarantee the delivery of quality health services by maintaining a sufficient supply of nurses in the country. It contains specific provisions called the health human resource development provisions that were formulated to address the concerns of nurse shortage in the country by providing incentives to encourage Filipino nurses to remain in the Philippines. These incentives include the following: (1) increase in the minimum base salary of nurses working in public hospitals and health facilities<sup>12</sup>; (2) the establishment of a nursing specialty program in selected government hospitals to upgrade the skills and competence of nurses and to require participating nurses to work in the country for two years; (3) the conduct of studies on health human resource development; and (4) the provision of non-financial incentives and benefits such as scholarship grants, free medical care for nurses and their families, etc.

The Philippine Congress has received reports that these provisions have not been implemented. These reports, however, remain anecdotal since they have not been formally investigated and documented. Six years after the approval of the Philippine Nursing Act, it is high time to look into and assess the implementation of the health human resource development provisions in the light of the continuing mass migration of Filipino nurses.

## **1.2. Research Objectives**

The general objective of the research study is to assess the health human resource development provisions of the *Philippine Nursing Act* and its implementation, with an overarching goal of contributing to the improvement of the policy. The research is guided by the following specific research objectives:

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<sup>12</sup> During the deliberations of the *Philippine Nursing Act* in the Philippine Congress, there was a consensus among the legislators not to include private hospitals in the mandated nurse salary increase because of the objections raised by private hospital owners that they cannot pay for the stipulated salary increase.

- To examine the working conditions and problems of nurses in government hospitals;
- To find out the status of the implementation and the processes done to implement the health human resource development provisions;
- To examine the factors that affect the implementation of the health human resource development provisions;
- To examine whether the provisions are responsive to the needs of nurses working in government hospitals; and
- To identify the deficiencies in the nurse retention strategies specified under the Nursing Act.

### **1.3. The Researcher**

The impetus for doing the research study stems from my personal and professional circumstances. I am from the Philippines where I lived most of the 39 years of my life, except in the past two years which I spent studying in New Zealand to earn a degree of Master of Public Policy at Massey University. After completing this degree, I will resume my job as a Legislative Staff Officer for the Committee on Health and Demography of the Philippine Senate, where I have been working for the past 14 years. The Philippine Senate is the “Upper Chamber” of the Philippine Congress or the Philippine Legislature. The basic function of the Senate Committee on Health and Demography is to formulate and enact laws to address issues on population and public health. Among the many health laws that the Committee has crafted is Republic Act 9173, the Philippine Nursing Act of 2002. My work with the Philippine Legislature has obviously influenced the choice of the research topic and my involvement in the process of formulating the Philippine Nursing Act will expectedly inform the analyses in this study.

The other significant reason for the choice of the research topic has something to do with the fact that my country is the leading exporter of workers in the world – there are more than eight million Filipinos who are working abroad. We call these workers the Overseas Filipino Workers or OFWs. The OFW phenomenon looms large in the national consciousness of Filipinos. Its

impact is felt in many aspects of our lives, as individuals, as families and as a nation. Almost every Filipino has a family member, relatives or friends who are living and working overseas. In my country, we hail the OFWs as “*bagong bayani*” or “modern-day heroes” because the dollar remittances they send home not only help their families, but have become essential to the survival of our national economy. And Filipino nurses make up one of the biggest groups of professionals that my country deploys abroad.

#### **1.4. Significance of the Study**

The significance of the health human resource development provisions of the *Philippine Nursing Act* cannot be overemphasized because it is the first concrete policy response by the national government to mitigate the impact of nurse migration in the country. Despite its importance, the implementation of these provisions has not been given due attention.

The monitoring and evaluation of policies are important aspects of policymaking because these can provide information on the implementation process that can affect the intended policy outcomes. Moreover, as will be pointed out in the next chapter, there is a dearth of empirical and qualitative studies on retention strategies that are effective in the context of the nurse-sending countries.

The research study hopes to inform policymaking by looking at the actual working conditions of nurses and by providing empirical evidence on the status and problems in the implementation of these provisions. Finally, this research can hopefully contribute to the policy discussion and formulation of evidenced-based strategies to alleviate the impact of nurse migration in the Philippines.

#### **1.5. Structure of the Thesis**

Chapter Two is a review of relevant literature on nurse migration with a special focus on Filipino nurse migration. To understand why thousands of Filipino nurses leave the country to work abroad, the review of literature

examines the individual motivations of nurses as well as the structural factors occurring in the international and domestic arena that facilitate the large-scale exodus of Filipino nurses. It also discusses the policy response to migration, specifically the nurse-retention policies, which are being proposed to mitigate the impact of nurse out-migration on developing countries like the Philippines.

Chapter Three discusses the research methodology that is based on the constructionist philosophy and interpretive approach to policy analysis. It is argued here that a qualitative approach to the evaluation of a policy and its implementation enables an understanding of how a policy problem is “framed” by the people affected by the policy and allows their perspectives to be heard in the policymaking process. This chapter also describes the research design and the process of collecting and analyzing the data

Chapters Four and Five present the analyses of the findings of the study. Chapter Four describes the working conditions of nurses characterized by dissatisfaction with their salaries, heavy workload and low nurse-to-patient ratio, lack of supplies and equipment, and extended working hours without overtime pay. Chapter Five assesses the implementation of the health human resource development provisions by examining the processes and the factors affecting their implementation.

Chapter Six concludes by stating the key findings and concluding comments. It also provides recommendations for policy directions for the retention of nurses in the Philippines.

## **Chapter Two**

### **REVIEW OF LITERATURE**

#### **2.1. Introduction**

The health human resource development provisions of the *Philippine Nursing Act of 2002* were formulated in response to the growing concerns over the impact of the Filipino nurse migration on the country's health care system. These provisions constitute the national policy for the retention of nurses in the Philippines. This retention policy employs two main strategies: (1) increasing the salaries of nurses in government hospitals and, (2) establishing a nurse specialty training program in selected government hospitals wherein participating nurses are required to render a two-year return service in the country. This research study aims to examine the status of the implementation of these provisions and assess whether these provisions are responsive to the needs and current working conditions of Filipino nurses. But before such assessment can be done, it is critical to understand why Filipino nurses are migrating. The main purpose of this review of literature is to present and examine the factors and conditions that cause or facilitate the migration of Filipino nurses. It also provides an overview of the impact of nurse migration in the Philippines and the policy options that have been recommended to manage nurse migration.

International migration is defined as “the movement of people from one country to another to take up employment, to establish residence or to seek refuge from persecution, either temporarily or permanently” (Stilwell, Diallo, Zurn, Dal Poz, Adams & Buchan, 2003, p. 2). It is a widely discussed topic because it is a phenomenon that affects both the developed and the developing countries, thus literature on this subject matter is quite extensive and can be overwhelming. The topic on nurse migration can fall under the purview of the literature on international labor migration, brain drain and the migration of health professionals, many of which, inevitably, discuss nurse migration as an issue that exemplifies the international movement of labor. Moreover, since the Philippines is a major sending country, Filipino nurse migration also figures

prominently in many studies that examine nurse and health professional migration taking place in developed countries such as the United States (US) and United Kingdom (UK).

To remain focused on the purpose of this literature review and not be overwhelmed by the extensiveness of the literature, I initially set the following criteria in selecting the literature to be included: (1) the main topic of the book or article must be nurse migration, not international labor migration or even Philippine labor migration; (2) it must specifically discuss Philippine nurse migration or at least, discuss nurse migration in the context of developing and sending countries like the Philippines and; (3) it must explain the factors why nurses from the Philippines and other developing nations are migrating to the developed countries. In addition, I also decided to include only current studies starting from year 2000 onwards. The key concepts that I used in finding books, research reports and articles are: Philippines nurse migration, Filipino nurse migration, Philippines' labor export policy, international recruitment of nurses, impact of nurse migration and nurse retention policies. But as I read through the selected articles I realized that I needed to extend beyond the set criteria to include some literature on the theories of international labor migration, the role of globalization in nurse migration, the socio-economic conditions in the Philippines and its health care system because these are vital in comprehending the larger forces operating in the international and domestic arena within which the Philippine nurse migration is occurring. Furthermore, I discovered along the way that there are some studies written as far back as the 1970s that already documented the Philippine nurse migration and its findings are still relevant today. Hence, I have included these earlier studies that I considered to be essential in shedding light to the context and history of Philippine nurse migration.

The website of the International Council of Nurses was an important starting point in the search for relevant articles as it directed me to several online resource centers such as the International Center for Nurse Migration, Human Resources for Health and the International Center for Human

Resources in Nursing, which were rich sources of current and significant literature on nurse migration (please see the list of Bibliography for listing of the websites). I also accessed several peer-reviewed journal articles through the article databases of the Massey University Library, e.g. Academic Search Elite, Wiley Interscience, JSTOR, Biomed Central, Business Source Premier, Highwire, Sage Publications, Science Direct. Documents and reports from international agencies (e.g. WHO, ILO, OECD, IOM) as well as from national government agencies (e.g. DOH) were also included in this literature review.

In summary, this review of literature presents a general picture of the factors that motivate the Filipino nurses to go abroad, focusing on the national and international conditions that aid the mass migration of Filipino nurses, the reasons why such large movement of nurses is raising concerns worldwide and the policy discussion on how to manage the impact of nurse migration.

## **2.2. History of the Migration of Filipino Nurses**

The migration of Philippine nurses is not a recent phenomenon. In what is perhaps the earliest documentation of the migration of nurses and doctors from more than 40 countries during the late 1960s, the Philippines was already named a leading source of nurses (Mejia, Pizurki & Royston, 1979). According to this study, from the late 1960s until the early 1970s, 2,400 Philippine nurses were already registered as nurses in Canada and in the United States. In fact, Filipino nurses made up nearly 50 percent of the registered foreign nurses in the US from 1970-1972. In Canada, Filipino nurses constituted 23 percent of all registered foreign nurses in 1971 and twelve percent in 1972. The sum of registered Filipino nurses in Canada and in the US was equivalent to 111 percent of the nurse licenses registered in the Philippines in 1971 (Mejia, et al., 1979).

Ball (2004) identified two main historical and migratory episodes of Philippine nurses: the first wave began in 1965 and lasted until the early 1980s through permanent migration to the United States; the second wave, started in 1982 and continues to the present through a systematic and government-

sponsored program of sending nurses and other workers as contract workers to foreign countries. A historical account of the first migratory episode can be found in Choy's work (2003) which examined the dynamics behind the development of the Philippine nursing workforce in the early 20<sup>th</sup> century and the subsequent permanent migration of Filipino nurses to the United States in the late 1960s. Choy (2003) argued that the establishment of the Philippine nursing education in 1907, as part of the American colonialist agenda to impose Western medicine on their colonies, laid down the foundation for the Philippines to become a leading exporter of nurses in the present century. The American-based nurse education in the Philippines, the teaching of the English language, and the assimilation of the American culture predisposed and prepared the Filipino nurses to work in the US and in other Western countries.

The vehicle for the first wave of mass migration of Filipino nurses to the US was the Exchange Visitor Program (EVP), established in 1948 to promote a better understanding of the US during the Cold War (Choy, 2003). The EVP allowed foreign students to study and work in the US, with the agreement that they must return to their home countries after the completion of their studies. Eighty percent of the EVP scholars were Filipinos and more than 11,000 Filipino nurses joined the program between 1956 and 1969. Studying in the US became a pathway for professional advancement among Filipino nurses who, upon their return to the Philippines, became chief nurses in hospitals, educators or heads of nursing schools. However, their American experience also sowed the seeds of desire among many Filipino nurses to eventually migrate to the US. The experience of working and living in America idealized the US for the Filipino nurses as a land of promise that offered them the opportunity to achieve socio-economic success, gain material possessions and enjoy travel and leisure activities – a lifestyle that was not possible in the Philippines (Choy, 2003). It was, therefore, not surprising that many Filipino nurses opted to remain in the United States after they finished their studies and worked towards getting a permanent resident visa. The other nurses who returned to the Philippines eventually went back to the US, especially after the US Immigration Act was approved in 1965 allowing skilled professionals to

enter the US as immigrants. Between 1966 and 1985, about 25,000 Filipino nurses migrated to the US (Kingma, 2006). By 1989, 73percent of the foreign nursing graduates registered in the US were nurses from the Philippines (Pizer, Collard, Bishop, James and Bonaparte as cited in Choy, 2003). The “transformative potential of working abroad” (Choy, 2003, p. 73) subsequently changed the Philippine nursing education as subsequent generations of young Filipinos enter nursing school with the dream of going to the United States. In the last two decades a “culture of migration” has become apparent among Filipinos who are eager to work abroad (Asis, 2006, p. 1). For many of the young Filipinos, the nursing profession is their visa to the United States.

### **2.3. The Stock and Flow of Nurses in the Philippines**

More than three decades later, the story remains essentially the same. Filipino nurses still go out of the Philippines to work abroad, but this time their number has increased tenfold. Due to the absence of a national database to monitor the stock and flow of health professionals in the Philippines, it is difficult to establish the exact number of nurses who are working abroad. Generally, data on international migration are limited, even those that come from international sources are fragmented and not timely (Diallo, 2004; OECD, 2003). The recent phenomenon of Filipino doctors becoming nurses and leaving the country to work as nurses abroad has made it more difficult to monitor the stock and flow of Philippine nurses<sup>13</sup>. Different sources provided varying estimates on the total number of Filipino nurses working abroad ranging from 150,000 to 250,000 (Lorenzo, 2000; Aiken, Buchan, Sochalski, Nichols & Powell, 2004; Ball, 2004). One report estimated almost 15,000 Filipino nurses leave the country every year (Adversario, 2003).

Based on the official records of the Philippine Overseas Employment Agency (POEA), 87,852 nurses were deployed abroad from 1992-2003, the highest among the group of Filipino health professionals that included

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<sup>13</sup> Due to the high international demand for nurses, more than 3,000 Filipino physicians are enrolled in nursing schools and another 3,000 left in 2002 to work abroad as nurses (Crisostomo, 2007).

physicians, physiotherapists, pharmacists, midwives and medical technologists among others. The POEA figures from 1994-2003 showed that the annual deployment ranged from about 5,000 to more than 7,000 nurses and reached its highest in 2001 when 13,536 nurses were sent abroad (Ronquillo, Lorenzo & Nodora, 2005). The deployment of Filipino nurses was generally on the upward trend, except for a two-year decline from 1995 to 1997, after which it rose again, posting an average growth of 26 percent from 1998 to 2004. The official Philippine government figures, however, do not present the actual magnitude of nurses leaving the country because these do not include the nurses who found employment abroad through private recruitment agencies, those who went to the US on employment-based immigrant visas, or those who left on tourist and student visas (Institute of Health Policy and Development Studies, 2006). To illustrate, a discrepancy between the records of the US Embassy in the Philippines and the POEA was noted. Based on the US Embassy figures, 7,994 Filipino nurses were granted US work visas in 2004 while the POEA records listed only 373 nurses deployed to the US in the same year (Lorenzo, Galvez-Tan, Icamina & Javier, 2007).

The number of destination countries has also increased, indicating an expansion of the international market for Filipino nurses. The landmark study of Mejia, et al. (1979) noted that in the early 1970s, nurses from developing countries moved to a select few developed countries that included United States, Canada, United Kingdom, New Zealand, Federal Republic of Germany, Australia, and the oil-rich country of Saudi Arabia. Among these countries, the US and Canada were the preferred destinations of 70 percent of the emigrant Asian nurses. Until the early 1990s, majority of Filipino nurses went to the US, but after 1995, Saudi Arabia and UK replaced the US as the number one destination country. Based on POEA records, from 1992-2003, 47,596 Filipino nurses, representing nearly 60 percent of all deployed nurses went to Saudi Arabia, making this country the top destination for 11 years (Ronquillo, et al., 2005; Institute of Health Policy and Development Studies, 2005). The UK was second to Saudi Arabia as a major destination but in 2001, it surpassed Saudi Arabia when it received 40 percent of all the Filipino nurses deployed during

this year (Buchan, Kingma & Lorenzo, 2005; Institute of Health Policy and Development Studies, 2005). However, for many of the Filipino nurses in the UK, this was just a stepping stone in getting to the United States, which was intended to be their ultimate destination (Buchan, 2006; Kingma, 2001). A recent survey of international nurses in UK revealed that 63 percent of the more than 20,000 Filipino nurses had plans of moving to the US (Buchan, Jobanputra, Gough & Hutt, 2006; Buchan & Seccombe, 2006). Emerging as new destinations for Filipino nurses are European Union countries like Ireland, Norway and Netherlands, and the developed Asian countries of Singapore and Japan. The International Labor Organization (ILO) has made a distinction between the top destinations for temporary migrants and permanent migrants. Temporary migrant workers commonly go to the Middle East countries like Saudi Arabia, Kuwait, Qatar and United Arab Emirates while the permanent migrants go to the US, Canada, Australia and New Zealand (Institute of Health Policy and Development Studies, 2005).

Filipino nurses are highly in demand abroad because of their competent and caring ways, their fluency in English and their Western-oriented training (Aiken, Buchan, Sochalski, Nichols & Powell, 2004; Ortin, 1990). As pointed out earlier, the proficiency in the English language and the Western-based nursing education are vestiges of the Philippines' colonial ties with the US. To serve the huge demand in the international market, the Philippines produces nurses more than its domestic requirement. Based on 2003 estimates, the country's stock of nurses was 332,206 nurses while the domestic demand was only 193,223, resulting in an excess of 138,983 nurses (Institute of Health Policy and Development Studies, 2006). The nurse surplus can be ascribed to the mushrooming of nursing schools in the Philippines, from 80 in the 1970s to 460 in 2005. These nursing schools churn out 25,000-50,000 graduates each year, with only half of them passing the licensure examinations (Institute of Health Policy and Development Studies, 2005 & 2006).

Clearly, nursing education is an export industry in the Philippines and produces well beyond the number of nurses who can be employed

domestically. In 2003, 85 percent of all employed Filipino nurses were likely to be working abroad and only 15 percent were employed locally. The local employment consisted of 10 percent in the public sector, four percent in private agencies and one percent in nursing education institutions (Institute of Health Policy and Development Studies, 2006; Lorenzo, Corcega, Yabes, de la Merced & Vales<sup>b</sup>, 2000). The overproduction of nurses will likely continue in the years to come as indicated by the Department of Health (DOH) projections showing an average surplus of 29,608 nurses from 2005 until 2010 (Department of Health, 2005).

#### **2.4. Push and Pull Factors**

The “push and pull” model is the most frequently used theory to explain the factors that motivate nurses to leave and work in another country. The literature on nurse migration abounds with descriptive and empirical studies that identify the push and pull factors to nurse migration. Push factors are conditions in the sending countries that drive nurses to move and work in another country. Pull factors, on the other hand, are conditions present in the destination countries that attract nurses to migrate to these places (Mejia, et al., 1979; Kline, 2003). Both push and pull factors must operate in unison for migration to occur, because no matter how strong the pull forces in the destination country are, large scale migration will not happen if there are no strong push factors in the sending country (Mejia, et al., 1979). Moreover, other facilitating factors must also exist such as the absence of legal constraints to migration (Mejia, et al., 1979; Kline, 2003).

Conditions that push nurses to migrate may be present in both sending and destination countries, but the situation in the destination countries are often perceived to be much better than the circumstances in the sending country (Clark, Stewart & Clark, 2006). The search for greener pastures is illustrated in a study that compared the characteristics and views of long-term migrants, return migrants and non-migrant Filipino nurses. The long-term migrants as opposed to the non-migrants and returned migrants perceived that there are lesser opportunities in the Philippines and more opportunities in the

US (Joyce & Hunt, 1982). Mejia's pioneering study (1978 & 1979) and other more current studies identified the common push and pull factors to nurse migration: wages, working conditions, educational and training opportunities and career advancement.

#### **2.4.1. Wages**

The opportunity to earn higher wages is regarded as a pivotal factor in labor migration (Bach, 2003). Many studies have underscored low salaries as the primary motivating force for the movement of nurses from developing to developed nations. This explanation is based on the neoclassical economic theory that sees migration as the workers' response to international wage disparities (Stalker, 2000). Geographic differences in labor supply and demand lead to differential wages between countries, causing workers from a low-wage country to move to a high-wage country. Often cited as an example are the nurses in the Philippines who get monthly salaries of only US\$75-200 (PhP3,150-8,400) while nurses in the US and UK earn a monthly income of US\$3,000-4,000 (PhP126,000-168,000) and GBP1,000-2,000 (PhP83,000-166,000), respectively (Bach, 2003; Buchan, Jobanputra, et al., 2006; Buchan & Seccombe, 2006)<sup>14</sup>. A Philippine study benchmarked the local nurses' monthly salary (PhP8,500) against the salaries of Filipino nurses in other countries, providing some measure of the wage disparities between nurses working in the Philippines and those working overseas. The monthly salaries of Filipino nurses in Singapore is estimated at PhP45,000 (380 percent higher than local wages); in Saudi Arabia, it is PhP54,000 (530 percent); in UK, PhP119,000 (1,300 percent); and in the US, PhP216,000 (2,900 percent) (Borromeo, n.d. as cited in Agoncillo, 2005). According to the neoclassical economic model, labor migration will end only when wage disparities between countries are eliminated (Massey, Arango, Hugo, Kouaouci, Pelligrino & Taylor, 1993). Under this premise, Philippine health officials and policy analysts have

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<sup>14</sup> Using the conversion rate as of April 14, 2008: 1US\$=41.99700 Philippine peso and 1GBP=82.71603 Philippine peso.

argued that the Philippines will likely continue to experience large outflow of nurses because its domestic wages will never be able to compete with the international wage rates (Galvez-Tan, 2005).

There are studies that challenged the notion that wage differential is the most critical factor in nurse migration, citing other significant factors such as career advancement and working environment as also influential in the migration decision. Currently, there is, as yet, no consensus in literature on the weight of importance of each of the push factor (Kingma, 2006). Using national-level characteristics<sup>15</sup> of 98 source countries of foreign nurses in UK, Ross, Polsky and Sochalski's model (2005) showed that a country's level of income, the use of the English language and bilateral trade overshadowed wages as major determinants of migration. Low-income and English-speaking countries that were engaged in bilateral trade with UK were found to be more likely to have large migration of nurses to UK than other countries which do not possess the above-mentioned characteristics. This research did not support the standard neoclassical theory that wage differential encouraged labor migration, but neither did it deny that wage differential is a major factor. The authors argued that the international labor market for nurses is markedly different from the conditions of neoclassical economics because it is subject to immigration policies and licensing requirements. At the same time, they also acknowledged that their study is limited by the lack of good quality data on international wages and the non-inclusion of career advancement opportunities in their model (Ross, Polsky and Sochalski, 2005).

On the personal motivations of nurses, the International Council of Nurses' (ICN) survey indicated career advancement as the strongest incentive to migrate, but after classifying the respondents into two groups based on the income level of the countries where they came from, the results gave further

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<sup>15</sup> The model used the following variables or characteristics of the source countries: income per capita, population, life expectancy, gross secondary female enrollment, the use of English language, stock of foreign population, bilateral trade with UK, distance in miles from UK, real monthly wages of nurses in 1995 USD, ratio of monthly wages of nurses to kindergarten teacher wages, health expenditure as percent of GDP, stock of nurses per 100,000 population, stock of doctors per 100,000 population, adult prevalence of HIV/AIDS.

insights about the role of wages and professional advancement. For the nurses who came from middle and low income countries, salary was a powerful incentive to migrate while nurses from high-income countries were driven by the desire to find better career opportunities (Kingma, 2001). Another survey involving health professionals in six African countries indicated that wage was an important reason in migration but was not always the most important factor. Living conditions, lack of promotion, gaining experience, upgrading of qualifications were equally important motivations for working abroad and improvements in their working environment, continuing education and fringe benefits would make these health professionals stay in their home countries (World Health Organization, 2003).

A Philippine study that did a regression analysis of the influential factors in the decision to migrate among nurses, doctors who became nurses and graduating nursing students showed that lighter workload, better facilities and better economic and political environment abroad were more significant than wages (Calma, 2005). In another local study that conducted focus group discussions among Filipino nurses, it was revealed that not all of the motivations in going abroad are financial in nature as the participants mentioned gaining independence, experiencing adventure, travel and professional advancement as part of the reasons for seeking employment overseas (Institute of Health Policy and Development Studies, 2006). Even during the early phase of nurse migration in the 1950's-1960s, these were also the same reasons cited by Filipino nurses for participating in the US Exchange Visitor Program (see Choy, 2003).

Another important factor found to be as important as wages and the other push factors is the existence of migration networks in the destination countries (Piore, Bauer & Gang as cited in Vujicic, Pascal, Diallo, Adams & Dal Poz, 2004). Migration networks, defined as ties with migrants who come from the same country as the prospective migrant, provide the latter with information about job opportunities and the needed support to adjust to a life in a new country (Martin, 2003; Massey, et al., 1993). For instance, the presence of

Filipino nurse friends and relatives who were already in the US was a major factor in the Filipino nurses' choice of job locations in the US (Choy, 2003). An important element in these migration networks is the formation of overseas nurse associations, which have played a role in fueling nurse migration (Bach, 2006). These empirical findings indicated that networks increase the likelihood of moving abroad because they lower the risks and increase the benefits of migration (Massey, et al., 1993).

#### **2.4.2. Professional Advancement**

Nurses also migrate to seek professional development or to acquire specialist training that are not attainable in their current job or country (Bach, 2003; Kline, 2003). According to the International Council of Nurses (ICN) survey, nurses usually make it their personal goal to improve their theoretical and learning experience, which often requires moving to a new setting or job and sometimes to another country where opportunities exist for them to acquire new knowledge and skills. This is especially true for highly skilled nurses who consider continuing professional development as integral to their career planning and advancement (Kline, 2003). The proclivity of health professionals from developing countries to seek training abroad can be ascribed to their Western-based medical education. In the case of the Philippines, the curricula of the medical and nursing education, the methods of teaching and the use of high technology equipment are more suited to meet the health care demands in developed nations, rendering the skills and knowledge of health care professionals irrelevant in their own country (Mejia, et al., 1979; Department of Health, 1995). When these health professionals seek advanced training or professional growth, they, inevitably, go to countries like the US or UK where such opportunities are available. Thus, the propensity to migrate is likely to increase with specialization or advanced practice and higher levels of tertiary education (Bach, 2003). As exemplified by the Filipino nurses who participated in the US Exchange Visitor Program in the 1960s, overseas postgraduate training was, indeed, the springboard for their permanent migration to the United States. Based on more current data, the majority of migrant Filipino nurses are nurses who have acquired specialties in the operating room,

intensive care unit, emergency room, critical care unit, hematology and pathology among others (Institute of Health Policy and Development Studies, 2006).

### **2.4.3. Working Conditions**

There are few studies that provide in-depth discussion on the impact of working conditions on the nurses and how these induce nurses to migrate, in striking contrast to the extensive discussion given to wages as the main motivating factor in migration. More often than not, international literature on nurse migration merely mention work-related issues such as poor working environment, heavy workload, job dissatisfaction, inadequate staffing, lack of medical supplies to protect workers from infectious diseases, and work-place violence as among the many causes for nurse migration (Kingma, 2001; Bach, 2006; Hamilton & Yau, 2004). Other external conditions such as war, civil unrest and political instability are also included as among the factors that push nurses to seek employment outside of their country (Dumont & Meyer, 2004; Kingma, 2001). In the Philippines, there is a dearth of studies that examine the work conditions of nurses. The recent case study on Philippine nurse migration simply cited the following work conditions as among the reasons given by Filipino nurses for wanting to migrate: work overload, stressful working environment, slow promotion, lack of employment opportunities, decreasing budget, government corruption and the socio-economic and political instability in the Philippines (Institute of Health Policy and Development Studies, 2006; Lorenzo, et al., 2007).

## **2.5. Globalization and International Migration**

There is no single unified theory on international migration (Massey, et al., 1993); instead an array of theories on international migration offers different levels of analyses on the factors to migration (i.e. individual, household and structural). For example, the new economics of migration model explains labor migration as a household decision to raise family income while the theories of dual labor market and world systems view labor migration as both a requirement and an outcome of the capitalist global economy (Massey, et al.,

1993). Although migration is ultimately a personal choice, it is a decision that is largely shaped by the interplay of various social, economic, cultural, historical and political forces (Massey, et al., 1993; Bach, 2003; Mejia, et al., 1979). Since the “push and pull” model focuses on the personal incentives to migrate, it can overlook the broad structural factors that affect the individual’s decision. In particular, the “push-pull” model tends to minimize the role of national governments, supra-national and private institutions in promoting and sustaining international migration (Bach, 2003). Furthermore, many authors have argued that the current trend of international nurse migration can be best understood if examined in the context of the structural changes and processes attendant to globalization – i.e. trade liberalization, the integration of international labor market, public health sector reforms and changes in immigration policies (Van Eyck, 2004; Buchan & O’May, 1999).

No single theoretical framework can adequately explain the range of socio-economic and political factors to migration, and using only one level of analysis will not aid us in fully understanding the complex processes associated with migration (Massey, et al., 1993; Clark, et al., 2006). Thus, this review of literature complements the “push and pull” theory with a discussion on the structural conditions underlying the international migration of nurses. The ensuing discussion is by no means an exhaustive treatise on the different migration theories and the relationship between globalization and international migration because these topics are beyond the scope of this paper. The purpose of presenting the structural conditions, specifically, the global shortage of nurses, the international recruitment of nurses and the Philippine government labor-export policy is mainly to sketch the larger landscape within which the Philippine nurse migration is occurring.

The international migration of labor is one of the hallmarks of the contemporary economic globalization. In the last decade (1990-2000), a phenomenal increase of 21 million migrants worldwide has been documented, prompting social scientists to call this era the “age of migration” (United Nations, 2002; Castle & Miller as cited in Skeldon, 1997, p. 4). An estimated

175 million persons, constituting three percent of the world's population are now currently residing outside the country of their birth. International migration has existed for centuries but the current migration trend signals a shift in quantity, velocity and direction of population movement (International Organization for Migration, 2002). This trend is distinguished by large-scale movement of people from poor countries to rich countries, referred as the South-North migration. Sixty percent of the world's migrants who now live in developed nations like United Kingdom, United States, Australia and New Zealand are from less-developed countries (United Nations, 2002). Employment is a major reason for the South-North migration. In 2006, migrant workers comprised 90 million of the global workforce, and health care professionals made up a large percentage of this group (United Nations, 2002; Martin, Abella & Kuptsch, 2005; Bach, 2003). Globalization will expectedly intensify the international movement of labor as more countries open up their economies to international trade and capital flows (International Organization of Migration, 2008).

International labor migration is an integral component of a divergent globalization (Adlung, 2002; Castles, Ghosh, Stalker as cited in Ball, 2004). The inequitable socio-economic development characterized by rising income inequalities within and between nations has spurred the massive movement of skilled workers and professionals from less-developed to developed countries (Stalker, 2000). The migration of workers reflects the role of developing nations in the global economy as labor-sending nations and as rich sources of low cost labor that are urgently needed in the industrialized economies (Ball, 2004). A telling evidence is the rise in the number of labor-sending countries from 29 to 55 and the increase in the number of receiving countries from 39 to 67 from 1970 to 1990 (Stalker, 2000). International trade agreements such as the General Agreement on Trade in Services (GATS) and changes in immigration rules have facilitated the movement of human resources. In addition, lower travel costs, advancements in communication and information technologies have made migration easier and circular migration more prevalent (Doyle, 2004).

### **2.5.1. Global Shortage of Nurses – The New Pull**

According to the World Health Organization (2006), health systems around the world are facing a serious shortage of health professionals. The most prominent is the nursing shortage because nurses constitute the largest group of health care professionals in many health care systems (Clark, et al., 2006). The overall scale of the nursing shortage is staggering and evidence indicates that this will not abate in the coming years. There is no universal definition for nursing shortage, but from a country-level perspective, it can be measured in terms of the relation of the current availability of nurses to a country's own historical staffing levels, resources, and estimates of the demand for health services (Buchan & Calman, 2004). In 2005, the United States experienced a shortage of 150,000 nurses, which is projected to increase to more than 275,000 by 2010 and to over 800,000 by 2020 (US Department of Health and Human Services, 2002). In Canada, the Canadian Nurses Association said they will have a nurse shortfall of 78,000 in 2011 and 113,000 in 2016 (Buchan & Calman 2004; RNABC as cited in Clark, et al., 2006). UK's National Health Service needed to recruit 110,000 nurses in 2004, and by 2010, Australia will have to hire 40,000 more nurses (Finlayson, Dixon, Meadows & Blair, 2002; Buchan & Calman, 2004). Less-developed countries are experiencing the same problem such as the Sub-Saharan African region which needs 600,000 nurses (Buchan & Calman, 2004).

The worldwide shortage of nurses is a result of an imbalance in the demand and supply of nurses (Clark, et al., 2006). In developed countries, there is an increasing demand for health services because of their growing elderly population who requires a disproportionate amount of health care. For instance, between 2010 and 2030, the proportion of persons aged 65 and above in the United States is projected to grow from 13 percent to 20 percent, which means more nurses have to be hired to care for this population group (Clark, et al., 2006). Ironically, in the face of rising demand, the supply of nurses in developed countries is falling. A number of reasons are cited for the dwindling supply of nurses in these countries. One reason is women, who

make up more than 90 percent of the nursing workforce, are less inclined to enter the nursing profession because they now have more career options than in the past (Cherry & Jacobs as cited in Clark, et al., 2006; Buerhaus, Staiger & Auerbach, 2000). Consequently, there is not enough replacement for the aging nursing workforce in developed countries where the average age of nurses is more than 40 years old. In the United States, only nine percent of the nurses are under 30 years old and in New Zealand, more than one-third of its nurses are over the age 40 (Kline, 2003; Clark, et. al., 2006; Bland, 2005).

Other authors went past the demographic factor to expose the underlying structural causes for the nursing shortage. The role of neo-liberal economic policies, also known as health care reforms or structural adjustment programs is underscored in the declining supply of nurses (Pond & McPake, 2006). The health care reforms implemented in many countries resulted in reduced government health care expenditures, decreased hospital staffing, laid-off nurses, lesser wages and benefits and substitution of registered nurses with nursing aides (Kingma, 2006; Van Eyck, 2004; Bach, 2003; Clark, et al., 2006). In the US, the decrease in nurses' real wages, and the decline in the recruitment and retention of nurses were associated with the implementation of managed health care in the 1990s, which reduced the growth of nurse positions in hospitals (Pond & McPake, 2006). In New Zealand, the sweeping national economic reforms in the 1990s that covered the health sector were pinpointed as the cause of the high turnover of nurses and deterioration of hospital quality (Bamford & Porter-O'Grady, 2000). The effects of the health sector reforms on the nurses such as heavy workload, long working hours, job dissatisfaction, stress and burnout forced many nurses in developed countries to reduce their working hours or leave their profession entirely. Other nurses decide to move to another developed country where the work situation is relatively better. For instance, in New Zealand, one in five new nursing graduates leave to work in countries like Australia and UK (Aiken, et al., 2001; Bland, 2005). In less developed countries in Asia and Africa, the consequences of World Bank-imposed structural adjustment program were similar to what happened in the developed countries. It placed further constraints to the

already limited resources that these countries allot for health care. Just as the nurses from Australia and New Zealand move to UK and US to find jobs with better conditions, so do the nurses from Asia and Africa (Clark, et al., 2006).

Kingma (2006) described the present global shortage of health care professionals as the “new pull” factor for nurse migration. The worldwide shortage of nurses has created a strong and growing international labor market for health professionals, facilitated by the integration of the global health care market (Clark, et al., 2006; Buchan and O’May, 1999; Kingma, 2001). Trade liberalization has made it possible for financial capital to flow freely between countries, resulting in the rapid expansion of transnational or multinational health care companies specializing in pharmaceuticals, medical equipment and health insurance across the globe (Van Eyck, 2004). Indeed, the health care sector is one of the fastest growing industries in the global economy and the integration of the global health care market has made it easier for developed countries experiencing nurse shortage to recruit nurses from developing nations (Van Eyck, 2004; Kingma, 2006).

### **2.5.2. International Recruitment of Nurses**

Active international recruitment of nurses is the expedient solution adopted by developed countries to alleviate their nursing shortage (Buchan & Calman 2004; Van Eyck; 2004). In the last couple of years, countries like the US, UK, Canada, Australia and New Zealand have been increasingly recruiting nurses from other countries through the use of commercial recruitment agencies (Bach, 2006). Recruiting nurses from other countries is less costly for the receiving countries because they do not pay for the costs of the nurses’ education, a strategy that is in line with the health care cost containment instituted in developed countries (Vujicic, et al., 2004; Van Eyck, 2004). Among the destination countries, the UK has, perhaps, the most organized recruitment program (Clark, et al., 2006). The UK’s National Health Service (NHS) sources its foreign nurses mainly from China, Philippines and India, three countries which forged a bilateral agreement with UK that it is acceptable to recruit

nurses from their countries<sup>16</sup> (Clark, et al., 2006; Buchan, 2006). The NHS has established a network of recruitment coordinators and has set up a website to facilitate the direct recruitment of foreign nurses (Buchan, 2006). It also provides information on job locations, immigration procedures and living arrangements (Buchan & Dovlo, 2004; Buchan, Jobanputra & Gough, 2004). As testament to its systematic recruitment, a survey found that 96 percent of Filipino nurses in UK came there through a recruitment agency. Filipino nurses were also the most likely among foreign nurses in UK to have made payments to recruitment agencies (Buchan, Jobanputra, Gough & Hutt, 2005).

## **2.6. The Philippine Context**

The large-scale nurse migration from the Philippines is a response to the dynamics of global nursing shortage and a national government program that fills the international demand for labor (Ball, 2004). The convergence of market forces operating at the international and national levels along with the prevailing socio-economic conditions in the Philippines has made this country one of the top labor-sending countries in the world, second only to Mexico.

### **2.6.1. The Philippine Labor Export Policy**

The active international recruitment of nurses is matched by a vigorous labor-sending program of the Philippine government. While there is no explicit labor export policy,<sup>17</sup> the Philippine government has, nevertheless, institutionalized the sending of Filipino workers to foreign countries. Government agencies have been established to facilitate the deployment of workers abroad and to promote and protect the welfare of Overseas Filipino Workers (OFWs) (Buchan, 2006). The Philippine Overseas Employment Administration (POEA) is the government agency that is responsible for

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<sup>16</sup> The Commonwealth Code of Practice for the International Recruitment of Workers requires UK that it can recruit only from developing countries which agree to active international recruitment of their nurses (Buchan, 2006).

<sup>17</sup> It is stated in RA 8042, the *Migrant Workers and Overseas Filipinos Act of 1995* that while the significant contribution of Filipino migrant workers to the national economy through their foreign exchange remittances is recognized, the State does not promote overseas employment as a means to sustain economic growth and achieve national development.

promoting and developing the overseas employment program; regulating the private sector recruitment through licensing; protecting the rights of migrant workers; and monitoring the placement of overseas workers through a registration system. The Overseas Workers Welfare Administration (OWWA) is the lead government agency that provides welfare services to OFWs and their families; and administers the OWWA fund, a trust fund pooled from the membership contribution of foreign employers and overseas workers. In addition, the Philippine Legislature also enacted Republic Act 8042, known as the *Migrant Workers and Overseas Filipinos Act of 1995*, which promotes and protects the rights of Filipino migrant workers.

What started as a stop-gap measure to ease unemployment in the 1970s, the overseas deployment of workers has now become a key source of growth for the Philippine economy (Aiken, Buchan, et al., 2004). The labor-sending program was intended to be a temporary measure to address the country's economic problems during the oil crisis in the 1970s, but the continuing demand for workers in the Middle East and the opening of new labor markets in Asia fueled further migration in the succeeding years (Asis, 2006). By 2006, the number of Filipinos working abroad was estimated at 1.5 million. The OFWs are called "the new heroes" in the Philippines because the remittances they send home, which reached US\$12.8 billion in 2006 prop up the Philippine economy (Bangko Sentral ng Pilipinas, 2007; Dumlao, 2007). Furthermore, the Philippine government is unable to provide employment to a rapidly growing population of more than 80 million Filipinos; hence, sending workers abroad remains a vital government strategy to cope with the continuing high unemployment rates in the country.

Earlier in the discussion, it was mentioned that Philippine nursing schools produce an estimated 25,000-50,000 nursing graduates annually; however, it is uncertain how many of these new nurses can be employed locally since there are no available data on the total number of nursing positions in the Philippines. What is known is that the Philippine government, which is the biggest employer of nurses, has only 16,000 positions available for

nurses in national and local government health facilities (Lorenzo, et al., 2007). Another report stated that only 1,000 new positions are allocated for the more than 10,000 nursing graduates each year (Pacquiao as cited in Brush and Sochalski, 2007). By all indications, the country is unable to absorb locally the thousands of nursing graduates being produced annually.

### **2.6.2. The Philippine Health Care System**

An overview of the Philippines' health care system and the many problems and issues beleaguering it will help us understand the push factors driving the current trend of nurse and health worker migration in the country (Ronquillo, et al., 2005). The country has an extensive health care delivery system with 662 public hospitals and 1,057 private hospitals with a total bed capacity of 84,761 or 1 bed per 1,304 people. The government hospitals, which provide free medical care services, have more than 45,000 beds, constituting 53 percent of the total bed capacity. The public health delivery system also includes 2,405 rural health units (RHU), which serve an estimated 30,000 people; and 13,556 barangay health stations (BHS), with each BHS serving more than 5,000 people (Department of Health<sup>a</sup>, 1999).

Despite an extensive network of public health facilities, inequitable access to health care is a major problem in the Philippines. It is a multifaceted issue that is rooted in the geographical, political, social and economic conditions in the Philippines. Majority of Filipinos have limited access to health care services due to financial and physical barriers. The 2003 National Demographic and Health Survey cited "getting money for treatment, distance of health facility, and having to take transport" as the most common reasons why people cannot avail of health care services (National Statistics Office & ORC Macro, 2004, p. 30). To begin with, the country is an archipelago made up of more than 7,100 islands, so there are areas where physical accessibility of hospitals is a given fact. Most Filipinos also cannot afford health care services yet they shoulder the bulk of health care costs, since the national health insurance only covers eight percent of the total health care expenditures (National Statistical Coordination Board, 2006).

Another dimension to the inaccessibility of health care is the unequal distribution of health care personnel. Forty-seven percent of doctors and 42% of nurses working in the government sector can be found in two urban regions, while the rest are distributed in the rural areas of the 14 regions in the Philippines (see Ronquillo, et al., 2005). The inequitable access to health care services is also largely attributed to the limited resource allocation for health care. As a proportion to the gross national product (GDP), the health care expenditures in the Philippines are declining and are well below the WHO-recommended five percent of the gross national product (GNP). From a 3.5 percent share of the GNP in 1997, the Philippine health care spending went down to 2.7 percent in 2002 and 2.9 percent in 2003 (National Statistical Coordination Board, 2008).

In 1991, the delivery of health care services was devolved to local government units (LGUs) with the enactment of Republic Act 7160, or *The Local Government Code*, which granted LGUs fiscal autonomy and certain powers to perform and deliver specific functions and services. Under the devolved set-up, the Department of Health (DOH) remains the lead agency on health policies and oversees the management of 72 tertiary-level hospitals, but the bulk of government health facilities, consisting of 590 secondary and primary care facilities have been turned over to the management and ownership of provincial, city and municipal governments. The devolution of health services brought into the spotlight the sorry state of public hospitals that the LGUs inherited. These hospitals are ill-equipped and badly need repair and upgrading. The LGUs, however, do not have the financial capacity to upgrade the devolved hospitals as indicated by the reduced spending for hospital maintenance and other operating expenses (Department of Health<sup>b</sup>, 1999). The LGUs' health care expenditures in 2003-2004 barely grew from PhP23.5 billion to only PhP23.8 billion (National Statistical Coordination Board, 2006). Studies pointed out the huge disparity between the financial resources transferred to LGUs to cover the costs of devolved health functions and the actual costs of operating the hospitals (Loehr & Manasan, 1999; Eaton, 2001; Department of Health<sup>b</sup>, 1999; Bossert & Beauvais, 2002; Furtado, 2001). One

of the consequences of the pathetic conditions of devolved health care facilities is the overcrowding in tertiary-care level hospitals as patients flock to these hospitals where they can avail of relatively better medical treatment.

The transfer of the corresponding health personnel to the LGUs sparked protests from the more than 40,000 devolved public health workers who feared diminution of their salaries and positions. The Local Government Code conferred to LGUs the authority to implement their own organizational structure, staffing pattern and compensation scheme for their officials and personnel based on the LGU's income classification<sup>18</sup> and the guidelines set by the Civil Service Commission (Del Prado, Diwa, Estabillo, Lorenzo, Santos & Sia, 1999). To appease the health workers' apprehensions, the Philippine Congress approved Republic Act 7305 or the *Magna Carta for Public Health Workers* in 1992, giving more benefits to health workers in the form of salary increase for rural doctors and laundry and subsistence allowances for all other health workers (Perez, 1998). However, due to the financial constraints of the LGUs, the implementation of these benefits is uneven - some LGUs provide only partial of the mandated benefits while others simply cannot afford to give these benefits. Even with the existence of the *Salary Standardization Law* that supposedly harmonizes the salaries of all government workers some devolved health workers still receive less than half of the salaries and benefits that their national counterparts are receiving.

The devolution of health services has caused demoralization among the devolved health care workers. Aside from the diminution of their salaries, it has affected their security of tenure and professional development. There is evidence that political influence interferes in the selection, promotion and security of tenure of health personnel (Del Prado, et al., 1999). Since it is the local chief executive (i.e. governor and mayor) who appoints all employees under his unit, health workers who are sympathetic to the incumbent administration are likely to get promoted or stay in position while personnel

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<sup>18</sup> Local government units (LGUs) are classified from 1<sup>st</sup> to 6<sup>th</sup> class based on their annual income; LGUs classified as 1<sup>st</sup> class have the highest income while those that are considered as 6<sup>th</sup> class have the lowest income.

identified with the previous administration are likely to get sacked, demoted or transferred to another office (Perez, 1998). Moreover, due to meager resources, the LGUs do not give priority to human resources development such as trainings and further education of health personnel (Del Prado, et al., 1999). Evidently, the aftermath of the devolution of health services engenders the very conditions that drive Filipino nurses and other health workers to seek greener pastures abroad.

## **2.7. Impact of Nurse Migration on the Health Care System**

Warning bells have been sounded about the dire consequences of the current pattern of international nurse migration. Fingers are pointed at the aggressive international recruitment of nurses by developed countries, which is perceived to be exacerbating the shortage of health care professionals in developing countries (Bach, 2003; Van Eyck, 2004). It has been argued that the international recruitment of nurses is contributing to brain drain by siphoning away valuable human resources from rudimentary public health care systems of poor nations (Van Eyck, 2004; Joyce & Hunt, 1982; Ball, 2004). Both developed and developing countries are experiencing shortfalls, but it is the developing countries which lose out because they cannot compete in the global labor market and have limited resources to replace the health care professionals they have lost to migration (Commonwealth Secretariat, 2003). Not only do source countries lose essential human resources, they also incur financial losses in terms of foregone investment in the education and training of health care professionals and the potential tax revenues from their earnings had they stayed in their own country. In Africa, each health professional that leaves their country represents an investment loss of US\$184,000 (United Nations Environment Program as cited in Marchal & Kegels, 2002).

The impact of nurse migration especially on source countries is a highly contentious subject matter. For every argument against nurse migration, there is always a counter-argument. The loss of human and financial resources, for instance, is said to be offset by the substantial remittances that migrants send back home. However, there is little proof that the remittances can compensate

for the damage done to the health care systems of source countries because the remittances go directly to the migrants' families (Clark, et. al., 2006). In addition, since highly skilled professionals tend to migrate with their families, the remittances may decline over time (Wickramasekara, 2002). The issue of brain drain has been challenged by the ideas of brain exchange and brain circulation, which contends that the contemporary migration trend is hardly permanent and when health care professionals return to their country, they bring with them enhanced human capital (Clark, et. al., 2006; Bach, 2003; Wickramasekara, 2002). But then, again, empirical evidence shows that only about 10 percent of the emigrants return home to their countries. All the same, even if a nurse does return to her own country, she may not be able to apply the advanced training she acquired overseas because the high-tech medical equipments commonly used in developed countries are rarely available in Third World countries (Clark, et al., 2006). Perhaps the strongest argument raised against the migration of nurses is that it is contributing to the inequitable access to health care in developing countries, and in the scheme of things, it is always the poor who suffer the most from unavailable health care services (Van Eyck, 2004; Marchal & Kegels, 2002). In this manner, the international migration of nurses is seen as undermining the developing nations' public health care systems by limiting their capacities to provide vital health care to their citizens (Clark, et al., 2006).

### **2.7.1. Impact on the Philippine Health Care System**

In the Philippines, which is the leading source of nurses to the world, there has yet to be a definitive study that assesses the impact of migration on the country. In fact, gathering hard evidence on the effects of nurse migration has just been started (Lorenzo, et al., 2007). The picture is still unclear as to how the country is affected by the continuing exodus of Filipino nurses. For instance, the arguments about the negative impact of migration, particularly the loss of huge amount of investment and potential tax revenues do not seem to apply in the Philippine case. Eighty-nine percent of the nursing schools in the country are private establishments and only 11 percent are state-funded, so the government could not lose an investment that it did not pay for in the first

place (Tenorio, 2002; Bach, 2003). On the loss of tax revenues from potential earnings of nurses, the lack of employment opportunities as evidenced by the high unemployment rates in the country easily refutes this argument (Bach, 2003).

The most serious and oft-reported impact of the unabated nurse migration is the shortage of nurses in the country. However, reports and findings about this matter are mixed and sometimes conflicting (Kline, 2003). On one hand, there are findings that the Philippines continues to have a big surplus of nurses as the estimated supply exceeds the demand for nurses (Lorenzo, et. al., 2000; DOH, 2005; Bureau of Labor and Employment Statistics, 2003; Institute of Health Policy and Development Studies, 2006). The surplus is attributed to the large annual production of 25,000-50,000 nursing graduates (Institute of Health Policy and Development Studies, 2006). On the other hand, there are catastrophic predictions of a breakdown of the Philippine public health care system caused by a serious nursing shortage in the country. One report estimated the Philippines' nursing shortfall at six percent which may rise to 29 percent by 2020 if the on-going large migration continues (Padilla, 2003). Calma's study (2005) disputed the findings about the nursing surplus in the country. According to this study, despite the dramatic increase of nursing enrollees after 2000, the number of licensed or registered nurses has not increased in the same manner. From 1995 onwards, the passing rate in the nursing licensure examinations has declined to 50 percent, which means that the number of board examination passers has also decreased from 25,477 in 1994 to only 7,371 in 2004. Comparing these figures with the number of deployed nurses after 2000,<sup>19</sup> Calma (2005) concluded that the deployment of nurses is actually greater than what was being produced, resulting in a nurse shortfall in the Philippines.

Reports on the shortage of nurses are mostly anecdotal. Newspaper articles have given accounts of several Philippine hospitals with severe nursing

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<sup>19</sup> The POEA figures show that in 2001 and 2002, the Philippines deployed 13,252 and 11,530 nurses, respectively (Ronquillo, Lorenzo & Nodora, 2005).

shortages, which were readily ascribed to nurse out-migration. The reported turnover rate of nurses in hospitals has reached as high as 40 percent to 50 percent during periods of high demand and as low as three percent to five percent during lean periods (Tenorio, 2002). There were also accounts of 30,000 nurse vacancies in 2004 (McKenna as cited in Clark, et al, 2006). Because of the shortage of nurses, 200 hospitals have reportedly closed down in the last two years and another 800 have shut down some of their clinical departments for the same reason (Philippine Hospital Association, 2005).

The findings of two recent studies may shed more light on the reported shortage of nurses in the Philippines. Agoncillo (2005) who studied the relationship of nurse migration and patient care in six DOH medical centers maintained that nurse shortage has always been a “status quo in hospitals even without migration” because public hospitals lack plantilla<sup>20</sup> positions for nurses (p. 235). She argued that the effect of nurse migration can be seen through the rapid turnover of nurses in hospitals, which aggravates the existing nurse understaffing and places onerous burden on the nurses who are left behind. While there was no difficulty in getting replacements for the nurses who have left, bureaucratic procedures prolonged the hiring process. Moreover, the hospitals’ training costs increased since they had to train the newly-hired nurses who are fresh nursing graduates without prior professional experience (Agoncillo, 2005). The Perrin, et al. study (2007), which interviewed chief nurses from 200 government and private hospitals, supported the findings that there is no shortage of nurses who can fill the void left by nurses who migrated. However, the study also noted that government and private hospitals have difficulty recruiting nurses with more than one year of work experience. These findings lend credence to the alternative view that the problem in the Philippines is not a shortage of nurses but a lack of skilled, experienced and specialist nurses, many of whom have already gone abroad (see Kline 2003; Institute of Health Policy and Development Studies, 2005, 2006). In the same study of Perrin, et al (2007), the chief nurses identified the barriers to adequate nurse staffing in hospitals, which include limited positions for nurses because

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<sup>20</sup> Plantilla positions means permanent positions created for a particular government agency.

of budget constraints, low salaries, lack of skilled applicants and high turn-over of nurses. Government hospitals, however, fared better than private hospitals in terms of employment tenure, vacancy rates, turnover rates and ability to recruit and retain nurses. The low wages in the private sector (US\$69/month) relative to the wages in the public sector (US\$86/month) is a disincentive for nurses to work in private hospitals, which could help explain why some private hospitals had to close down due to the lack of doctors and nurses. In addition, many small private hospitals have financial difficulties and are struggling to survive; thus, the shortage of nurses is only one of the many reasons for the closure of small private hospitals (Manila Times, 2007). Understaffing, low wages, poor working conditions, and the closure of some hospitals are some of the symptoms of an ailing health care delivery system in the Philippines.

Apparently, there is a dearth of local studies that examines how the Philippines is being affected by the migration of its nurses and other health care professionals. Moreover, there is a lack of studies that specifically examine the impact of migration on the staffing levels in government and private hospitals as well as on the distribution of health care personnel throughout the country. Notwithstanding these limitations, the lack of nurses and other health care professionals as well as the dismal conditions of health care facilities are legitimate and urgent concerns which are often raised in public forums and in the media and which demand immediate response from the government. Knowledge about the impact of nurse migration is vital to the planning and development of appropriate policies and mechanisms.

## **2.8. Nurse Retention Policies**

The international migration of nurses has stimulated vigorous policy debates on how to mitigate its impact on developing countries. The policy options found in literature range from broad measures addressing the structural factors to specific strategies targeting the push factors operating at the individual level. The proposed options include macro-economic policies to spur economic growth in source countries; public and private investments in health; multilateral agreements between countries to manage migration; improvements

in pay, working conditions, prestige, and job satisfaction of nurses (see Buchan & Sochalski, 2004; Wickramasekara, 2002; Stilwell, Diallo, et al., 2004; Baumann, Yan, Degelder & Malikov, 2006). The International Council of Nurses (ICN) developed a policy framework consisting of four (4) interdependent key components: workforce planning, recruitment and retention, deployment and performance, and utilization and skill mix aimed at curbing the worldwide nursing shortages, especially in developed countries (Buchan & Calman, 2006). The ICN policy framework is generally oriented towards retaining nurses as part of the nursing workforce in their country.

Nursing shortages around the world are attributed to inadequate retention policies of health workers (WHO, 2006). Retention of the nursing workforce is defined as the “maintenance of an appropriate supply of nursing personnel to meet the health needs of a given population” (Baumann, et al., 2006, p. 5). Retention is closely related to recruitment, two concepts that refer to processes and mechanisms to attract and keep the right personnel in the health system. These two are deemed important because the performance and quality of health care services rely on a well-motivated health workforce. Recruitment and retention strategies can take the form of monetary and non-monetary incentives that include career and professional advancement, workload management, flexible working hours, positive working environments and access to benefits and supports (see Global Health Workforce Alliance- WHO, 2008).

A number of studies have been done in recent years to investigate what policies and mechanisms are effective in recruiting and retaining nurses. These studies shared common results---that non-financial incentives play a significant role in motivating health care professionals. The study of Vujicic, et al. (2004) examined the probable effects of wage increases in slowing down migration flows and concluded that wage increase in source countries, unless very substantial, will not decrease the willingness to migrate among health professionals. This study also suggested that non-wage instruments may be more effective in reducing nurses’ outflow. The growing body of literature on

retention and recruitment of health professionals, however, are mostly focused on the experiences of developed countries. Empirical and qualitative studies on retention strategies implemented in developing countries are still limited (Mathauer & Imhoff, 2006; Yumkella, 2006).

A multi-country report documented the success of the following strategies in retaining doctors and health workers in several African countries: (1). rural and scarce skill allowance in South Africa; (2). additional duty hours allowance and post-graduate medical training in Ghana; (3) housing facilities in Malawi; (4). refresher training courses in Zambia; and (5) a combination of continuing education, housing facilities and clear career paths for health workers in Ethiopia (Yumkella, 2006; Lehman & Sanders as cited in Yumkella, 2006; Dovlo & Martineau, 2004; Dovlo, 2004; Mathauer & Imhoff, 2003). A qualitative study involving nurses and doctors in Benin and Kenya concluded that non-financial incentives and human resource management tools are important in strengthening the professional ethos of doctors and nurses, which is essential in enhancing the motivation of health professionals. The tools for human resource management referred to in this study included acknowledging the professionalism of health care workers and addressing their needs for career development (Mathauer & Imhoff, 2006). These abovementioned studies emphasized the importance of combining financial and non-financial incentives for a comprehensive retention strategy, which bode well for resource-constrained countries that cannot afford to increase the financial remuneration of their health workers (Mathauer & Imhoff, 2006; Yumkella, 2006). However, it must be pointed out that the reported successful retention strategies such as those implemented in Africa still need rigorous evaluation and that many of the available evidences in other developing countries remain anecdotal (Yumkella, 2006).

### **2.8.1. The Philippine Policies**

The policy proposals that have been put forward to mitigate the impact of migration, such as the strategic solutions under the Philippine Nursing Development Plan are based on the premise of a continuing nurse exodus and

are designed to maximize the benefits that nurse migration can bring to the country. One proposal is to forge bilateral agreements with countries recruiting Filipino nurses to recompense the loss of nurses and alleviate its impact on the health care system. These compensatory mechanisms include investment packages to upgrade nursing education, increase nurses' salaries, provide training and education scholarships for Filipino nurses. A North-South hospital-to-hospital partnership is also being proposed whereby the hospital in the developed countries will have to pay Philippine hospitals that employed the recruited nurses for the total cost of training, estimated at US\$1,000 (at 2002 prices) per nurse. This amount of money is intended to provide Philippine hospitals the resources to train more nurses to replace those who have been recruited (Lorenzo, et al., 2007; Galvez-Tan 2005; Galvez-Tan<sup>a</sup> n.d.). None of the proposed compensatory mechanisms have come to fruition yet since these entail high-level negotiations which the Philippines, a developing country, has to initiate with the economically powerful countries of the North. To ensure an adequate supply of nurses in the country, the Philippine Nursing Development Plan urged the institution of a National Health Service Act compelling health professionals who graduated from state-funded universities and colleges to serve in the Philippines for a few years before they can go abroad (Lorenzo, et al. 2007; Galvez-Tan<sup>a</sup>, n.d.). But based on past experience, compulsory service did not work in the Philippines – a Philippine law that required medical doctors to serve in the rural areas was not successful and was, thereby, repealed. Moreover, criticisms have been raised against compulsory service for targeting only graduates of state-funded universities and for its infringement on a person's right to freedom of movement. Critics of compulsory service contend that a more acceptable and effective approach is to formulate retention strategies that would address the reasons why nurses go abroad (Clark, et al., 2006). However, none of the abovementioned policy proposals seek to do this and for this reason, the Philippine government is being accused of promoting migration rather than stemming the outflow of nurses and other health care professionals (Institute of Health Policy and Development Studies, 2006).

### **2.8.1.1. The Philippine Nursing Act of 2002**

Notwithstanding the lack of serious efforts to regulate the outflow of Filipino nurses and other health care professionals, there are policies already in place that can be harnessed as retention mechanisms (Institute of Health Policy and Development Studies, 2006). One of these is the Republic Act 7305, the *Magna Carta of Public Health Workers of 1992*, which aims to promote and improve the social and economic well-being of health workers by improving their work conditions and strengthening their capacities in delivering health care services. The other is Republic Act 9173, the *Philippine Nursing Act of 2002*.

The Philippine Nursing Act is the first deliberate effort by the national government to specifically address the consequences of unabated Filipino nurse migration. The health human resource development provisions of the Philippine Nursing Act were intentionally formulated and enacted to address the growing concerns that the mass migration of nurses is causing a shortage of nurses in the country. The Nursing Act's Declaration of Policy (Section 2) states:

It is hereby declared the policy of the State to assume responsibility for the protection and improvement of the nursing profession by instituting measures that will result in relevant nursing education, humane working conditions, better career prospects and a dignified existence for our nurses. The State hereby guarantees the delivery of quality basic health services through an adequate nursing personnel system throughout the country.

The basic premise of the Nursing Act is that it is necessary to encourage nurses to stay in the Philippines in order to maintain an adequate number of nursing personnel in the country. The Law provides two main strategies to retain nurses in government hospitals: (1) increasing the minimum base salary of nurses to Grade 15 and; (2) establishing a nurse specialty training program

in government hospitals, whereby participating nurses are required to render a two-year return service. These strategies are supplemented by the following mechanisms: (1) the undertaking of studies on health human resource production, utilization and development and; (2) the provision of non-financial benefits such as scholarship grants, free medical care for nurses and their dependents and mandating government and private hospitals to maintain the standard nurse-patient ratio set by the Department of Health.

The objectives and intent of the health human resource development provisions are laudable and of great importance, yet not one assessment has been done to determine whether these retention mechanisms are relevant to the conditions and needs of Filipino nurses and how these are being implemented. There are questions raised as to whether salary increase is enough to make the nurses stay in the country given research findings to the contrary. Moreover, details about the establishment of the nurse specialty training program are hazy. Worse, there are reports that these provisions have not been implemented at all since the approval of the Nursing Act in 2002. So far, there has not been any study that looked into the reported non-implementation of these provisions. Apparently, there is an information gap that needs to be addressed concerning the retention strategies provided under the Philippine Nursing Act of 2002.

Retention strategies must be realistic and deliverable, well-designed and strategic, contextually appropriate and reflect the health professionals' needs and preferences. These are some of the characteristics of an effective incentive scheme for health professionals (Global Health Workforce Alliance-WHO, 2008). My research study hopes to inform policymaking and contribute to the formulation of evidence-based nurse retention strategies in the Philippines by bringing in the perspectives and experiences of the policy implementers and of the intended beneficiaries – i.e. the nurses working in government hospitals. It seeks to fill the gap in knowledge by examining the factors affecting the implementation of the retention policy under the Nursing

Act and by examining the actual conditions and needs of the nurses working in government hospitals.

## **2.9. Summary of the Review of Literature**

As shown in this chapter, the Philippines was already a leading source of nurses as far back as the 1960s-1970s, with the US as the top country of destination. The 1990s saw a dramatic increase in the number of Filipino nurses going abroad and in the number of destination countries, which include Saudi Arabia, United Kingdom, European Union countries, Japan and Singapore, indicating a rising demand for Filipino nurses in the international market.

A number of studies have identified the common “push-and-pull factors” that motivate nurses to work overseas, which are: wages, career and professional advancement and working conditions. These factors are compounded by the worldwide shortage of nurses in developed countries and the globalization of world economies. Under a divergent globalization, the migration of workers also reflects the role of developing nations like the Philippines as rich sources of cheap labor for the developed countries. The literature review also extensively discussed the impact of the unprecedented large scale nurse migration on the developing countries’ health care systems. It deprives countries like the Philippines valuable health care professionals who are vital in the delivery of health care services to their citizens. Reports of a nurse shortage brought about by the continuing migration of Filipino nurses prompted the Philippine government to formulate the health human resource development provisions under the Philippines Nursing Act of 2002. These provisions seek to provide mechanisms for the retention of nurses in the Philippines in order to ensure an adequate supply of nursing personnel in the country.

To conclude, this review of literature has presented a general picture of the factors that motivate nurses to go abroad, focusing on the national and international conditions that aid the mass migration of Filipino nurses, and discussed the impact of large outflow of nurses on developing countries, and the policy discourse on how to mitigate the negative effects of nurse migration.

## **Chapter Three**

### **RESEARCH METHODOLOGY**

#### **3.1. Introduction**

This chapter explains the qualitative research methodology employed in the assessment of the health human resource development provisions of the Philippine Nursing Act. The methodology is anchored on a combination of constructionist philosophy, interpretive and pragmatic approaches, which focus on the meanings and experiences of the people who are affected by the policy and consider these as significant inputs to policymaking. This chapter also describes the research design and data collection methods, the selection process for the participants of the focus group and key informant interviews, the ethical issues involved and the organization and presentation of data. Also discussed at length are the triangulation of methods as a means to enhance the comprehensiveness of the study and the concept of validity as excellence in the production of research findings and analysis.

#### **3.2. Theoretical Perspectives**

The research study is a qualitative inquiry into the health human resource development provisions of the Philippine Nursing Act of 2002 and their implementation. It is guided by the social constructionist epistemology, which is founded on the assumption that human beings interpret and construct reality in their social settings (Patton, 2002). The focus of social constructionist epistemology is on the “multiple realities constructed by people and the implications of those constructions for their lives and interaction with others” (p. 96). In other words, constructionist research aims to elicit the diverse perspectives of people and the different meanings they attach to objects and events they have experienced. For the constructionists, there is no one true construction of reality as two or more conflicting interpretations of an event or object can be true at the same time (Schwandt, 2000; Patton, 2002; Rubin & Rubin, 2005). These varied interpretations of reality are molded by culture, which encompasses the shared language and common practices of a community (Schwandt, 2000; Patton, 2002). Constructionist philosophy also

asks how the researcher's own constructions affect the outcomes of the research. On this matter, constructionists acknowledge the influence of the researcher's own cultural assumptions on the interpretation of the research findings. The researcher, however, need not abandon these assumptions; rather he/she needs to listen carefully to many other interpretations offered by the people being researched (Rubin & Rubin, 2005).

The use of constructionist philosophy in this study allows the views and experiences of the implementers of the Philippine Nursing Act and of the nurses who are affected by the Law's provisions to be heard and shared. The study considers how the larger milieu, such as workplace conditions, the hospital's organizational set-up, the state of the Philippine health care system and even the national socio-cultural and economic conditions, shape the nurses' and the implementers' perceptions and experiences. The research analysis is guided by the constructionist's tenet that the researcher's role is to synthesize and build an understanding of the multiple interpretations of reality (Berger & Luckmann; Charmaz & Mitchell; Gergen, Gubrium & Holstein; Hammersley as cited in Rubin and Rubin, 2005).

By the nature of the objectives of this study, this research is a policy analysis of the health human resource development provisions of the Philippine Nursing Act. McCool (1995) provides some definitions of policy analysis culled from different authors:

- ...an applied social science discipline which uses multiple methods of inquiry and argument to produce and transform policy relevant information that may be utilized in political settings to resolve policy problems. (Dunn, 1981, p. 35)
- ...principally concerned with describing and investigating how and why particular policies are proposed, adopted, and implemented... (Cochran, Mayer, Carr & Cayer, 1986, p. 3)

The above definitions underscore three important features of policy analysis – (1) that it is a form of applied research; (2) that it uses varied methods of inquiry to address a policy issue, and (3) that its meaning has been

expanded to include the evaluation of the policy itself after it has been approved and the evaluation of the policy implementation. The third feature is a departure from the traditional understanding of policy analysis as an activity that precedes decision-making (Yanow, 2000). In this study, the terms policy “analysis” and “assessment” are used interchangeably.

This research study is grounded on the interpretive approach to policy analysis. The interpretive approach to policy analysis is an emerging methodology that was developed as an alternative to the conventional positivist tools for policy analysis, such as cost-benefit analysis and decision analysis. In contrast to the positivist methods, which assume an objective and value-free assessment of a policy<sup>21</sup>, the interpretive approach focuses on a set of policy meanings, which refer to the values, beliefs and feelings of policy communities. These policy communities include legislators, policymakers, officials of implementing agencies, clients or potential clients, potential voters and other groups that may be affected by the policy (Yanow, 2000). The central question asked in interpretive policy analysis is: *how is the policy issue being framed by the policy communities?* The framing of a policy issue is likened to a camera lens or a skeletal frame of a house, which provides the “interpretive framework within which policy artifacts makes sense” (p.11). Policy analysis is, therefore, about exploring the varied meanings of a policy since policymaking is about constructing a shared understanding of the problem (Fischer, 2003). In this sense, the interpretive approach explores the differences between the policy meanings or interpretations of the policymakers, the implementers and the clients or beneficiaries. For instance, problems in implementation may arise from diverse understanding of the policy language among the different policy communities. The differing policy meanings or interpretations are treated as “different ways of seeing, understanding and doing” and demands from the researcher/analyst to respect the conflicting views (Yanow, 2000 p. 8). Thus, the role of an interpretive policy analyst/researcher is to broaden the

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<sup>21</sup> The term “policy” as used in this study refers to public policy which is defined as “the combination of basic decisions, commitments and actions by those who hold or affect government positions of authority,” which often is a result of the “interactions between those who demand change, those who make the decisions and those who are affected by the policy in question” (Gerston, 1997, p.7).

understanding of a policy through an interweaving of varying perspectives, facilitate participation in the policy discourse and give voice to groups who are excluded or under-represented in policymaking (Fischer 2003). The concepts of interpretive policy analysis are based on the works of neo-idealist philosophers, phenomenologists and hermeneutic scholars and enriched by the works of Guba and Lincoln in program evaluation and policy implementation. Its other influences are varied as it includes symbolic anthropology, the philosophy and history of science, literary theory and contemporary political philosophy (Yanow, 2000).

Notwithstanding the theoretical perspectives of this research, there is a practical purpose to qualitative inquiry that can contribute to pragmatic knowledge (Patton, 1990):

In short, in real world practice, matters can be separated from the epistemology out of which they have emerged. The methods of qualitative inquiry now stand on their own as reasonable ways to find out what is happening in programs and other human settings. (pp. 89-90)

Qualitative research can generate evidence and knowledge that can be valuable inputs to policymaking such as: the personal, structural and environmental contexts in which a policy operates and their implications for the design and successful implementation of the policy; how a program is being implemented, delivered and experienced by the intended beneficiaries; the impacts of a program or policy; the causes why a policy succeeds or fails, and under what circumstances; the experiences and opinions of the beneficiaries, and so on (Government Social Researcher's Office-UK, 2004). These are the very information that needs to be generated about the implementation of the nurse retention strategies under the Philippine Nursing Act.

Implementation is "the carrying out of a basic policy decision" (Sabatier & Mazmanian, 1995, p. 153), the "follow-through component in the public policymaking process" (Gerston, 1997, p. 95). By its definition, implementation

is an essential part of the policy process and represents the difficult transition of transforming policy plans and objectives into a program (Rist, 2000; Patton; 2002). Yet it is also often overlooked, undervalued and relegated to the “backend” of the policy cycle (Gerston, 1997, p. 97). Indifference to policy implementation is the main obstacle to improving complex social programs, policy analysis and experimentation in social policies (Williams, 1976). In policymaking, implementation evaluation serves three important functions: (1) assess the impact of policies in place; (2) inform-decision making about whether to continue, modify, or terminate policies; and (3) raise new problems and issues that need to be addressed (Lunt & Davidson, 2003). Thus, while the implementation of a policy may denote the completion of the policy cycle in one sense, it also signifies the continuation of the policymaking process (Gerston, 1997) because findings from implementation evaluation can set off the improvement of an existing policy or the formulation of a completely new policy.

In the Philippine setting, legislative monitoring is an intrinsic function of the Philippine Legislature. But more often than not, Philippine legislators give more focus to the process of formulating legislations and working for their enactment, and are less concerned with monitoring the implementation of the enacted policies. Once a legislative bill has been signed into law, legislators leave the implementation aspect to the executive agencies and turn their attention to enacting more policies. Reports of numerous unimplemented Philippines laws are indications of the Philippine Legislature’s neglect in monitoring the implementation of the policies they have approved. The inattention to how these laws are being carried out could very well be a major reason for their non-implementation and their failure to meet the needs of their target group.

### **3.3. Research Design and Its Limitations**

The purpose of the research determines the design and analysis of the research (Patton, 2002). Since the overarching purpose of this study is to contribute to the improvement of the policy on nurse retention, this research is a formative evaluation of the health human resource development provisions of

the Philippine Nursing Act. Formative evaluation, also known as implementation evaluation, inquires into the implementation processes and outcomes of a particular policy or program in a specific setting to improve the implementation of the said policy within the given context. This type of evaluation gathers details about inputs, activities, processes and structures of a program. It asks specific questions such as what the program is doing, what services are provided to clients, what are the clients' experiences in the program, how has the program developed and how has it deviated from the original plan (Patton 1990).

It must be pointed out that this research study is only a limited assessment because it only evaluates two aspects of the health human resource development provisions of the Philippine Nursing Act. First, it assesses the adequacy and relevance of the retention policy by exploring their underlying assumptions and objectives, and contrasting these with the actual experiences, perceptions and recommendations of nurses from two government hospitals and of the officials of agencies tasked to implement the said provisions. Second, it only describes and evaluates the extent to which the health human resource development provisions have been implemented and the factors that have affected their implementation. The study is not an evaluation of the outcomes or of the effectiveness of the nurse-retention strategies. The decision to focus only on the implementation processes and the attendant issues was largely influenced by anecdotal reports about the non-implementation of the health human resource development provisions. In addition, the researcher also had to consider the limited time and resources available for conducting the study. According to Patton (1990), given limited resources and a choice between conducting an evaluation of the implementation processes and outcomes, information about the implementation process has more value to policymakers because processes determine the outcomes. Until the policy has actually been implemented, there is no justification for evaluating the outcomes (Patton, 1990).

Formative evaluation as a research design has an inherent limitation since its findings are context specific and cannot be generalized other than the

setting under which the evaluation was conducted. This represents the classic trade-off between depth and breadth in qualitative studies (Patton, 2002). Hence, the scope of the findings and analysis of this study, particularly about the nurse working conditions can only be valid within the two government hospital settings where the nurses who participated in this study are employed. Having said this, the findings of this research study may still be relevant and useful to other similar health care settings.

### **3.3.1. Data Collection Methods**

Formative evaluation relies primarily on qualitative data collection (Patton, 1990). This research study basically used four data collection methods: (1) focus group interviews; (2) key informant in-depth interviews; (3) documents and records analyses; and (4) researcher's field notes/journal.

#### **3.3.1.1. Focus Group Interviews**

An interview is a conversation that has structure and has a purpose of obtaining knowledge on a specific subject matter (Kvale, 1996). A focus group interview is a question-and-answer forum with a small number of people about a particular topic and usually lasts for one-half to two hours. Its participants are selected based on common experiences related to the research topic. Focus group interview is an efficient way of collecting qualitative data because the researcher can do in-depth interviews with six people in one hour, instead of just one person (Patton, 1990). More importantly, it is useful in policy evaluation research because it can elicit varied opinions, views and experiences of the people affected by the policy as well as amplify issues through dialogue and interaction in a group (Government Social Researcher's Office-UK, 2004). Examining people's beliefs, attitudes, understanding and culture through in-depth interviews can be an essential tool in testing the assumptions of a policy (Murphy & Dingwall, 2003). In this study, exploring the nurses' experiences, work conditions, views and feelings is crucial in examining the relevance and adequacy of the retention mechanisms provided under the Philippine Nursing Act. I conducted five focus group interviews, with each group consisting of two to five nurses from two government hospitals. A total of 15 nurses participated in the five focus groups. The group interviews concentrated on the experiences,

views, perceptions and feelings of nurses about their salaries, workload, career advancement, training and education, and other work-related problems that the nurses encounter.

The study employed a combination of purposive and snowball sampling in selecting the participants for the group interviews. This is a practical decision on my part in order to get participants who possess certain characteristics, which I considered to be essential in meeting the objectives of the study. The use of non-probability sampling is another “pragmatic compromise between depth and breadth” because qualitative research often necessitates the choice of depth over breadth that is assured by probability sampling techniques (Murphy & Dingwall, 2003, p.105). The participants for the focus groups interviews must be professional nurses. A professional nurse in the Philippines, as defined in the Nursing Act of 2002, is a person whose name and professional license number is registered with the Professional Regulations Commission as legally authorized to practice the nursing profession.

The participants of the focus group interviews were chosen based on the number of years of working experience – i.e. they must have been working in the hospital where they are currently employed for at least two (2) years. It was my goal to get a mix of nurses with varied lengths of service to allow a comparison between the experiences and views of nurses who are relatively new and who have long been working in the profession. To recruit nurse participants who meet this criterion, I relied on the referrals from the chief nurses, nurse supervisors and staff nurses from the selected government hospitals. The process of choosing the participants actually consisted of two stages: (1) the first stage was the selection of the government hospital from where the nurse participants were recruited; (2) the second stage was the recruitment of the nurses from the selected government hospitals. Although the units of analysis were the nurses, the hospitals where they work are equally important in the data analysis because these are the settings in which the nurses live through their experiences, their working conditions and the problems they encounter as they go about performing their professional duties.

- ***Selection of the Participating Hospitals***

At the outset, I decided to recruit the focus group participants from two government hospitals - one must be a national government hospital and the other, a local government hospital. There are two reasons for these specifications. One, the Philippine Nursing Act stipulates that the nurse salary increase and the specialty training program are to be implemented only in government hospitals. The other has to do with the fact that the Philippines has a devolved public health system since 1991. Under a devolved set-up, majority of the country's health facilities are managed and funded by the local government units (LGU) while a number of tertiary level government hospitals are retained by the national government under the management of the Department of Health (DOH). The devolution of health services has resulted in a fragmented health care delivery system wherein LGU-managed hospitals have different management structures and financial resources from national government hospitals. Consequently, the local hospitals deal with problems that are distinct from retained national hospitals. It is, therefore, essential to capture and understand the differences in the working environments of the nurses in the public health sector.

The other major considerations in the selection of the two government hospitals were: (1) the category of the hospital – it has to be a tertiary-level<sup>22</sup> hospital because tertiary hospitals receive bigger funding than primary and secondary hospitals and presumably have better facilities and better capacities to implement the nurses' salary increase and the specialty training program; (2) contacts within the hospital management who can facilitate the process of requesting permission from the head of the institution; (3) physical accessibility to the researcher, which means that the hospital has to be located within Metro Manila, the capital region of the Philippines; and (4) the consent of the hospital management, namely the chiefs of the Hospitals and chief nurses to become key informants for the study and for their nurses to participate in the focus group interviews.

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<sup>22</sup> Tertiary hospitals are teaching and training hospitals that provide clinical care and management on the prevalent disease in the locality, as well as specialized and sub-specialized forms of treatment, surgical procedure and intensive care.

To establish communication with the hospital management, I sent letters and information sheets about the research study to the heads of the selected hospitals coursed through a colleague in the Department of Health in April 2007. Based on the abovementioned criteria, for the national hospital I initially chose the country's largest government hospital run by the University of the Philippines and for the local government hospital I selected a hospital owned by the city government of Manila. However, the former declined to participate in the study, so I decided to look for another tertiary level national government hospital whose management will readily allow its nurses to be interviewed for the study. The final choice for the government hospital was a tertiary level national government hospital under the management of the Department of Health. The two Hospitals are referred throughout this report by their generic names: the National Hospital and the LGU Hospital to distinguish one from the other. The management of the two participating Hospitals signified their consent to participate in the study through emails and during my personal conversation with the Chiefs of the two Hospitals. After the selection of the two Hospitals had been settled, I proceeded to recruit nurses to take part in the focus group interviews, which took place from June to July 2007.

- ***Recruitment of the Nurse Participants***

The Chief Nurses of the two Hospitals facilitated the recruitment of the nurses for the focus group interviews. Because nurses work in shifts, "catching" them at an opportune time was important in recruiting them for the focus groups, which means that I had to talk to the nurses before the start of their shifts. It was also easier to recruit the nurses by clinical departments. At the LGU Hospital, the Chief Nurse recommended that I go to the Emergency Room Services (ER) since the most of the nurses assigned to this clinical area have been with the hospital for a number of years, and she gave this researcher a list of ER nurses together with their "duty" schedule for the week. I proceeded to talk with the Charge Nurse and Nurse Supervisor in the ER, explained to them the objectives of the study and requested them to refer me to ER nurses who have two or more years of work experience. I talked individually with each of the referred ER nurses before their duty hours, which required that I go to the

ER department at odd hours, as early as 7:00 in the morning or as late as 11:00 in the evening. Fortunately, all the four nurses that I had initially recruited agreed to participate and they even referred three more participants with more than five years of experience, allowing me to get the mix of nurses that I wanted for the focus groups. At the National Hospital, the recruitment of nurses was easier because the Chief Nurse arranged for the researcher to talk to the nurses during the clinical departments' monthly meetings, where all the nurses assigned to a particular clinical area are required to attend. There were two clinical areas that had their monthly meetings around the time I conducted my research in June 2007: Ward II and Delivery Room. This was serendipitous because from these two clinical areas, I was able to recruit a mix of "old" and "new" nurses. Three relatively young nurses from the Ward II area and five experienced Delivery Room nurses agreed to be interviewed.

- ***Conducting the Focus Group Interviews***

Due to the varying duty schedule of the nurses, it was necessary to hold the focus group interviews at a time and place that was most convenient to them. At the LGU Hospital, the nurses requested that the interviews be conducted before or during the first few hours of their shift when they were not busy. Because there were only three nurses assigned per shift in the ER, each focus group consisted of only two to three nurses. A total of three focus group interviews were conducted on separate occasions in the nurse supervisor's room that also doubled as the ER nurses' lounge area. The venue was not auspicious because the group interviews were interrupted by persons knocking on the door to request a supply or to ask a question from the nurses. Once in a while a nurse would leave the room to attend to a patient's request and come back to participate in the interview. But there was no other room in the ER department where the focus group interview could be held. Another limitation was the time allotted to the discussion. The nurses were concerned about the duration of the discussion since they have to do their duties, so I had to assure them that it would only take a maximum of one hour. Although this researcher observed that the nurses had plenty of experiences to share, I was conscious of keeping within the agreed time limit so as not to keep them from their duties.

“Seizing the moment” was another key element in conducting the focus group interviews. At the National Hospital, the nurses opted to hold the focus group interviews immediately after their department meetings. Two separate focus group interviews were held on different occasions: the first had three Ward II nurses as interviewees and the second group consisted of five Delivery Room nurses. The interviews flowed smoothly and lasted longer than one hour since the participating nurses were “off duty” and hence, they did not feel the pressure to go back to their duty posts. Moreover, the venues, i.e. the nurse supervisor’s room in the Delivery Room department and an empty room in the Ward area, also offered privacy.

This researcher conducted five focus group interviews: three at the LGU Hospital and two at the National Hospital. At the LGU Hospital, each of the focus groups consisted of two to three nurses, while at the National Hospital, one focus group had two participants and the other had five participants. The group interviews, guided by a list of open-ended questions, focused on the nurses’ salary, workload, career advancement, educational opportunities, migration of nurses and other work-related conditions. Before starting the interviews, I explained the purpose of my research, assured the nurses of the confidentiality of any information collected during the interview, and requested their permission to use a tape recorder throughout the interview. The interviews were conducted using both the English and Filipino language because although the interviewees can speak English, some were more comfortable speaking in Filipino. But most nurses talked using a combination of English and Filipino, a common way of conversing among the middle class, students and professionals who are residing in Metro Manila. The group interviews lasted from 45 minutes to one-and-a-half hours. The focus groups interviews were conducted from June to July 2007.

### **3.3.1.2. Key Informant Interviews**

Key informant interviews are conducted to collect information from a wide-range of people who have intensive knowledge and who can provide variety of perspectives about the research topic (The Access Project, 1999). Key informants can, therefore, give insights about the nature of a problem and

recommend solutions to a policy issue (UCLA, n.d.). Aside from the Chief Nurses and Chiefs of Hospitals of the two government Hospitals, the key informants for this study included the officials of the government agencies and private organizations tasked under the Philippine Nursing Act to implement the health human resource development provisions. The officials from the government side are: the Director of the Health Human Resources Development Bureau (HHRDB) of the Department of Health (DOH) and the current Chairperson of the Nursing Board of the Professional Regulations Commission (PRC). The officials from the private sector are: the president of the Philippine Nursing Association (PNA), the accredited national federation of nurses; and the president of the National League of Philippine Government Nurses (NLPGN), an organization of nurses working in the public sector. In the course of interviewing the abovementioned officials, they all referred me to the nurse leaders who previously lead the PNA and sat as Board of Nursing members because these are the persons who advocated for the passage of the Nursing Act and initiated the implementation of this Law. I decided to interview the immediate past presidents of the PNA & NLPGN and two former members of the Board of Nursing to get the wealth of information that I needed for this research. In sum, I conducted 12 face-to-face key informant interviews.

The key informant interviews complement the inherent weakness of formative evaluation --- i.e. the findings are applicable only in the specific setting in which the research was undertaken. The key informant interviews can provide a broader perspective on the issues affecting Filipino nurses and the processes that the national agencies have carried out to implement the relevant provisions of the Nursing Act. To draw out this kind of information, the interviews focused on the following topics: the status of the implementation; the efforts that have been undertaken to implement the health human resource development provisions of the Nursing Act; the factors that hinder the implementation; the impact of migration of nurses on the Hospitals; the challenges confronting the nursing sector; and the key informants' recommendations and insights on how the Philippine government can mitigate the impact of nurse migration in the country. The interviews, conducted using both the English and Filipino language, usually lasted from one hour to one

hour-and-a-half. These were also audio-recorded with permission from the key informants. The key informant interviews were also conducted from June to July 2007.

### **3.3.1.3. Documents and Records Analyses**

Documents and record analyses are important data collection methods for this research study. Documents are artifacts that occur in particular formats such as notes, letters, reports, statistics, contracts, expert opinions, transcripts, or minutes of meetings, which can be easy and accessible sources of data to the researcher (Wolff, 2004; Merriam, 1998). Documents are essential in policy analysis because they can offer valuable information on the socio-political context and the process of formulating and implementing the policy. They function as “institutionalized traces” that allows a policy analyst to understand about the activities, intentions and ideas of the policymakers and of the organizations they represent (Wolff, 2004, p. 204). Documents can be important evidences on how the provisions of the Nursing Act are being interpreted and implemented on the ground, what the implementers have been doing or what their plans are to carry out the policy directives. Moreover, documents can support and elucidate the accounts of nurses shared during the focus group interviews and bolster the information provided by the key informants.

The transcripts of the deliberation of the Philippine Nursing Act, which include the public hearings and the floor deliberations conducted in the Philippine Legislature, are vital in the interpretation of the Nursing Act. This is because these transcripts can explain the legislative intent of the provisions of the Law by providing a written account of the discussions, arguments and assumptions underlying the crafting of the provisions. Also included in the document analyses are policies, laws, regulations and official government reports from the Department of Health and other agencies that may have a bearing on the implementation of the health human resource development provisions. I also collected documents from the National and LGU Hospitals that include, among others, letters, internal memos and reports pertaining to the Hospitals’ management structures, nurse staffing, salaries and benefits, nurses’

work schedule and patient census. It must be pointed out that the amount and type of documents collected from each Hospital greatly vary because these depended on the accessibility of the documents and the willingness of the Hospital management to furnish me copies of such documents.

#### **3.3.1.4. *Field Notes/Journal***

As I went about collecting data for this research, I gathered a wealth of details and rich information during informal conversations with the Chief Nurses and some of the nurse participants, which I deemed to be very important. Hence, I decided to keep a notebook/journal primarily to record the essential information that I obtained outside of the formal interviews. The journal proved to have other uses as I found it necessary to write down immediately after each interview, the gist of the interviews, the non-verbal expressions of the participants (e.g. facial expressions and demeanor), and my own personal insights about the accounts shared by the nurses and the key informants. These notes later on became a significant starting point for the analysis of the findings of this study. Also recorded in the notebook/journal were details of the data collection process, especially the changes that I had made from the original research proposal as I made pragmatic decisions along the way.

### **3.4. Validity of the Research Findings**

Validity refers to the “extent to which a question or variable accurately reflects the concept the researcher is actually looking for” while reliability denotes consistency of results when measures are used in another study, in a different setting and by a different researcher” (Davidson & Tolich, 2003, pp. 31-32). Qualitative researchers have argued that the above definitions of validity and reliability are conceptions of the positivist paradigm and are, therefore, not appropriate for qualitative research (Murphy & Dingwall, 2003). Critics have assailed the validity of social constructionist research because of its philosophical stance on the multiple interpretations of reality. The positivist definition of validity renders constructionist research invalid as it begs the question, which among the multiple interpretations of reality is the truth. The question on validity goes to the heart of the debate between positivist and

interpretive social science – their conflicting beliefs about the nature of knowledge. In the positivist paradigm, the researcher unearths objective knowledge but in the interpretive paradigm, an interviewer does not discover knowledge but co-creates meanings of reality through interactions with the interviewees (Kvale, 1996). As an alternative to the positivist paradigm, qualitative researchers have offered varied ways of determining validity, ranging from a total abandonment of any criteria for validity to a redefinition of the concept of validity. Some examples of these alternative concepts of validity are: successor validity, catalytic validity, interrogated validity, situated validity, ironic validity, imperial validity and voluptuous validity (Altheide & Johnson as cited in Murphy & Dingwall, 2003).

This study adopts the conceptualization of validity as a “quality of craftsmanship” (Kvale, 1996, p. 241). The concept denotes excellence in the production of the research findings and analysis. Ensuring the validity of research entails limiting the sources of invalidity throughout the research process (Kvale, 1996). One source of invalidity is the researcher’s bias for evidence that only confirms the assumptions she has formed during the initial data collection. A distinctive feature of superior craftsmanship in research is the systematic and rigorous search for contradicting or modifying evidence to the emerging analysis (Murphy & Dingwall, 2003). Achieving validity in research implies a researcher’s responsibility to adopt a critical stance in the analysis of research findings. This demands that a researcher reveal her biases, gather empirical evidence supporting or critical of an interpretation, evaluate and compare the plausibility of varied interpretations in order to present to the readers a well-crafted research (Runyan as cited in Kvale, 1996). Ultimately, it is the readers who judge on the validity of the research findings and analysis (Murphy & Dingwall, 2003).

The use of different methods of data collection, known as the triangulation of methods, is one way of enhancing the validity of a social research because it enables the investigation of a phenomenon from different perspectives (Flick, 2004). For this study, four methods of data collection were used: focus group interviews, key informant interviews, documents and

records analyses, and the researcher's field notes/journal. The purpose of triangulated data collection in qualitative research, however, has been seriously debated in literature. The notion of enhancing validity by supplementing the weakness of one method with another to achieve convergence of results has been criticized in some literature because this ignores the diverse theoretical orientation of the different methods (Blaikie as cited in Flick, 2004). Likewise, the idea of using multiple methods to gain a complete picture of a phenomenon is rejected by other qualitative researchers because this implies an assumption of an objective truth (Fielding & Fielding as cited in Flick, 2004). In line with the concept of validity as a quality of craftsmanship in research, this study embraces the understanding of method triangulation as a means to enhance the comprehensiveness of a study (Murphy & Dingwall, 2003), to add breadth and depth to the research analysis (Fielding & Fielding as cited in Flick, 2004) and to gain deeper knowledge about the research issue being investigated (Denzin & Lincoln, 2003; Flick 1992).

### **3.5. Research Ethics**

This research abided by the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants of Massey University. Even though the Philippines does not have strict rules on the conduct of research in the same way that New Zealand has, this researcher adhered to New Zealand's regulations on privacy and confidentiality, especially in the recruitment of the participants for the focus groups. I did not obtain personal information about the nurses such as their contact numbers without their permission when it could have been easier and more convenient to have asked these from the chief nurses. Instead, the researcher approached the nurses individually and discussed with each of them the objectives of the study. The nurse participants also signed consent forms attesting to their willingness to participate in the study. Issues of confidentiality were addressed in this study by maintaining the anonymity of the nurses and the key informants in the transcription of the interviews and in the write-up of the analysis. The official designations of the key informants are mentioned in the study but this could not

be avoided because these key informants were chosen precisely because they represent the government agencies tasked to implement the provisions of the Philippine Nursing Act.

When I introduced myself to the nurses and explained the objectives of my research study, I received enthusiastic response and an enumeration of their woes and complaints. In the course of my interaction with the nurses and in the interest of full disclosure, I revealed that I work as a legislative staff in the Senate. This raised a serious concern on my part that my research may lead to false impressions that it is being sponsored by the Philippine Congress for the purpose of addressing the issues they have raised and thereby, create expectations among the nurses that the government will take actions to solve their problems as a result of the study. Hence, I decided that it was very important to make it clear to the nurses that the research study was being undertaken to fulfill the requirements of the researcher's postgraduate studies and that it is not done under the auspices of the Philippine Congress or any other Philippine government agency. Even though the main objective of this study is to contribute to policymaking, I had to strike a balance wherein I did not make any claim to the nurses that the research findings will certainly be utilized by Philippine legislators because in reality, policymaking is a much more complicated process; but on the other hand, I also did not discount the possibility that the research findings may indeed be useful to policymakers.

### **3.7. Data Analysis**

#### **3.7.1. Role of the Researcher**

Before starting the data analysis, I pondered on how I am going to present the different experiences and perceptions of the nurses and the key informants in a form that is intended to be a policy analysis of the health human resource development provisions. Kvale's (1996) metaphor of the researcher as a traveler on a journey who hears stories of people and reconstructs these stories to be told to the researcher's audiences provides a guiding framework for the analysis and interpretation of the data gathered:

...What the traveling reporter hears and sees is described qualitatively and is reconstructed as stories to be told to the people of the interviewer's country, and possibly also to those with whom the interviewer wandered. The potentialities of meanings in the original stories are differentiated and unfolded through the traveler's interpretations; the tales are remolded into new narratives, which are convincing in their aesthetic form and are validated through their impact on the listeners. (Kvale, 1996, p. 4)

Moreover, I also grappled with the question on how my first-hand knowledge and involvement in the process of drafting the Philippine Nursing Act will affect the analysis and interpretation of the nurses' and the key informants' accounts. This question is addressed by Holliday (2002) who recognizes the influence of the researcher's background and her fundamental assumptions in the way she sees the data, and by Lincoln and Guba (as cited in Erlandson, Skipper & Allen, 1993) who acknowledge that the researcher's interpretation is only one of the many probable constructions of reality.

### **3.7.2. Presentation and Organization of Data**

Data analysis involves the organization and presentation of data. Patton (1990) suggests that data analysis should begin by revisiting the process used to conceptualize and refine the key issues in the research. For this study, the research objectives served as the focal point for the organization of the data that were largely generated from the transcribed interviews. The transcription of the interviews, done with the help of an experienced transcriber, tried as much as possible to record verbatim the interviews. The data were coded and organized into the following main themes predetermined by the researcher to correspond to the objectives of the study: (1) working conditions of nurses; (2) status of implementation; (3) factors hindering the implementation; and (4) views, perceptions and recommendations of the nurses and key informants on the retention of Filipino nurses. After grouping the data according to the main themes, these were further broken down into categories and sub-categories emergent from the transcribed interviews. In addition, quantitative data were

extracted from the documents provided by the two Hospitals, adding more substance and details to the nurses' and key informants' accounts.

An integral part of the analysis is the "meaning interpretation" of the transcribed statements of nurses and key informants, as well as of the non-verbal cues (e.g. facial expressions and demeanor) which were woven into the narrative of the interviewees' lived experiences. The researcher's field notes were an indispensable tool in the interpretation of the meaning of the transcribed interviews as these recorded the gist of the interviews and my personal insights and observations, which I had written down immediately after each interview. "Meaning interpretation" is a more or less speculative interpretation of the deeper meaning of a text as contextualized within a broader frame of reference and often results in expansion of the text (Kvale, 1996). The nurses themselves provided the frame of reference for the interpretation of their accounts as they linked their personal experiences and their current work conditions to the broader context of the socio-economic conditions affecting the Philippine health sector.

I decided to use a narrative approach to the structuring of the analysis of the study in order to bring focus to the nurses' and key informants' stories. A narrative structuring enables the creation of a meaningful, logical and organized plot from the tapestry of stories told during the interviews (Kvale, 1996). Moreover, it supports a "unity of form among the original interview situation, the analysis and the final report" (p.184). The separate accounts of the nurses and key informants were reconstructed into one coherent narrative of the nurses' lived experiences that is rich with detailed description of their work conditions and of the larger environment under which they are working.

As a final note, the narrative is interspersed with direct quotations from the interviews, which, as mentioned earlier, were done using both the English and Filipino language. Since the primary intended audiences of this research are the nurses and policymakers in the Philippines I decided not to translate into English the transcripts of the interviews to preserve the essence of the statements of the nurses and the key informants. However, in the final report of

this study, I provided English translations for the quoted portions of the interviews in consideration of the readers who are not from the Philippines. In translating the quoted portions of the interviews, I did not give primary importance to achieving perfect grammar and syntax; instead, I strived to convey the essence of the quoted text and at the same time, capture the manner in which the statements were originally expressed. Thus, the English translations are not the perfect equivalent but rather, they are the imperfect equivalent of the quoted texts from the transcribed interviews (Halai, 2007).

### **3.8. Summary of the Research Methodology**

The study is a qualitative assessment of the health human resource development provisions of the Philippine Nursing Act and their implementation. This chapter has explained the theoretical framework adopted for this study, which is a combination of constructionist philosophy, interpretive and pragmatic approaches. The use of constructionist philosophy allows the views and experiences of the stakeholders and beneficiaries of the Nursing Act to be expressed, specifically the officials of the agencies tasked to implement the provisions and the nurses in government hospitals. The study is also grounded on the interpretive approach to policy analysis, which is interested in knowing a how a policy issue is being framed by the policy communities that include among others legislators, implementers and the intended beneficiaries of a policy. The purpose of an interpretive policy analysis is to explore the different meanings of a policy to different policy actors in order to arrive at a shared understanding of the problem. Furthermore, the research has been guided by a practical purpose – to generate evidence and knowledge on how a policy is being implemented and how it is experienced by the intended beneficiaries, which are essential inputs to the policymaking process.

Since the overarching purpose of this study is to contribute to the improvement of the policy on nurse retention, the research is a formative evaluation of the health human resource development provisions of the Philippine Nursing Act. Formative evaluation, also known as implementation evaluation, inquires into the implementation processes and outcomes of a

particular policy or program in a specific setting for the purpose of improving the implementation of the said policy within the given context, which in this case, are two government hospitals in the Philippines. However, the study is a limited assessment because it only evaluates two aspects of the health human resource development provisions of the Philippine Nursing Act. First, it assess the extent to which the Nursing Act's provisions have been implemented and the factors that affect the implementation. Second, it examines the adequacy and relevance of the retention strategies under the Nursing Act by exploring their underlying assumptions and objectives and contrasting these with the actual experiences, perceptions and recommendations of the nurses in government hospitals and of the officials of agencies tasked to implement the said policy.

Data for the study were collected through a combination or triangulation of methods, which are: (1) focus group interviews of nurses from two government hospitals, referred to in this study as the National Hospital and LGU Hospital; (2) key informant interviews of officials of government agencies and private organizations tasked to implement the Nursing Act; (3) documents and records analyses; and (4) researcher's field notes/journal.

Finally, this research study is a reconstruction of the varied accounts of nurses and key informants into one coherent narrative that highlights the lived experiences of the interviewees. Data generated from the transcribed interviews, complemented by quantitative data gathered from pertinent documents were organized into major themes derived from the study's objectives, and were further classified into sub-categories emergent from the transcribed interviews. An integral part of the data analysis was the "meaning interpretation" of the transcribed statements of the nurses and the key informants, which were woven into the narrative.

## **Chapter Four**

### **THE WORKING CONDITIONS OF NURSES**

#### **4.1. Introduction**

This chapter is a depiction of the conditions and experiences of the nurses working in the National and LGU Hospitals, reconstructed from the various accounts of nurses who participated in the study and supported by the key informant interviews, the researcher's field notes and the quantitative data generated from pertinent documents and reports. The focus group and key informant interviews have yielded rich data dissecting multi-layered issues that are affecting the nurses, the hospitals and the Philippine health care system. This chapter highlights the lived experiences of nurses and at the same time, it unravels a complex web of problems where the nurses' predicament is intertwined with the problems existing in the Hospitals and with the issues beleaguering the country's health care system. It also cites relevant literature to deepen the discussion of the issues raised by the nurses. In addition, I used unedited quotations from the interviews to support the reconstruction of the nurses' accounts, and since a large portion of the interviews were done in the Filipino language or in a mix of Filipino and English languages, the researcher provided the English translations after each quotation. As mentioned in the previous chapter, the English translations tried to capture how the original text was expressed in Filipino, so inevitably, the translated texts do not follow the rules on proper English grammar and syntax.

The work-related conditions have been grouped into two (2) main categories: (1) salary, and (2) workload. The section on salary examines the reasons for the nurses' dissatisfaction with their salaries, foremost of which is their perception that their salaries are incommensurate to their heavy workload. Under the section on workload are several subtopics: nurse-to-patient ratio, the inadequate nurse staffing, patient census, the factors to inadequate staffing, the lack of supplies and equipment, working hours, no overtime pay and the nurses' coping mechanisms. Preceding the discussion of these topics is a section that describes the nurses and the two government Hospitals involved in

this study, to provide a backdrop for the subsequent description of the nurses' working conditions.

## **4.2. Description of the Nurses and the Hospitals**

To give the readers a background on the nurses' working environment, this section explains the characteristics of the nurses who participated in the group interviews and of the two Hospitals where the nurses were working at the time of the interview,

### **4.2.1. The Nurses**

The nurses who participated in the focus group interviews came from two different hospitals, one is owned by the national government and the other by a local government unit (LGU), specifically the City of Manila. For the purpose of this discussion, the nurses have been classified according to the Hospitals where they are working: LGU nurses refer to the nurses who are working in the LGU hospital and National nurses refer to the nurses working in the national government hospital.

Seven LGU nurses participated in the focus group interviews, consisting of six females and one male who, at the time of the interview, have been working in the Emergency Room (ER) for three to five years. The group consisted of nurses with varying professional experience measured in terms of the number of years they have been working as a registered nurse: the shortest is three years, the longest is 26 years, and the median is 11 years. Only nurses with considerable experience in various clinical areas are assigned to the ER because the ER, a specialty area in the LGU Hospital, has six clinical areas: Obstetrics-Gynecology; Eyes, Ears, Nose & Throat; Family Medicine; Internal Medicine; Pediatrics; and Trauma-Surgery. It is also the LGU Hospital's "showcase" for their brand of service, so the Hospital management only selects nurses who possess the "special" virtues of patience and caring to serve in the ER (Researcher's field notes).

The National nurses were a mixed group of five female nurses assigned in the Delivery Room (DR) and three nurses (i.e. two males and one female) from the Ward II area. The DR Nurses were the veteran nurses whose professional experience ranged from 10 to 22 years. The group's average length of service in the National Hospital was 11 years. Prior to their assignment in the DR, these nurses have served in the different clinical areas of the National Hospital. The Ward II nurses were the young nurses who have only three to four years of professional experience and the National Hospital was their first employer.

#### **4.2.2. The Hospitals**

The hospital owned by the City government of Manila is referred herein as the LGU Hospital. The other government hospital that is under the management of the Philippine Department of Health (DOH) is referred herein as the National Hospital. Despite the dissimilarity in ownership and management, the two Hospitals shared common characteristics. Both Hospitals began its operations in 1969 to provide free medical care to patients. The City of Manila initially established the LGU Hospital to give free medical care to its residents, but in recent years, the City government has extended its services to non-Manila residents. Likewise, the national government conceived the National Hospital to cater exclusively to government employees but eventually, the Hospital offered its services to the public. The two Hospitals are teaching and training hospitals, which means they have at least one accredited residency-training program for physicians, nurses and other allied health professionals. Both Hospitals are tertiary care hospitals, a category level indicating the Hospitals' capacity to "provide clinical care and management on the prevalent diseases as well as specialized and sub-specialized forms of treatment, surgical procedures and intensive care" (Department of Health Administrative Order 2005-0029, p. 3). Their service capabilities include clinical services in general medicine, pediatrics, obstetrics and gynecology, surgery, specialty and sub-specialty areas, third-level clinical laboratories, radiology and pharmacy. Based on the Department of Health (DOH) guidelines, as tertiary-care Hospitals, their nursing service are able provide

total and intensive skilled care for 24 hours or longer, as well as continuous and highly specialized critical care. Figures 1, 2, 3 & 4 illustrate the organizational structures of the LGU and National Hospitals and their Nursing Services.

#### **4.2.2.1. The LGU Hospital**

Manila is the capital city of the Philippines and being a first class<sup>23</sup> city with an annual income of more than PhP300 million, it is one of the few local government units (LGU) that can afford to build and finance a tertiary-level hospital. The LGU Hospital is part of the network of health facilities under the Manila Health Department, which consists of four (4) hospitals, 49 health centers and 12 lying-in centers. As shown in its organizational structure (Figure 1), the LGU Hospital has a Board of Trustees, which formulates the Hospital policies and a Hospital Director or Chief of Hospital who manages the Hospital's day-to-day operations. At the top of the LGU Hospital's organizational structure is the Mayor of the City of Manila who has direct supervision and control over the Hospital management and has the final decision-making powers over and above the Board of Trustees and the Chief of Hospital. This is in consonance with the provisions of the Local Government Code of 1991 (Section 455) that confers to the mayor the power and function of supervision and control of all programs, activities and services of the city or municipality under his jurisdiction. The official designation of the Hospital Director as City Government Department Head II underscores the fact that she is an employee under the City government's Health Department.

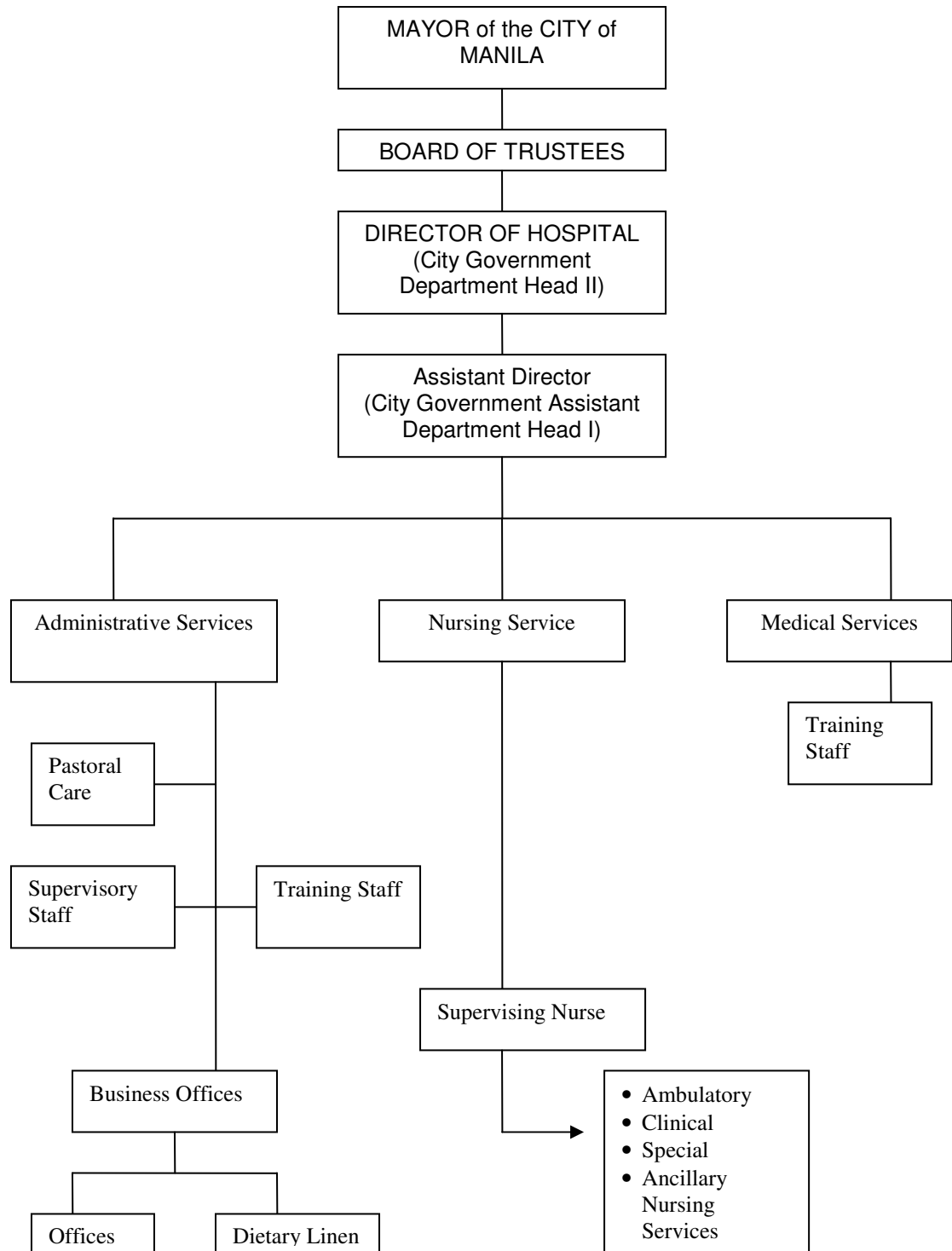
#### **4.2.2.2. The National Hospital**

The National Hospital is one of the 72 national hospitals retained under the management of the Department of Health (DOH). It is located in Quezon City, one of the big cities in the Greater Metro Manila Region, the country's capital region. Since it is a DOH-attached hospital, the Secretary of Health heads its Board of Trustees. The management and day-to-day operations of

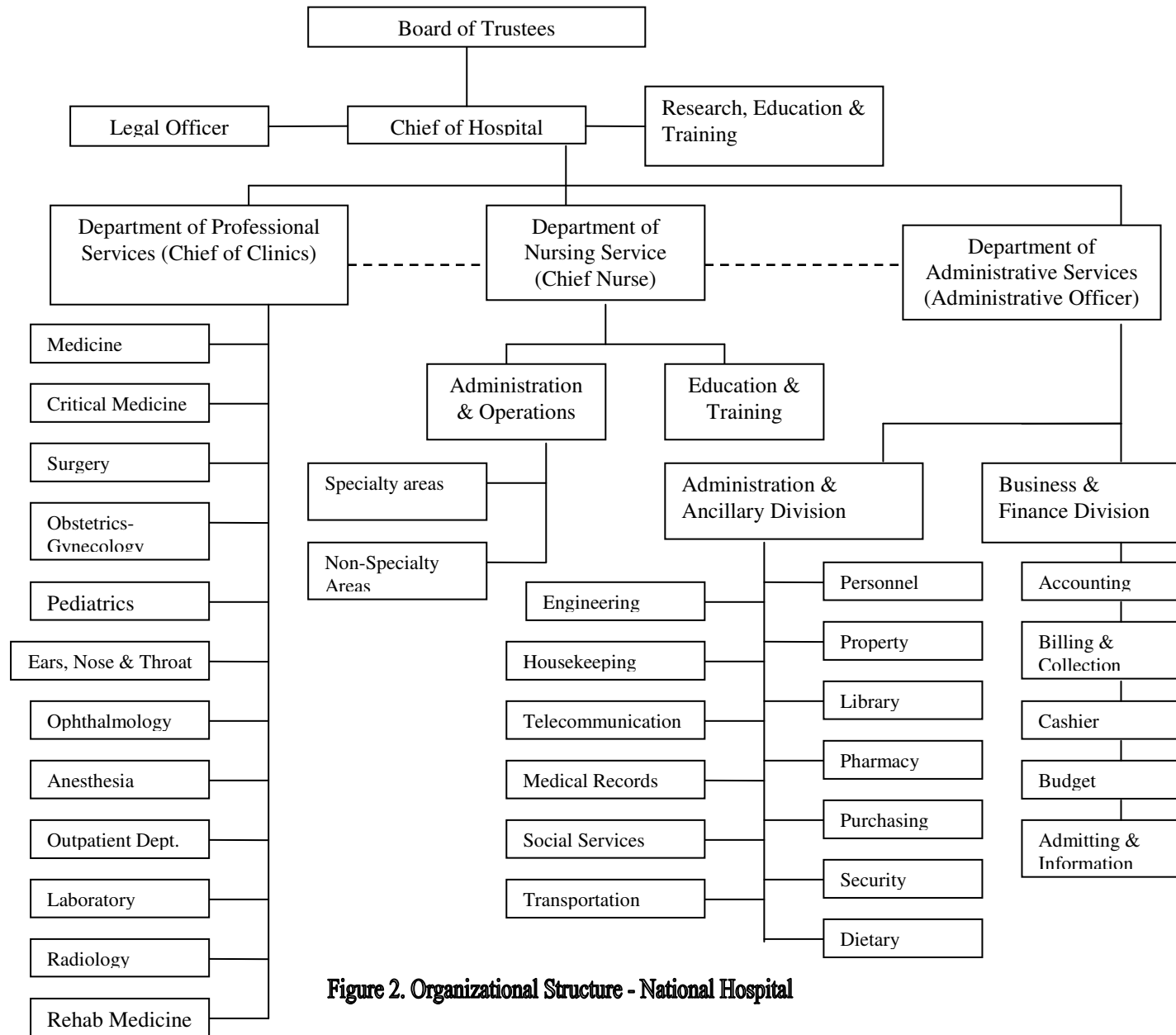
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<sup>23</sup> The Local Government Code of the Philippines provides a classification of provinces, cities and municipalities based on their annual income and these categories are: 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup> and 5<sup>th</sup> class. Cities classified as 1<sup>st</sup> class have the highest income while 5<sup>th</sup> class are the poorest.

the Hospital is overseen by the Medical Center Chief, who is an employee of the national government (pls. see Figure 2). The national government appropriates the annual budget of the National Hospital through the General Appropriations Act (GAA).



**Figure 1. Organizational Structure - LGU Hospital**



**Figure 2. Organizational Structure - National Hospital**

#### ***4.2.2.3. The Nursing Service of the LGU & National Hospitals***

A Chief Nurse, whose official designation is Nurse VII, heads the Nursing Services of the LGU and National Hospital (see Figures 3 & 4). The LGU Hospital has three Assistant Chief Nurses, each of whom heads the three main divisions of its Nursing Service: (1) staffing and operations division, (2) training and continuing education division, and (3) equipment and supplies division. The National Hospital has only two Assistant Chief Nurses who are in-charge of the operations and the training divisions. The official designation of the Assistant Chief Nurses is Nurse VI.

Table 1 shows the similarities and differences in the official position classification of the nurses in the LGU and National Hospitals. The differences in the official position classifications are ascribed to the Department of Budget and Management (DBM), the national agency that approves the organizational staffing of government institutions and releases their annual budget appropriations. The National Hospital has no Nurse V position while the LGU Hospital has no Nurse II position. In addition, the staff nurses in the National Hospital hold the position of Nurse II and I, which are permanent positions. On the other hand, the staff nurses in the LGU Hospital have two classifications: Nurse III, a permanent position and Nurse III-Medicare<sup>24</sup>, a contractual position. In both Hospitals, the lowest position is Nurse I, which is reserved for new graduates who have no hospital experience, but in the LGU Hospital, a Nurse I is a contractual position while in the National Hospital, it is a permanent position. A Nurse I in the LGU Hospital has to undergo a training of two years in the Hospital before he/she can get a permanent nurse position.

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<sup>24</sup> The position is named after the source of funding for this position which is supposedly the Medicare or health insurance program of the City government. According to the Nursing Service Office, there were no nurses holding the position of Nurse III-Medicare in the LGU Hospital at the time the interviews were conducted.

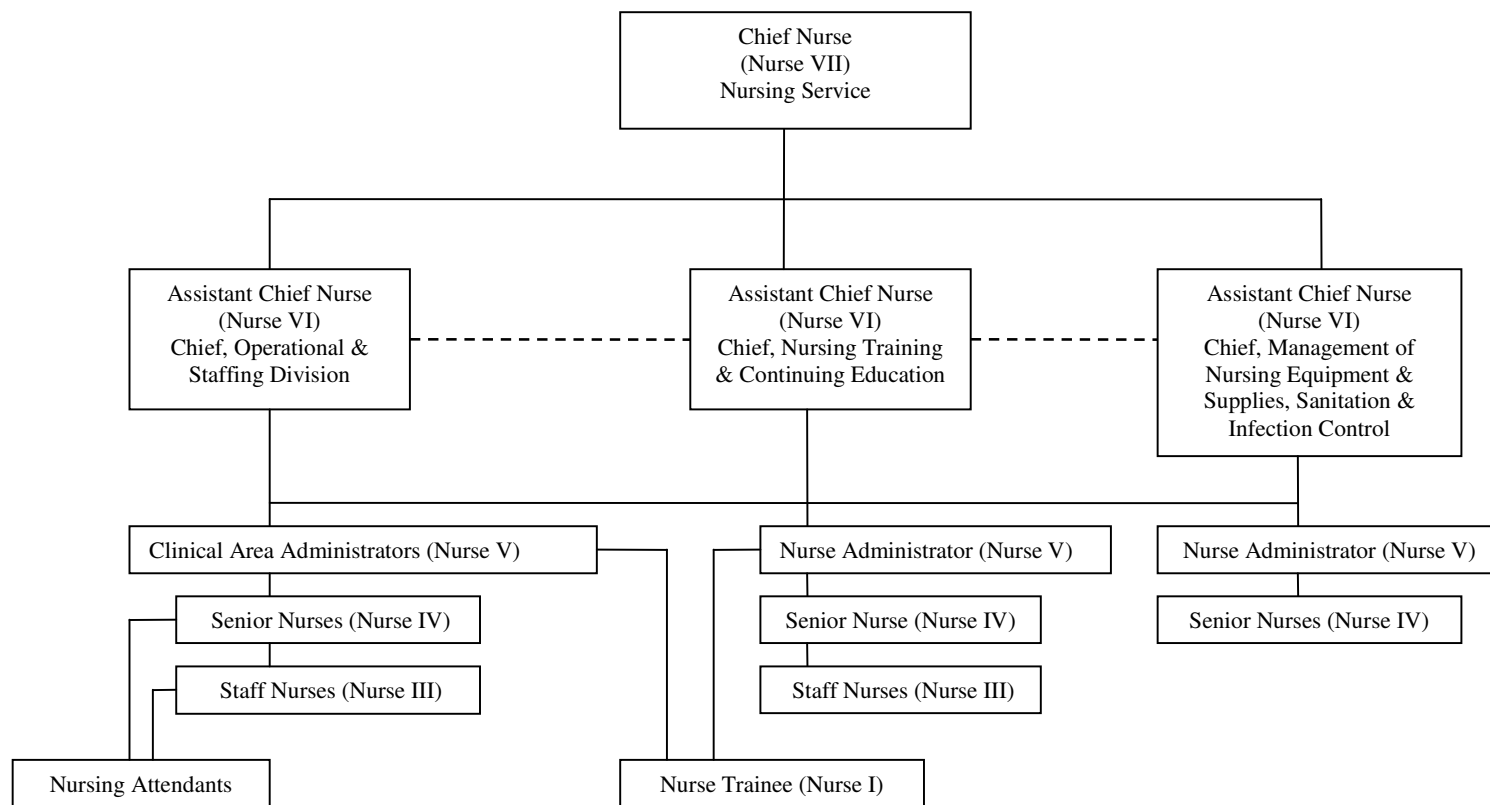
**Table 1. Nurse Positions in the National & Local Government Hospital**

National Hospital		LGU Hospital	
Nurse VII	Chief Nurse	Nurse VII	Chief Nurse
Nurse VI	Assistant Chief Nurse	Nurse VI	Assistant Chief Nurse
-----	-----	Nurse V	Nurse Administrator
Nurse IV	Nurse Administrators	Nurse IV	Senior Nurse/Supervisor
Nurse III	Senior Nurse/Supervisors	Nurse III (permanent) Nurse III- Medicare (contractual)	Staff Nurse
Nurse II	Staff Nurse	-----	-----
Nurse I	Staff Nurse	Nurse I	Nurse Trainee

Sources: Nursing Service Offices – LGU & National Hospitals

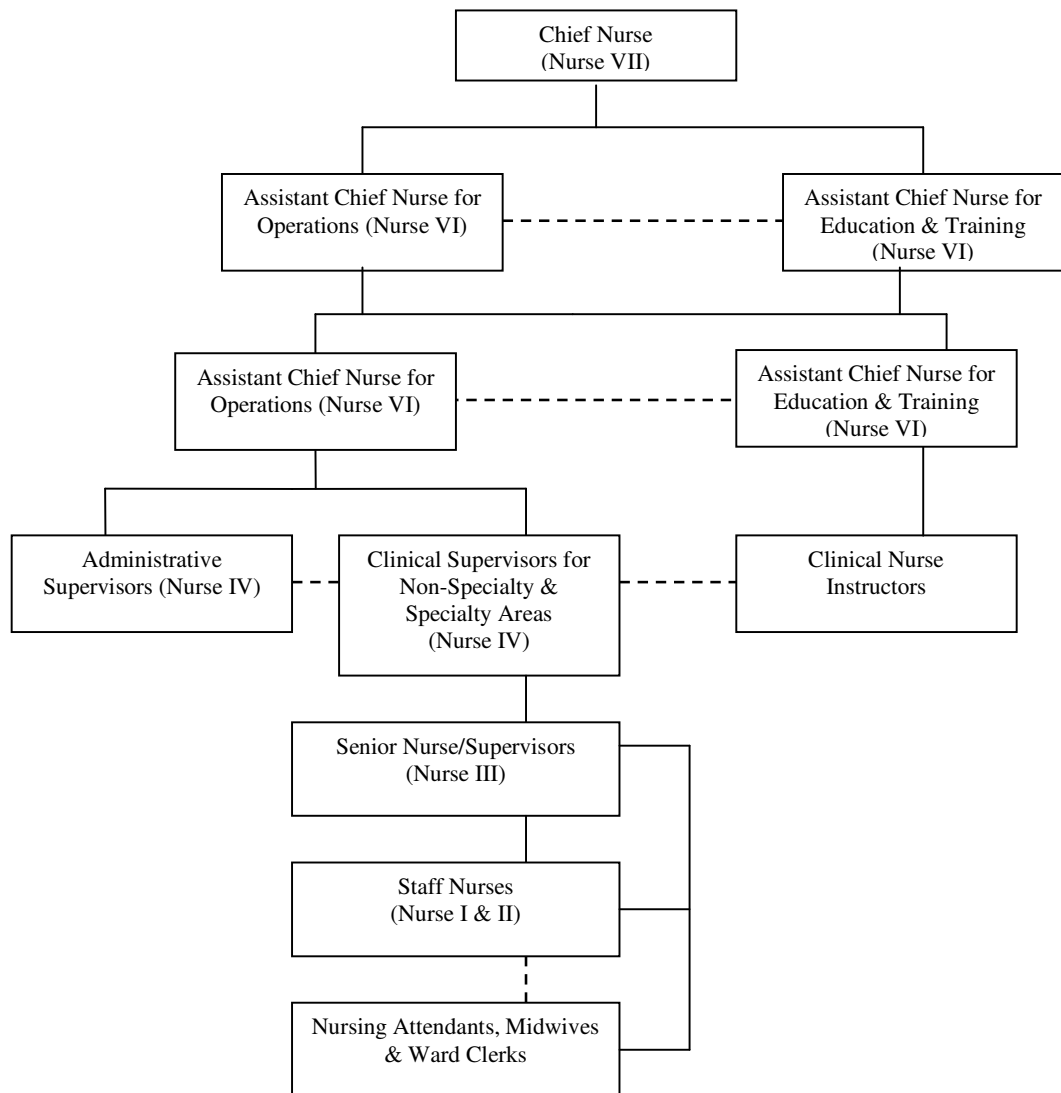
The position classification for the nurses is prescribed under Republic Act (RA) 6758, the *Compensation and Classification Act of 1989*, also known as the *Salary Standardization Law*, which regulates the salary structure and position classification of government personnel. RA 6758 provides a compensation classification system based on the responsibilities and qualification requirements of each position, which has a corresponding salary grade scheme ranging from Salary Grade 1 to 33, with 1 to 8 steps for each salary grade (see Annex B for illustration of the salary grades). Each government agency formulates the position classification for their personnel based on the provisions of RA 6758, which the Department of Budget and Management (DBM) must approve. RA 6758 provides some flexibility for local government units (LGU), whereby the rates of pay for their personnel are based on the LGU's financial capability subject to specific guidelines.<sup>25</sup>

<sup>25</sup> Sec. 10 of RA 6758 stipulates that “the rates of pay in LGUs shall be made on the basis of the class and financial capability of each LGU” and provides that for each class of LGU, the salaries shall not exceed specified percentages of the rates in the salary schedule prescribed in the law. A first class city like the City of Manila must not exceed 100% of the salary schedule prescribed under RA 6758.



**Figure 3. Nursing Service - LGU Hospital**

**Figure 4. Nursing Service Organization - the National Hospital**



### **4.3. The Working Conditions of the Nurses**

Examining the nurses' perceptions of their working conditions is essential in the analysis of the adequacy and relevance of the health human resource development provisions of the Philippine Nursing Act of 2002. Perceptions can reflect the aspects of the work environment that contribute to job dissatisfaction, work environment deterioration, heavy workload and intentions to resign from work (Zeytinoglu, Denton, Davies, et al., 2007). Thus, perceptions can reveal how the nurses frame the issues and problems they encounter, their attitudes and feelings about their jobs, which are important in formulating and assessing nurse retention policies. The subsequent sections present the nurses' feelings and views about their salary, their heavy workload and the causes and impact of heavy workload.

#### **4.3.1. Dissatisfaction with Salaries**

The nurses are dissatisfied with their salaries. They shared a common opinion that their salaries are low. Majority of the nurse participants were staff nurses whose monthly salaries ranged from PhP14,000-15,000 (NZ\$424-NZ\$455)<sup>26</sup> at the time of the interview. Notably, when nurses complained about their low salaries, they did not compare their salaries with the salaries of nurses who are working abroad; rather, they cited several work-related reasons for their discontent, which are discussed below.

##### **4.3.1.1. Many Duties and Responsibilities**

The nurses perceived that their salaries do not compensate the numerous duties and responsibilities they carry out in the Hospital(s). They also felt that the government does not properly pay them for the hard work and sacrifices they make just to fulfill their duties. The following are examples of the nurses' sentiments about their salaries:

- I have been working here for 17 years as Delivery Room nurse. My salary is P14,098. Sa tingin ko it's not compensated sa work place, dahil ang work ng Delivery Room nurse is not solely for

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<sup>26</sup> Using the exchange rate of NZ\$1=PhP33.00.

Delivery Room, but we perform operations for Gyne cases and medication, we give medication and we admit patients and we monitor high-risk patients. (Transcript, FGI DR-National Nurses, p. 1)

I have been working here for 17 years as Delivery Room nurse. My salary is P14,098. In my view, I am not well compensated in the work place because my work as a Delivery Room nurse is not solely [confined] in the Delivery Room, but we also assist in operations for Gyne[cology] cases, we give medication and we admit patients and we monitor high risk patients.

- Pero kung iisipin mo talaga parang hindi mukhang – ano ba ang term doon – unfair o hindi properly commensurated iyong aming pagod at saka iyong sacrifice namin na ganoon. (Transcript, FGI DR-National Nurses, p.17)

If you think about it, it seems unfair. It is not commensurate to our hard work and sacrifice.

In a hospital setting, the nurses are the ones who provide uninterrupted health care to patients 24 hours a day. To give round-the-clock nursing care to patients, nurses report for hospital duty in three shifts: morning (6:00 am-2:00 pm), afternoon (2:00 pm- 10:00 pm) and night (10:00 pm-6:00 am). When on duty, nurses perform a wide range of functions that include carrying out the orders of the doctor, coordinating with other health care team members, giving medications to patients, and practically doing any task that falls within the purview of preventive, curative and rehabilitative care of patients. Their assigned clinical area determines the specific functions that nurses have to perform. National nurses assigned in the Delivery Room and the LGU ER nurses described their tasks as follows:

- We admit patients, we assist in the delivery of the patients, at saka we circulate, we scrub, we give medications. Tatlong nurses ang gumagawa nun. We performed operations for Gyne[cologic] cases... and we monitor high-risk patients. (Transcript, FGI DR-National Nurses, p. 3)

We admit patients, we assist in the delivery of the patients, we circulate, we scrub and we give medications. Only three nurses are performing these. We perform operations<sup>27</sup> for Gyne[cologic] cases ... and we monitor high-risk patients.

- Assist the doctors in all emergency cases particularly in the medication. Kami lang talaga ang nagbibigay ng medication sa patient. (We are the only one who gives medication to patients). (Transcript, FGI II-LGU Nurses, p.1)

- Marami kaming duties and responsibilities and we covered five areas as follows: pedia, IM [Internal Medicine], surgery, OB [Obstetric-Gynecology] .... Pag sa ER lahat ng areas covered mo. (Transcript FGI I-LGU Nurses, p. 1)

... We have many duties and responsibilities and we cover five areas as follows: pedia, IM [Internal Medicine], surgery, OB [Obstetric-Gynecology]... In the ER, you cover all areas.

The nurses are the mainstays and the core of patient care in the hospital. A key informant portrayed the nurses as the pillars that hold up the hospital structure and without them, the hospital operations will break down. Just like the sturdy yet unobtrusive pillars, the nurses are often unnoticed and overlooked. The metaphor implies an undervaluing of the nurses.

- Ang mga nurses ang halige. Hindi mo sila nakikita...pero sila iyong nandiyan na talagang nakatayo, pero malalaman mo lang na wala na palang nangyayari sa agency pag nawala na sila, babagsak na iyong operations, kasi sila ang operations. If you go to the hospital, who runs the hospitals? It's not the administrators. It is the nurses who make the hospital run from 8:00 o'clock in the morning to 8:00 o'clock the next day... sila iyong nandiyan putting things together. (Transcript of Interview, NLPGN-past president, p.10)

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<sup>27</sup> In mentioning "Gynecological operations," the nurses referred to internal examination during labor and "suturing of perineal laceration," which they are allowed to perform under the Philippine Nursing Act.

The nurses are the pillars. They are not seen, but they are there standing and supporting the hospital. Their absence is noticed only when hospital operations break down because the nurses are the operations. If you go to the hospital, who actually runs the hospitals? It's not the administrators. It is the nurses who make the hospital run from 8:00 o'clock in the morning up to 8:00 o'clock the next day. They are the ones who are always there, putting or holding things together.

#### **4.3.1.2. Professional Qualifications and Years of Service**

In the same line of argument, the nurses asserted that their salaries are not commensurate to their skills, professional qualifications and long years of service in the Hospital where they are currently working. One of the nurses' assertions best captured this sentiment: "*Pero kung ibe-base sa credentials at experience ko, dapat nasa P20,000 per month na yong salary ko... (But if you base the salary on my credentials and experience, my salary should now be P20,000 per month...)*" (Transcript, FGI II-LGU Nurses, p. 5). Many of the LGU nurse participants have been in service for almost 10 years, and some of them have been with the LGU Hospital for as long as 18 years. According to the LGU nurses, they even have colleagues who have been serving the LGU Hospital for 25 years. Similarly, many of the National nurses in the focus groups have been working for the National Hospital for more than 10 years while others have more than 20 years of professional experience. Yet majority of them only receive a basic monthly wage of about PhP14,000 (NZ\$424), which is the salary of a staff nurse, a middle-level position in the two Hospitals' nursing service organization.

#### **4.3.1.3. Costs of Living**

Another dimension to their complaints is that their salaries are not adequate to cover the costs of their daily living expenses. A nurse pointed out, "*Ang P14,000 monthly puede yan if you are single. Pero kung may pamilya ka na, medyo mababa ang P14,000 at super hirap i-budget (A PhP14,000 monthly salary is adequate if you are single. But if you have a family to raise, PhP14,000 is small, and it's very difficult to budget)*" (Transcript FGI II-LGU

Nurses, p.5). To help their families, nurses have often resorted to borrowing money from moneylenders who charge high interest rates. A nurse supervisor at the National Hospital shared that many nurses in their Hospital have pawned their ATM (Automated Teller Machine) cards as a guarantee of payment for their loans, which means that the nurses have already advanced their next salary to the moneylender. This kind of situation has trapped many nurses in a cycle of debt. Aggravating the situation is the occasional delay in the release of salaries and benefits, which happened in the past at the National Hospital. For one nurse, a delay in her salary meant she could not report for work.

- Ang suweldo palagi nade-delayed. Minsan hindi kami makakapasok dahil walang pamasaha. Kasi, ini-expect mo susuweldo ka sa araw na to, tapos hindi pala. Pero dahil sa maraming nag-complain, naayos naman at on-time na ang suweldo at hazard pay. Yong clothing allowance naman, nade-delay pero matatangap naman yan within the year. (Transcript FGI, Ward II-National Nurses, p.4)

The salaries were often delayed. Sometimes we could not report for work because we expect to receive our salaries on a particular day, and when we do not get our salary on time, we do not have money for transportation fare. However, because many nurses had complained, the problem had been fixed and the salaries and the hazard pay are now paid on time. The clothing allowance is still delayed but we will receive it within the year.

#### **4.3.1.4. Salaries in Other Government Hospitals**

While the nurse participants did not make any comparison with the salaries of nurses working abroad, they did compare their salaries with the wages and benefits of nurses working in other government hospitals. The nurses in the focus groups criticized the uneven salary schemes of nurses in the government sector. They named two other government hospitals that give higher salaries and benefits to their nurses: the Philippine General Hospital (PGH), the country's leading government hospital and the Philippine Heart Center, a specialty hospital located right next to the National Hospital. Although the *Salary Standardization Law* prescribes the salaries of government nurses

and all other government employees, some government agencies such as the PGH are exempted from the standardized salary schedule. These exempted agencies can give salaries to their employees that may possibly be higher than what the existing Law has set. Moreover, the payment of the benefits stipulated under the *Magna Carta for Public Health Workers*<sup>28</sup> is dependent on the budget of the government agency that employs the health workers. As a result, some agencies are able to provide the full Magna Carta benefits to their workers, while others like many local government units are only able to give partial of the mandated benefits. For instance, the LGU nurses stated that they do not receive the full amount of the hazard pay stipulated under the Magna Carta, but they knew that their counterparts at PGH do.

#### **4.3.1.5. Salaries in the Private Sector**

The nurses also compared their salaries with those in the private sector and in doing so, their perspectives changed and they displayed ambivalent feelings about their salaries. They are generally dissatisfied with their low salaries, but when contrasted with the salaries of nurses in the private sector, they thought their salaries are good enough.

- The compensation here is good at malaki rin naman. Mahirapan ka rin lilipat kasi dadaan ka naman sa umpisa ng hiring kasi di mo madala ang position mo dito. (Transcript, FGI II-LGU Nurses, p.4)

The compensation here is good and it is relatively big. It is not easy to transfer because you will have to start all over again since you cannot bring your position to the hospital where you will transfer.

- Okay na rin as compared to the private. Kasi the salary in the private hospital is lower compared to the government hospital. (Transcript, FGI I-LGU Nurses, p. 2)

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<sup>28</sup> Republic Act 7305, the “Magna Carta for Public Health Workers” of 1992 sought to increase health worker’s benefits through salary increase for rural doctors and laundry and subsistence allowance for all other health workers.

I guess it is okay as compared to the private because the salary in the private hospital is lower as compared to the government hospital.

The study of Ronquillo, et al. (2005) documented the disparity between the wages of nurses in the private and public sectors. Through government-mandated increases in the private sector, the gap has gradually diminished - as of 2002, the average monthly salary of nurses in public hospitals is PhP 9,939 (NZ\$301) while it is PhP9,869 (NZ\$299) in private hospitals. However, due to poor implementation and monitoring, there are nurses, particularly those working in small private hospitals who still receive monthly salaries as low as P2,000-P3,000 (NZ\$60-90) (Ronquillo, et al., 2005).

In addition to their base salaries, nurses in government hospitals also get benefits such as longevity pay, hazard pay, laundry and subsistence allowances mandated under the *Magna Carta for Public Health Workers*, which their counterparts in the private sector do not enjoy . A National nurse pointed out, "*Kung sa private P7,500, sa government nakukuha naming doble kasama pa ang other financial benefits (If the salary in the private is P7,500, in the government we get double, plus other financial benefits)*" (Transcript FGI, Ward II-National Nurses, p. 4). In the LGU Hospital, the nurses receive additional benefits from the City government such as the P2,000 "Clean and Green allowance" and "Medicare sharing", which is their share of the Philippine Health Insurance's payment to the LGU Hospital (Transcript FGI II-LGU Nurses, p. 9).

The accounts of the nurses demonstrates that salary is a major consideration in the choice of place to work because many of them have opted to work and remain in government service for many years. Their statements also indicate that the general work situation for nurses offers them only limited choices as they have to choose between two less than satisfactory situations: the private sector that pays low wages but probably has better working conditions, or the government sector that gives relatively higher salaries but has heavier workload. Almost all of the nurses considered the latter as the better option.

- Lahat ng nurses mas prefer nila magtrabaho sa government kasi mas mataas ang salary compared sa private. But, ideally, mas maganda ang training sa private kasi sa government understaff na at hindi ideal yong training sa nurses lalo na yong mga bagong nurses. (Transcript, FGI II-LGU Nurses, p.6)

All nurses prefer to work in the government because the wages are higher as compared to the private. But, ideally, the training in the private hospital is better because government hospitals are understaffed and the nurse training is not ideal, especially for the new nurses.

The reasons for opting to work and remain in the government hospitals are obviously economic. For one young nurse, the relatively higher wages in government hospitals provide her the financial means to pay for the costs of applying for overseas jobs. To quote her, "*Dito kahit papaano, makaka-save ka at masustain mo yong mga exam going abroad (At least here, I am able to save some money to pay for the exams required for going abroad)*" (Transcript FGI, Ward II-National Nurses, p. 4).

#### **4.3.1.6. Summary - Nurses' Dissatisfaction with their Salaries**

The nurses are generally dissatisfied with their salaries because these are not commensurate to their workload, the myriad duties and responsibilities that they carry out and their professional qualifications. At the time the study was conducted, the National and LGU nurses were receiving a monthly base salary of about PhP14,000-15,000 (NZ\$424-454). Many of the nurses have been working in the Hospitals for more than 10 years and have significant professional experience, yet many of them only get a salary of a staff nurse. Another assertion is that their salaries are insufficient to support their families' daily needs. The LGU and National nurses also complained about the uneven salary structure for government nurses, citing nurses in other government hospitals who get higher salaries than what they receive. However, when compared with the nurses' salaries in the private sector, the nurse participants thought their salaries are relatively good enough. Despite their complaints, the

nurses have remained working in the two government hospitals because they perceived it to be the best option that is available to them in the country.

#### 4.3.2. Heavy Workload

In all the group interviews, the nurses' description of their work conditions converged on the topic of workload. Aside from wages, the nurses raised other work-related issues such as nurse staffing and patient admissions in the context of how these problems impact on their workload. Often using the term "toxic", a Filipino slang that means "loaded with work," the nurses bemoaned their heavy workload that exceeds the standard amount of work of nurses. A nurse supervisor described their work as "trabahong kalabaw" (carabao-like work<sup>29</sup>) (Transcript FGI, DR-National Nurses, p. 7), a description that conjured an image of overburdened nurses who are arduously carrying on with their duties.

Workload is, thus, a pivotal issue for the nurses. As evidenced in the previous discussion, workload is central to their argument for increased salaries because they feel that their salaries are not commensurate to their heavy workload. An LGU nurse stated this concisely: "*Dapat ang workload mag-bi-based kung ano yung salary mo. Ang nangyari, masyadong mabigat ang workload para sa salary* (*The salary should be based on the workload. What is happening now is that the workload is too heavy compared to the salary we are receiving*)" (Transcript FGI II-LGU Nurses, p. 7).

Nursing workload is defined as the amount and type of nursing resources needed to care for an individual patient on a daily basis (O'Brien-Pallas & Giovannetti as cited in O'Brien Pallas, Meyer & Thomson, 2005, p. 106). Put in another way, workload is the amount of care that a patient requires. Workload can also be defined as "the nurses' perceptions of the amount of work they do" (Zeytinoglu, Denton, Davies, et al., 2007, p.S35). All the nurses

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<sup>29</sup> The carabao is a domesticated animal that belongs to the water buffalo species. It is a farm animal used by Philippine farmers to pull the plow and the cart that brings the farm produce to the market. In the Philippines, the carabao is aptly called the "beast of burden" denoting both the heavy load the animal is pulling and the arduous task of plowing the field.

in the focus groups as well as the key informants described their workload by illustrating the nurse-to-patient ratios in the two government Hospitals during the time the interviews were conducted, which was from June-July 2007.

- Ang ideal workload ng nurse is 1:5 based on book. Noong nasa ward ako, the ratio of my workload was 1:18, pero ang maximum noon is 1:30... Dito sa ER ang ideal is to assign one nurse in a single area. Gaya namin, tatlo kami in six areas. Di talaga namin kakayanin. (Transcript FGI II-LGU Nurses, p. 7)

The ideal workload is one nurse to five patients, or 1:5 based on the book. When I was assigned to the ward, the ratio of my workload was 1:18, but the maximum was 1:30. Here in the ER, the ideal is to assign one nurse in a single clinical area. Like us, for example, there are only three of us assigned in six clinical areas. The load is too heavy for us.

Nurse-to-patient ratio refers to the number of nurses in relation to the number of patients in the hospital. For instance, a nurse-to-patient ratio of 1:5 means that each nurse gives nursing care to five patients in the hospital. In the Philippines, the Department of Health (DOH) sets the minimum requirements for nurse staffing that hospitals must maintain in order to meet the prescribed standards of medical care. The DOH-prescribed nurse-to-patient ratio, often called by the nurses as the ideal nurse-to-patient ratio, is calculated based on the hospital's total number of beds (which represents the number of admitted patients) and on the level of medical care provided by the hospital. As a general guideline, the nursing service of tertiary hospitals like the LGU and the National Hospitals must have one chief nurse, one supervising nurse for every 50 beds, one nurse for every four beds per shift, one nursing attendant for every six beds per shift, and one midwife per shift (DOH Administrative Order No. 70-A, series 2002). However, the problem with this prescription of nurses-to-bed ratio is that the number of hospital beds is hardly an accurate measure of the total number of patients admitted in a hospital because in-patients commonly exceed beyond the hospitals' total bed capacity (to be discussed in the succeeding subsection on patient load). The supplementary DOH

guidelines on the management of the service capability personnel provide more flexibility and perhaps, are more helpful to hospitals in estimating the required number of nursing staff based on the type and intensity of care that their patients would need. According to these supplemental guidelines, the nursing service of a hospital should be able to:

- ...provide care and management for “intermediate, moderate and partial category of health care to 60% of patients who require assistance on special treatment and specific personal care; total and intensive category of health care to 70% of patients who require assistance on special treatment and specific personal care; and continuous and highly specialized category of health care to 80% of patients who are acutely or critically ill, in constant danger of death, in serious injury and require class monitoring. (DOH Administrative Order No. 70-A, series 2002, Annex 2, p. 22)

Based on the nurses' testimonies, the two Hospitals do not comply with the DOH guidelines for nurse-to-patient ratio. The nurse-to-patient ratios in the National and LGU Hospitals fail to meet the DOH benchmarks of one nurse for every 12 patients (1:12) in the wards and one nurse for each critically ill patient (1:1) in the ICU<sup>30</sup>. In the LGU Hospital, the nurse-to-patient ratio is 1:20-30 in the wards and 1:6 in the Intensive Care Unit (ICU). The situation is similar in the National Hospital where the nurse-to-patient ratios is 1:8 in the ICU, 1:40 in the wards, and 1:20-30 in the Delivery Room. The staffing levels in these two government Hospitals are certainly worlds apart from the situation of the hospitals in developed countries. For instance, in California, hospitals are required by law to maintain a nurse-to-patient ratio of 1:5 in medical-surgical wards, 1:1 in trauma centers, 1:4 in emergency rooms and 1:2 in Obstetrics-Gynecology (Neisner & Raymond, 2002).

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<sup>30</sup> The DOH benchmarks for nurse-to-patient ratio cited here is based on the information given by the National Center for Health Facility Development of the Department of Health.

The nurses' heavy workload is not eased by the presence of nursing attendants, medical interns and residents because there are specific tasks that only the nurses can perform, particularly administering medications to patients.

- Kami lang talaga ang nagbibigay ng medication sa patient. Usually, sila yong nag-aassist sa admission and transferring the patient sa ward. Malaking tulong. Kasi sa ibang hospital, nurse lahat ang nag-extract ng blood, IV insertion, nagpa-follow up ng mga laboratories. Dito sila [ang mga medical interns] na ang gumagawa....Minsan may nagro-rotate sa ER dalawa or tatlo sa isang department. Mabigat pa rin ang workload kasi ang isang area minaman ng isang nurse at lima ang areas naming. (Transcript FGI II-LGU Nurses, p. 1)

Only we nurses can give medication to the patients. Usually, the nursing attendants assist us in the admission and transfer of patients to the ward. They are a big help because in other hospitals, the nurse does everything from extracting the blood, IV insertion to following-up the laboratories. Here, the medical interns are the ones who do that. In the ER, two or three medical interns rotate in one clinical department. Our workload is still heavy because one nurse covers five clinical areas in the ER.

#### **4.3.2.1. Summary - Heavy Workload**

The nurses in the LGU and National Hospitals have heavy workload, which they illustrated by describing the nurse-to-patient ratios existing in both Hospitals. The nurse-to-patient ratios in the National Hospitals is about 1:40 in the wards and 1:8 in the ICU. In the LGU Hospital, it is 1:20-30 patients in the wards and 1:6 in the ICU. These do not meet the DOH standards of one nurse for every 10 moderately ill patients (1:10) and one nurse for each critically ill patient (1:1). Workload is a key issue for the nurses as they viewed their salaries and other work-related issues in relation to their workload.

### **4.3.3. Low Nurse-to-Patient Ratio**

For the purpose of this discussion, a low nurse-to-patient ratio is defined as a ratio that falls short of the DOH standard of one nurse for every 12 moderately ill patients (1:12) and one nurse for each critically ill patient (1:1). Like two sides of a coin, the problem of low nurse-to-patient ratio in the National and LGU Hospitals is twofold: one is inadequate nurse staffing, and the other is a large volume of patients. In other words, the two government Hospitals have a dual problem of few nurses attending to a large number of patients. The succeeding subsections present the nurse staffing and patient census of the LGU and National Hospitals. Also included in this subsection is a discussion of the structural factors that the nurses have identified to be part of the causes for the inadequate staffing and other work-related problems in the two Hospitals. These structural factors include the impact of the migration of nurses, the politicization of health and the decreasing resource allocation for health.

#### ***4.3.3.1. Inadequate Nurse Staffing***

The National and LGU Hospitals have a common problem of inadequate nurse staffing. However, the causes of the insufficient nurse staffing are different for each of the two Hospitals. The subsequent discussion on nurse staffing is based on the accounts of the nurses and key informants, enriched by quantitative data generated from relevant hospital documents. I must point out that the quantitative data on the LGU Hospital nurse staffing have different timelines because these were culled from the monthly reports of the Nursing Service Office. Nevertheless, these only underscore the variable nurse staffing in the LGU Hospital. Moreover, there is a difference in the extent of the evidences presented for the National and LGU Hospitals, with more quantitative data presented for the latter, simply because the LGU Hospital provided more documents and gave this researcher easier access to pertinent hospital records.

- ***LGU Hospital Nurse Staffing***

The nurses at the LGU Hospital perceived the inadequate nurse staffing in their Hospital as a critical problem. Using the Emergency Room (ER) as an

example, the nurses cited that, ideally, there should be six nurses for every shift to cover each of the six areas of the ER. Instead, only three nurses per shift covered the six areas in the ER. To elucidate the lack of nursing staff, the Nursing Service Office provided an estimation of the adequate or the “ideal” number of nursing staff based on the bed capacity of each clinical department, which this researcher then compared with the actual number of nurses working in the LGU Hospital as of December 2006.

Table 2 reveals that the estimated adequate or ideal number of nursing staff for a 361-bed facility like the LGU Hospital is 232 nurses and 134 nursing attendants. However, as of December 2006, the LGU Hospital employed only 127 nurses and 69 nursing attendants. To meet the ideal number of nursing staff, they need to hire 105 nurses and 65 nursing attendants.

Table 3 shows the number of authorized nurse positions created by the Manila city government for the LGU Hospital. The estimated *ideal* number of nurses and nursing attendants needed for the LGU Hospital is different from the number of *authorized* nurse positions. As seen in Table 3, the authorized number of positions for nurses is only 218 and 89 for nursing attendants, compared to the estimated ideal number of 232 nurse positions and 134 nursing attendants (see Table 2). The difference between the ideal and authorized positions is not large, but a scrutiny of how many of these authorized positions have been actually filled by the management unravels the story of inadequate nurse staffing in the LGU Hospital.

**Table 2. Adequate (Ideal) vs. Actual Number of Nurses and Nursing Attendants - January-December 2006**

Clinical Areas	Bed Capacity	Nurses			Nursing Attendants		
		Ideal Number	Employed	Still Needed	Ideal Number	Employed	Still Needed
In-patient							
OB-GYNE	60	20	11	9	11	6	5
Pediatric	45	20	9	11	11	5	6
Medicine	60	20	10	10	11	5	6
Surgery	60	20	10	10	11	5	6
Eyes, Ears, Nose & Throat	27	9	6	3	6	1	5
Infirmery	34	16	10	6	9	5	4
<b>Special Areas</b>							
Operating Rm Recovery Rm	5 8	20 11	17	14	9	7	2
Delivery Rm/ Labor Rm	-	22	9	13	11	5	6
Neonatal	50	20	10	10	14	5	9
Intensive Care Unit	6	12	7	5	5	4	1
Hemo-dialysis	6	9	5	4	5	2	3
<b>Ambulatory</b>							
Emergency Services	-	24	18	6	14	8	6
Out-patient Department	-	8	4	4	6	6	0
<b>Ancillary</b>							
Central Supply Service (CSS)	-	1	1	-	11	5	6
<b>Total</b>	<b>361</b>	<b>232</b>	<b>127</b>	<b>105</b>	<b>134</b>	<b>69</b>	<b>65</b>

Source: Nursing Service Annual Report-LGU Hospital, January-December 2006

**Table 3. Nursing Service Human Resources (March 2007)**

<b>Category</b>	<b>Authorized</b>	<b>Filled</b>	<b>Vacant</b>
Nurse VII	1	0	1
Nurse VI	3	0	3
Nurse V	18	10	8
Nurse IV	37	14	23
Nurse III	139	109	30
Nurse III	10	0	10
Nurse I	10	3	7
<b>Subtotal</b>	<b>218</b>	<b>136</b>	<b>82</b>
Nursing Attendant II	1	0	1
Nursing Attendant I	88	84	4
<b>Subtotal</b>	<b>89</b>	<b>84</b>	<b>5</b>
Human Resources Management Officer	1	1	0
Clerk III	2	2	2
<b>Grand Total</b>	<b>310</b>	<b>223</b>	<b>87</b>

Source: Nursing Service Monthly Report for March 2007

The nurses ascribed the inadequate nurse staffing in the LGU Hospital to the large number of unfilled nurse positions. As seen in Table 3, as of March 2007, the total number of nurses working in the LGU Hospital was 136, indicating that nine additional nurses were hired after December 2006 (there were only 127 nurses in December 2006 as shown in Table 2). However, the 136 nurses constituted only 62% of the 218 authorized nurse positions. Table 3 also reveals that 82 nurse positions or almost 40% were vacant. There were vacant positions starting from the top management, i.e. Chief Nurse and Assistant Chief Nurses down to the nursing attendants. Most of the vacancies were Nurse IV and Nurse III, which are the nurse positions that are directly involved in the provision of patient care – 40 Nurse III and 23 Nurse IV positions were unfilled. The staff nurses assigned in the various clinical areas absorb the impact of these vacancies on the nursing workload. For the nursing attendants, only five of the 89 authorized positions were vacant, but not all of these nursing attendants are serving in the LGU Hospital.

The practice of “detailing” or assigning members of the nursing staff to other offices aggravated the problem. Not all of the 136 nurses and 84 nursing attendants were serving in the clinical areas of the LGU Hospital because several of them have been detailed to other offices inside and outside of the Hospital. As the Assistant Chief Nurse explained, “*The actual position is filled up but di naman napakinabangan ng institution kasi they are working in other institutions (The actual position is filled up but the Hospital cannot utilize them since they are working in other institutions)*” (Transcript, Interview, Asst. Chief Nurse-LGU Hospital, p.1).

Table 4 shows that, as of March 2007 (up to the time of the interview), 15 members of the nursing staff have been detailed to other offices: 11 nursing attendants, two staff nurses and two administrative personnel. Three of the 11 detailed nursing attendants were working in the City Hall: one in the Mayor’s Office, and two in the Offices of two City Councilors. This means that of the 84 hired nursing attendants (see Table 3), only 73 were essentially assisting the LGU nurses in the different clinical areas.

**Table 4. Nursing Staff Detailed to Other Offices (March 2007)**

<b>Positions</b>	<b>Number</b>	<b>Office where they are detailed</b>
Nurse III	2	Hospital Director’s Office
Nursing Attendant	1	Medicare & Billing Section, LGU Hospital
Nursing Attendant	2	City Councilors Offices
Nursing Attendant	1	Office of the City Mayor
Nursing Attendant	1	Department of Public Service, City Hall
Nursing Attendant	1	Medical Record Section, LGU Hospital
Nursing Attendant	1	Personnel Office, LGU Hospital
Nursing Attendant	1	Housekeeping, LGU Hospital
Nursing Attendant	1	Engineering, LGU Hospital
Nursing Attendant	1	PLEB
Nursing Attendant	1	Administrative Office
Clerk III	1	Medical Records Section, LGU Hospital
HRMO	1	Accounting Office, LGU Hospital
<b>Total</b>	<b>15</b>	

Source: Nursing Service Monthly Report, March 2007

Table 5 further elaborates how the “detailing” of nurses to other offices affected the distribution of nurses in the different clinical areas of the LGU

Hospital. For instance, the Nursing Service assigned 18 nurses to work in the Emergency Room (ER), but in reality, only 16 were doing their duties in the ER since the two staff nurses have been detailed to the Office of the Chief of Hospital. This explains why the ER had only three nurses per shift instead of the ideal six nurses. Earlier, it was mentioned that the positions for the chief nurse and assistant chief nurses were vacant, which means that at the time this research was conducted, the LGU Hospital had no officially appointed chief nurse and assistant chief Nurses. The Chief Nurse and the Assistant Chief Nurse whom this researcher interviewed were only holding these positions in an “acting” capacity since 2005. Table 5 also shows that the acting Chief Nurse and Assistant Chief Nurse are actually Nurse V from the Training and Education Division. The Hospital management had detailed them to the Nursing Service Office to assume managerial responsibilities. According to the acting Chief Nurse, there was even a time when she carried out the dual functions of a chief training officer and a chief nurse.

**Table 5. Nurse Staffing by Clinical Departments – LGU Hospital**

Clinical Areas/ Services	Nurse VII Chief Nurse			Nurse VI Asst. Chief Nurses			Nurse V Chief, Clinical Area			Nurse IV Supervisors			Nurse III Staff Nurses			Nurse III – Staff Nurses Medicare (contractual)			Nurse I Trainee		
	Authorized	Actual	Vacant	Authorized	Actual	Vacant	Authorized	Actual	Vacant	Authorized	Actual	Vacant	Authorized	Actual	Vacant	Authorized	Actual	Vacant	Authorized	Actual	Vacant
<b>In-patient</b>																					
OB-Gyne							1	1	0	2	1	1	10	7	3	2	0	2	2	1	1
Pediatric							1	0	1	2	1	1	10	7	3	1	0	1	2	0	2
Medicine							1	1	0	2	1	1	10	8	2	2	0	2	2	0	2
Surgery							1	1	0	2	1	1	10	9	1	2	0	2	2	1	1
EENT							1	1	0	1	1	0	6	3	3	2	0	2	1	1	0
Infirmery							1	1	0	1	0	1	8	8	0	1	0	1	1	0	1
<b>Special Areas</b>																					
Operating Room Recovery Room							2	1	1	3	1	2	20	15	5						
Delivery Room/Labor Room							1	1	0	2	0	2	10	8	2						
Neonatal							1	0	1	3	2	1	10	8	2						
Intensive Care Unit							1	0	1	3	1	2	10	7	3						
Hemodialysis							1	0	1	3	1	2	7	4	3						
<b>Ambulatory</b>																					
Emergency Services							2	1	1	4	1	3	22	16**	4						
Out-patient Dept.							1	0	1	4	1	3	3	3	0						
<b>Ancillary</b>																					
Central Supply Section				1	0	1	1	0	1	2	1	1	-	-	-						
Nursing Service Training & Education Division				1	0	1	2*	↓	0	3	1	2	3	3	0						
Nursing Service Office	1	0	1	1	0	1	-	2*	-	-	-	-	-	-	-						
Detailed																					
<b>Total</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>3</b>	<b>0</b>	<b>3</b>	<b>18</b>	<b>10</b>	<b>8</b>	<b>37</b>	<b>14</b>	<b>23</b>	<b>139</b>	<b>108</b>	<b>31</b>	<b>10</b>	<b>0</b>	<b>10</b>	<b>10</b>	<b>3</b>	<b>7</b>

Source: Nursing Service Monthly Report, May 2007; \*Two Nurse(s) V from the Nursing Service Training & Education Division were assigned to the Nursing Service Office.

\*\* 2 Nurse(s) III from the ER were detailed to the office of the Hospital Director, hence out of the 18 filled Nurse III positions in the ER, only 16 were actually assigned to the ER.

Unfilled nurse positions and the detailing of nursing staff are perennial problems in the LGU Hospital that have remained unresolved over the years. Since I conducted this research shortly after the May 2007 national and local elections, I initially assumed that the LGU Hospital could not hire new nurses because of the election ban prohibiting government agencies from hiring employees during election period, which was still in effect during the time I did the interviews. However, an examination of the documents from the Hospital's Nursing Service Office proved otherwise. In letters written from the year 2000 until 2007, the Chief Nurse repeatedly apprised the Chief of the LGU Hospital about the serious inadequate nurse staffing and recommended the filling up of vacant nursing positions and recalling the detailed nursing staff. Judging from the similar contents of the letters spanning seven years, the situation has remained unchanged.

- ***National Hospital Nurse Staffing***

A big disparity between the size of the Hospital and the size of its nursing staff characterizes the problem of inadequate nurse staffing at the National Hospital. The Nursing Service has 532 authorized positions, consisting of 330 nurse positions, 199 nursing attendants and three midwives. However, the existing staffing pattern in the National Hospital is only appropriate for a hospital with 300-bed capacity. When the government upgraded the National Hospital from 300 to 600 beds, the number of authorized positions for the nursing staff was not correspondingly increased. Providing a brief historical background, the Chief of Hospital elaborated on their predicament:

- We were upgraded into a 600-bed by law in 1998. However, the upgrading did not involve the increase in manpower complement and resources. Our manpower complement is only good for 350 beds and yet we are implementing the 600-bed without increase in manpower from the nursing and from the doctors' side. Instead of a ratio of perhaps 1:20, or one nurse for 20 patients, some of the wards have a 1:40, which is way, way below the standards set forth by any country in the world. (Transcript of Interview, Chief of National Hospital, p.2)

The National Hospital does not have a problem of many unfilled positions since only 30 positions were vacant in June 2007 (see Table 6). Its main problem is that there are simply not enough nurse positions created for the National Hospital. At present, the National Hospital has only 50% of the nursing staff that it requires. Comparing the staffing pattern of the two Hospitals, the LGU and National Hospitals have almost the same number of nurses assigned per shift in each clinical area, yet the National Hospital has more patients and bigger bed capacity than the LGU Hospital (to be discussed at length in the succeeding subsection).

Table 6 also presents the distribution of the nursing staff at the National Hospital. For instance, it shows that in June 2007 only seven Nurse(s) I and one Nurse II were assigned to the sixth floor ward, which means that the ward had only two to three nurses for each shift. In addition, there were 21 nursing attendants loaned out to other offices, but unlike in the LGU Hospital, these offices were inside the National Hospital, e.g. admitting section, X-ray, surgery office, laboratory and property office. Nevertheless, these detailed nursing attendants were still unable to assist the nurses in the different clinical areas.

**Table 6. Nursing Service Distribution - National Hospital (June 2007)**

Unit	6 <sup>th</sup> Flr. West Wing	6 <sup>th</sup> East Wing	6 <sup>th</sup> West Wing	6 <sup>th</sup> South-east Wing	5 <sup>th</sup> North Wing	5 <sup>th</sup> East Wing	5 <sup>th</sup> West Wing	Pedia ICU	5 <sup>th</sup> South - east Wing	Acute Stroke Unit	4 <sup>th</sup> North Wing	4 <sup>th</sup> East Wing	OR	ICU	3 <sup>rd</sup> North Wing	3 <sup>rd</sup> East Wing	DR	Neonatal ICU	3 <sup>rd</sup> West Wing	Ward 1	ER	Burnt Unit	OPD	Training	Nursing Office	Specialty Area	Detailed	Total	Authorized	Vacancy
Bed Capacity	26	33	35	33	48	38	54	—	22	5	17	44	—	8	58	38	—	—	13	—	—	5	—							
NVII																								1			1	1	0	
NVI																							1	1			2	2	0	
NIV													1														1	1	0	
NIII	1	1	1	1	1	1	1	1	1		1	1	5	0	1	1	3	1	1	1	1	1	1	4	7	1	39	40	1	
NII	3	1	3	2	4	2	3	3	2	1	2	3	9	4	0	3	7	6	1	4	3	3	3	0	0	1	73	81	8	
NI	9	7	7	8	9	8	9	5	9	3	8	5	11	5	13	7	18	23	4	13	15	2	3	0	0	0	201	205	18	
<b>Subtotal</b>																											<b>317</b>	<b>330</b>	<b>27</b>	
Nursing Attendant II	2	0	0	2	1	2	0	3	1			1	4	2	2	1	8	3	0	1	3	0	3		3	2	6	50	50	0
Nursing Attendant I	4	5	4	3	6	4	6	4	6		6	4	8	5	4	4	7	10	3	7	10	5	9	1	0	6	15	146	149	3
Midwife II																			1								1	1	0	
Midwife I																	2										2	2	0	
<b>Total</b>	<b>19</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>21</b>	<b>17</b>	<b>19</b>	<b>16</b>	<b>19</b>	<b>4</b>	<b>17</b>	<b>14</b>	<b>38</b>	<b>16</b>	<b>20</b>	<b>16</b>	<b>45</b>	<b>43</b>	<b>10</b>	<b>26</b>	<b>32</b>	<b>11</b>	<b>19</b>	<b>6</b>	<b>12</b>	<b>10</b>	<b>21</b>	<b>516</b>	<b>532</b>	<b>30</b>

Source: Nursing Service Office, National Hospital

The Chief of the National Hospital is optimistic that the national government's rationalization program will address the lack of nursing staff in their Hospital. The Philippine government, through Executive Order No. 366, is currently implementing a rationalization program to improve efficiency in government service by focusing on the delivery of vital core services and streamlining the support systems, organization structure and staffing of executive agencies. Under this rationalization plan, most national government agencies will need to reduce the number of its staff, but for the National Hospital, this would mean increased number of personnel to match the functions and service capability of the Hospital. The Chief explained this further:

- Hopefully... the rationalization plan would increase our manpower commensurate to a 600-bed. That is the idea of the rationalization plan. So, most of the other agencies of government were downsizing their manpower. But fortunately, we have to increase because we are implementing the 600-bed capacity and our manpower is only good for 350. (Transcript of Interview, Chief of National Hospital, pp. 2-3)

However, only a small number of agencies have commenced the rationalization program and these do not include the national government hospitals. At the time this study was conducted (June-July 2007), the rationalization plans of the Department of Health (DOH) and its attached hospitals have yet to be approved by the Department of Budget and Management (DBM). The Chief of the National Hospital explained that the DOH had already submitted the rationalization plan for its hospitals, but the DOH needs to revise the plan because some of its regional offices were increasing their workforce, instead of downsizing it. The DOH has been reevaluating its rationalization program and has to submit it again to the DBM for approval.

- ***Summary - Inadequate Nurse Staffing***

The National and LGU Hospitals have a serious problem of inadequate nurse staffing. In the LGU Hospital, the inadequate nurse staffing is caused by the perennial problems of unfilled nurse positions and detailing of nursing staff to other offices inside and outside of the Hospital. More than one-third of the 218 authorized nurse positions were vacant at the time of the interview. The lack of available nursing positions is the root cause of the inadequate nurse staffing in the National Hospital. When the government upgraded the National Hospital from 300 beds to 600 beds in 1998, it did not correspondingly increase the Hospital's human resources. Thus, presently, the National Hospital has only 330 nurse positions and 199 positions for nursing attendants, which constitute only 50% of the required number of nursing staff for a 600-bed health facility. Inadequate nurse staffing is an important dimension of the problem of low nurse-to-patient ratios in the two government Hospitals, which the nurses have pinpointed as a primary factor for their heavy workload.

#### **4.3.4. Large Number of Patients**

The LGU and National Hospitals are flooded daily with large number of patients. This is because they provide free medical care to patients, not to mention that these two Hospitals are tertiary-level facilities with specialized and sub-specialized forms of medical treatment that are not available in the primary and secondary-level hospitals. This subsection presents the patient census of each of the Hospital culled from hospital records as well from the focus group and key informant interviews.

##### ***4.3.4.1. LGU Hospital Patient Census***

As early as seven o'clock in the morning, I went to the LGU Hospital to catch the ER nurses at the start of their morning shift. I noticed right away the growing number of people gathered in front of the LGU Hospital building, waiting for the doors of the Outpatient Department to open. An hour later, as the Outpatient Department opened, the waiting crowd rushed in and the lobby was immediately packed. This sight gave me a preview of the volume of patients that the LGU Hospital serves in a day.

In the Emergency Room (ER), the LGU nurses estimated that they attend to an average number of 100 of patients in one shift. The majority of patients seeking medical care in the ER are trauma cases, which usually arrive during the night shift. The nurses said that the number of cases in the ER sometimes varies; in one shift (equivalent to eight hours), they attend to a minimum of 70-80 patients and a maximum of 130 patients, but normally the number of patients does not fall below 100 for each shift. In addition, they noted that during rainy or typhoon season and during the Christmas holidays, there would be a rise in the number of patients.

- Sa isang araw, the average number of patient is 110-130. Yong iba hindi pa nala-log at naka-chart. Pero may mga shift din naman na 70-80 patients lang, depende rin kasi. (Transcript, FGI II-LGU Nurses, p.7)

In a day's shift, the average number of patients is 110-130. However, there are patients that we are not able to log and chart. Sometimes there are shifts when there are only 70-80 patients; it varies.

Based on the daily patient census records from June 1-20, 2007, the LGU Hospital treats an average of 500 patients daily in all the clinical departments and has bed occupancy rates (in-patients) ranging from 65%-74% (see Table 7). In the Emergency Room (ER), the average number of consultations in a day was 231. However, the official records may not capture the actual number of patients that go to the LGU Hospital for treatment. For instance, the Chief of the LGU Hospital also provided a higher estimate than what the Hospital's official patient census had reported. She roughly estimated that the LGU Hospital treats daily about 800-1,000 in-patients, 300 outpatients and 200-400 patients in the ER. According to the ER nurses, sometimes the three or four nurses doing their shift are unable to record all the patients that came to the ER.

**Table 7. LGU HOSPITAL DAILY PATIENT CENSUS (June 1-20, 2007)**

Days	CLINICAL SERVICES (In-patient)		SPECIAL SERVICES (ICU, Neonatal, DR, OR.)	ER	TOTAL
	No. of Patients (column 1)	Occupancy Rate (column 1/ bed capacity)	No. of Patients (column 3)	No. of consultations (column 4)	(=columns 1+3+4)
June 1	196	69%	81	193	470
June 2	190	66%	81	280	551
June 3	198	69%	79	174	451
June 4	192	67%	73	199	464
June 5	207	72%	79	232	518
June 6	209	73%	77	233	519
June 7	202	70%	76	253	531
June 8	203	71%	80	180	463
June 9	195	68%	84	192	471
June 10	201	70%	89	317	607
June 11	181	63%	69	276	526
June 12	208	70%	64	231	503
June 13	212	74%	66	199	477
June 14	196	69%	51	210	457
June 15	189	66%	52	202	443
June 16	185	65%	59	276	520
June 17	201	70%	64	275	540
June 18	204	70%	62	273	539
June 19	194	68%	61	206	461
June 20	197	69%	65	222	484
<b>Total</b>	<b>3,960</b>		<b>1,412</b>	<b>4,623</b>	<b>9,995</b>
<b>Average</b>	<b>198</b>	<b>69%</b>	<b>71</b>	<b>231</b>	<b>500</b>

Source: LGU Hospital 24 Hrs Patient Census – Nursing Service Office

#### **4.3.4.2. National Hospital Patient Census**

The number of patients admitted at the National Hospital often exceeds the Hospital's bed capacity. To highlight the sheer volume of patients who go to the National Hospital, the daily census of patients in June 2007 and the monthly census from January to September 2007 are placed side by side in Table 8. In June 2007, the National Hospital, which is a 600-bed health facility, treated a daily average of 611 patients. The daily patient census reached as high as 643 and seldom fell below 600. During a nine-month period (January to September 2007), the National Hospital admitted 164,620 patients or a monthly

average of 18,291 patients. The lowest monthly patient census was 16,000 and the highest reached almost 20,000.

**Table 8. Daily & Monthly Patient Census – National Hospital**

Daily Census		Monthly Census	
June 2007	No. of Patients	Months (Jan-Sept. 2007)	No. of Patients
1	637	January	18,884
2	616	February	16,366
3	631	March	18,318
4	643	April	17,576
5	634	May	19,524
6	637	June	18,333
7	628	July	18,467
8	600	August	18,749
9	597	September	18,403
10	629	<b>Total</b>	<b>164,620</b>
11	641	<b>Monthly Ave.</b>	<b>18,291</b>
12	638		
13	627		
14	622		
15	614		
16	589		
17	621		
18	614		
19	603		
20	598		
21	593		
22	546		
23	574		
24	624		
25	621		
26	614		
27	610		
28	574		
29	577		
30	581		
<b>Total</b>	<b>18,333</b>		
<b>Ave.</b>	<b>611</b>		

Source: Medical Records – National Hospital

The surplus of patients at the National Hospital results in a long queue of patients waiting for vacant hospital beds. The Delivery Room (DR) nurses explained how this queue of waiting patients intensifies their already heavy workload. According to them, normally, mothers who had given birth have to be immediately transferred from the Delivery Room to the Obstetric-Gynecological (OB) wards, but because there are no available beds in the ward, they remain in the Delivery Room. While waiting for vacant beds, the mothers stay in a

halfway room that the nurses called “*Bahay ni Kuya*” (*the Big Brother House*<sup>20</sup>). The room is a confined space with a floor area of about 15 square meters and contains only improvised beds.

- ...after delivery, after OR labas na sila. Impossible gawin iyon since wala namang bakante doon, so mayroon kaming isang room, ... meron kami doon na nilagyan na lang namin ng foam, nandudoon na iyong mga nanganak, iyong mga normal delivery. Iyon, nandoon sila sa bahay – tawag namin duon “Bahay ni Kuya”. Hindi na sila puwedeng humiga dahil sa dami nila. Kung minsan 20 plus, 30, 40. Imagine iyong ganitong kaliit na room, 40 na pasyente, so wala nang space para mahiga. (Transcript, FGI, DR-National Nurses, p. 20)

...after delivery, after OR, the mothers should have been gone. This is not possible since there are no vacant beds available, so we converted a room and put bed foams on the floor; it is where the mothers who had normal deliveries stay. So, the mothers are there in the “House,” we call it the “Big Brother House.” The patients cannot lie down because there are just too many of them. Imagine a room this small with 20, 30, 40 patients, there is no space for them to lie down.

In some instances, the patients stay in the halfway room for several days until such time the doctors discharge them simply because there are no available beds. So, rather than being relieved of workload, the three DR nurses have to give medications and attend to the needs of 50 to 70 patients, and at times, 80 patients.

- So andito sila, instead na ang pasyente naming lang sana naming ay 15, 20, ganoon, umaabot kami ng 50, 60, 70 kasi iyong mga pasyente dito hindi puwedeng lumabas dahil walang space

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<sup>20</sup> The nurses alluded to a reality TV show in the Philippines called “Pinoy Big Brother”, the Philippine version of the international show “Big Brother”. Aside from being a popular TV show in the Philippines, the reference to the show has something to do with the 10 or so participants in the show being cooped up inside a house for several weeks.

doon...Kung minsan nga iyong kahapon, tumatawa ako kasi iyong CS [caesarian section operation] namin na supposed to be after OR, nasa ICU na sila or sa ward, di ba, nandito pa rin hanggang sa ma-discharge na lang., pinauwi na lang ng doctor kasi wala silang place diyan. Sana naman madagdagan iyong OB ward. (Transcript, FGI, DR-National Nurses, p. 19)

So the patients are here, instead of just having 15, 20 patients, we have 50, 60, 70 because there are no beds in the OB ward. Sometimes, I just laugh at the situation, like yesterday we had a case, a woman who had CS [caesarian section operation] who was supposed to have been transferred from the OR [Operating Room] to the ICU or to the ward. But she stayed here until she was discharged yesterday. The doctor sent her home because there was still no bed available for her. I hope there will be additional rooms in the OB ward.

#### **4.3.4.3. Summary - LGU & National Hospital Patient Census**

. The other dimension to the problem of the low nurse-to-patient ratio is the large volume of patients who seek medical care at the National and LGU Hospitals. The National and LGU Hospitals not only share the same predicament of insufficient nurse staffing but both are swamped daily with large number of patients. The number of patients that flock to the two Hospitals often exceeds beyond their capacity in terms of the number of its nursing staff and the number of available beds. In the month of June 2007 alone, the LGU Hospital, a 300-bed hospital, served a daily average of 500 patients. The National Hospital, a 600-bed facility, treated more than 600 patients everyday. The two elements of inadequate nurse staffing and high patient census explain why the National and LGU nurses feel overburdened with work.

#### **4.3.5. Factors to Inadequate Nurse Staffing & Other Work-Related Conditions**

The nurses and key informants identified three main significant factors to the inadequate staffing and other work-related problems in the two government

Hospitals. These are: (1) the fast turnover of nurses brought about by the continuing migration of nurses, (2) the politics in health, and (3) the declining budgetary allocation for the health sector. This subsection presents an analysis that is based on the accounts of the nurses and key informants, enriched by empirical evidence from relevant literature and data gathered from official reports of national government and international agencies.

#### **4.3.5.1. The Migration of Nurses**

The nurses partly attributed the inadequate nurse staffing to the frequent turnover of nurses in the two Hospitals who leave their jobs to work abroad. The National and LGU Hospitals do not have a policy restricting their nurses from leaving the Hospitals. They do not bind their nurses to a contract requiring them to serve the Hospitals for a specified number of years. Although the LGU nurses sign a pledge of service of two years when they officially sign their appointment papers, the LGU Hospital management does not strictly enforce this agreement.

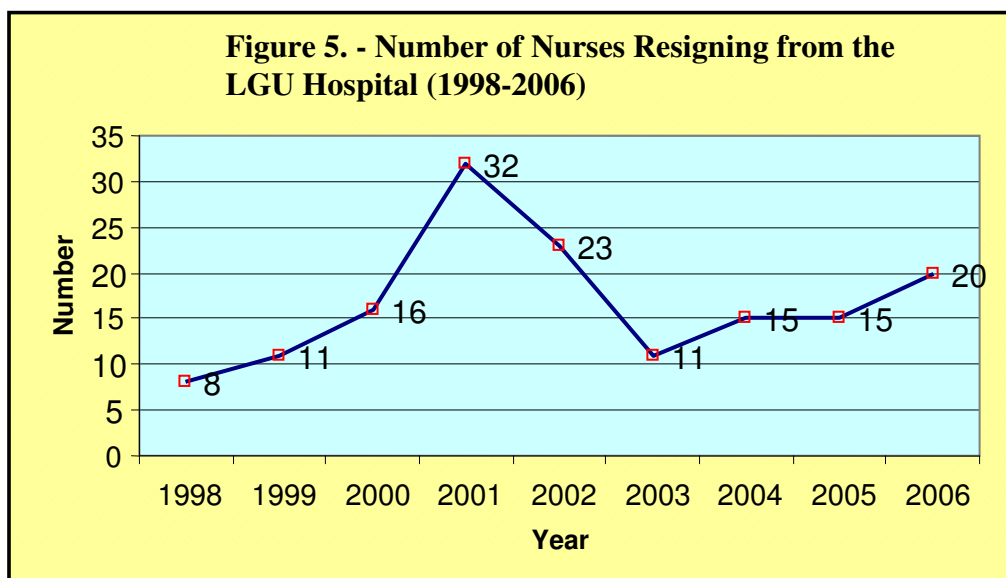
- Dahil siguro marami ng umalis, pero marami rin naman bagong hire. Kaya lang marami din talagang may gustong mag-abroad. Ang turnover sa mga bagong hire, after 1 or 2 years, umaalis na sila. Except sa mga matagal na dito at ayaw umalis. (Transcript, FGI II-LGU Nurses, p. 2)

Maybe because many nurses have resigned, but there are also many newly hired nurses. However, many nurses also want to go abroad. The turnover among the newly hired nurses - after one or two years, they already leave. Except for those who had been with this Hospital for so many years and do not want to leave anymore.

Even the Nursing Service of the LGU Hospital blamed the inadequate staffing to the migration of nurses, which is documented in the letters and reports submitted by the Chief Nurse to the Chief of the LGU Hospital. In these letters, the following phrases were often used: “...*marked depletion of nurses due to attractive offers abroad*” and “*alarming depletion of nurses brought about*”

*by the current trend of nurses leaving for abroad*" (Letters dated May 11, 2007 & Nov. 16, 2004).

To ascertain the rate of turnover of nurses in the two Hospitals, the researcher examined the pertinent documents provided by their Nursing Service Offices. Based on the resignation letters submitted by LGU nurses from 1998 to 2006, the most common reason for quitting their jobs is, indeed, to work abroad. However, upon further scrutiny, the data shows that the number of LGU nurses who resigned during this period represents only a small fraction of the total number of nurses at the LGU Hospital. In 2006, only 20 out of 127 LGU nurses resigned constituting only 16% of the total number of nurses working for the Hospital that year. Figure 5 shows the actual number and the fluctuating trend of nurses who resigned from the LGU Hospital during the same nine-year period. Starting from 1998, the number of resignations steadily rose and reached its peak in 2001 when 32 nurses resigned. After 2001, the resignations gradually decreased and stabilized in 2004-2005 and slightly increased again in 2006. According to the Assistant Chief Nurse, the number of nurses who resigned from the LGU Hospital reflected the rise and fall in the demand for nurses abroad. During the period 2000-2002, when the demand for Filipino nurses boomed in Saudi Arabia and in the United Kingdom, the number of nurse resignations also went up. In the succeeding years, when there was retrogression in the issuance of US visas for Filipino nurses, the nurses stayed put in the LGU Hospital and the number of resignations went down.



Source: Nursing Service Office – LGU Hospital

At the National Hospital, the nurses estimated that in a year about 20% of the nursing staff resigns. The Delivery Room (DR) nurses said that about 15 to 20 of their colleagues in the DR have already left to work abroad. An official document from the Nursing Service Office shows that in 2005 and 2006, an average of five nurses resigned every month (see Table 9), which included nurses who retired and who left to work abroad. Of the 61 staff members who resigned in 2005, 52 were nurses and nine were nursing aides. In 2006, 50 nurses and 11 nursing aides left their jobs. These numbers constituted about 16% of the total authorized number of nursing positions and 5% of the total number of nursing aide positions. The study of Perrin, et al. (2007) documented a similar turnover rate of 17% among the staff nurses in 200 government and private hospitals.

**Table 9. Resigned & Retired Nursing Staff (2005 & 2006) –National Hospital**

<b>MONTH</b>	<b>CY-2005</b>	<b>CY-2006</b>
January	5	4
February	2	5
March	2	3
April	7	6
May	5	6
June	7	9
July	7	8
August	3	8
September	7	7
October	5	1
November	6	1
December	3	1
<b>TOTAL</b>	<b>61</b>	<b>59</b>
<i>Breakdown:</i> Nurses	52	50
Nursing Aide	9	11
Total authorized no. of nurses	330	330
% of resigned nurses	15.75%	15.15%
Total authorized no. of nursing Aides	199	199
% resigned of nursing aide	4.52%	5.52%

Source: Reports on Resigned Staff, AWOL, Transfer, Retired and Due to Disability (2006) – Nursing Service Office, National Hospital

Although the total number of nurse resignations in the LGU and National Hospitals are not high, these resignations, nevertheless, exacerbate the existing inadequate nurse staffing in the two government Hospitals. More specifically, it adds to the heavy workload of the nurses in the Hospitals. For instance, in 2006, with nearly 50% of the nurse positions in the LGU Hospital vacant (pls. refer to Table 2) the impact of the resignation of 20 nurses is greatly felt by the remaining nurses who assumed the workload of the nurses who resigned. To illustrate, the ER nurses compared the current staffing in their department to the situation in the previous years.

- Before five ang nurse ang nag-duduty per shift sa ER about six years ago – 1996 or 1997. Now only three na lang since 2002. (Transcript, FGI I-LGU Nurses, p. 4)

Before, five nurses would go on duty per shift in the ER – this was about six years ago, 1996 or 1997. Now there are only three nurses per shift since 2002.

Generally, finding replacements for the nurses who have resigned is not difficult since many new nursing graduates are eager to gain hospital experience. However, problems pertaining to the nurses' leave credits have caused delay in the hiring of replacements. The Chief of the LGU Hospital explained that some nurse positions cannot be immediately filled up because nurses who have plans of resigning or retiring commonly avail of their "terminal leaves", (i.e. accumulated unused vacation and sick leaves) before they hand in their official resignation. Many LGU nurses had been with the Hospital for more than 10 years and, therefore, have accrued many unused leaves over the years. Hence, while the nurse is no longer working in the Hospital, the management cannot officially declare the position vacant and they cannot hire a replacement until her official resignation takes effect.

In addition, government bureaucratic procedures in recruiting employees have also caused time lag in the official appointment of new nurses. In the account below, the National nurses gave details on the administrative procedures that must be followed in the hiring of new nurses, which usually takes several months.

- They go slow because, you know *naman sa* government you have to make a clearance and has to pass through the DOH and then the item should be cleared before you hire and it has to be published iyong item muna bago ka mag-hire ng new nurses. Siguro mga three months ganoon, or five months. Okay lang kung nag-clear pa siya within that period. What if hindi pa siya nag-clearance at basta umalis na lang siya and ... Before you drop the item, you have to make a communication to the family for three times, three consecutive months. Pag walang answer, that's the time na walang ano – ida-drop pa lang iyong item na iyon. (Transcript, FGI, DR-National Nurses, p. 4)

They go slow because you know in the government you have to get a clearance [when you resign] and this clearance has to pass through the DOH. Then the [position] item has to be officially declared vacant and then published in the newspaper before you can

hire new nurses. It usually takes three to five months. What if the nurse who resigned had not submitted her clearance and just left? Before you can drop the nurse from the employment roll, you have to send an official communication to the family for three times in three consecutive months. If it remains unanswered, then that is the time you can drop her from the roll.

The hiring of replacements, however, does not necessarily alleviate the burden of the nurses who stayed. On the contrary, the DR nurses at the National Hospital pointed out that having newly hired nurses entails an additional burden for them because they have to train and supervise these new nurses.

- Hindi sila na-i-assign agad as ... Kasi may OJT [on-the-job-training] pa. Ite-train mo pa iyon... 1 month. And then after 1 month maghihintay pa siya ng months to be hired. Tapos pag may appointment na sila, iti-train mo pa sila ulit for another three months, kaya iyong mga naiwan talagang mahirap, kawawa. Kasi hindi mo naman kaagad-agad i-assign doon, mag-a-assist sa operation. Iwa-one-to-one mo pa yan, ite-train mo pa sila kaya matagal. (Transcript, FGI, DR-National Nurses, p.5)

They cannot be assigned right away because they have OJT [on-the-job training]. They have to be trained for about a month. Then after 1 month, the new nurses will have to wait for a few months before they are hired. Then when they get their appointment, they have to be trained again for another three months. This is the reason why the nurses who are left behind have a hard time; they are in a pitiful situation - because the new nurses cannot be immediately assigned to assist in the operating room. We have to give them one-on-one training, which is why it takes a long time.

Looking beyond the numbers, the National Hospital perceived the frequent turnover of nurses to have a serious impact on the Hospital in terms of the resources spent for training the newly recruited nurses and the decline of

the level of competence of its nurses. Since the new graduates have limited hospital experience, the National Hospital invests in time and resources to equip these inexperienced nurses with the necessary nursing skills. With an average of five nurses resigning each month, the National Hospital repeatedly trains every new batch of hired nurses.

- *Maraming nurse (There are plenty of nurses).* There are thousands applying, but these are newly grads without the necessary skills. So, even if they will be replaced by newer nurses, the problem for us is to re-train and re-tool again these nurses so that we spend a lot of time and resources doing it. Once these have been trained again to the level of what we desire, then we cannot prevent them from resigning again. (Transcript of Interview, Chief Hospital – National Hospital, p.5)

The Chief of the National Hospital lamented how the Hospital is becoming a training school for new nursing graduates who eventually leave to work abroad after gaining one or two years of hospital experience. In addition, the loss of previously trained nurses implies that the National Hospital is in short of skilled and experienced nurses. According to him, it actually takes about one year for the new nurses to acquire the required level of skills given the large volume of patients at their Hospital.

- Perhaps it will take you about—with the number of patients that we have in East Avenue, a training of one year is already, is sufficient enough. So, when they go out, these young nurses will go out, they were able to get some skills from these veteran nurses that we have. They go out after one and a half years and then it will be again a new nurse coming in. It is very sad to note na parang we are a training institution for nurses going abroad. Parang ganoon ang dating eh. (So it seems very sad to note that we are like a training institution for nurses who are going abroad. This is how the situation seems to appear). (Transcript of Interview, Chief Hospital – National Hospital, pp 5, 6 & 10.)

The Chief of the LGU Hospital, on the other hand, held contrary views about the impact of the migration of nurses on their Hospital, raising the issue about the quality of nursing education in the country. Firstly, she believed the presence of a large number of nursing students and medical interns in the LGU Hospital mitigates the effect of the turnover of nurses on workload. Secondly, she did not believe that the LGU Hospital has a shortage of skilled nurses, questioning the definition of skilled nurses. Arguing that if skilled nurses refer to the nurses trained in specialty areas such as oncology, then the LGU Hospital does not have them; but, despite this, the Hospital Chief maintained that their Hospital still provides the same level of nursing care that is given in other tertiary-care hospitals. Furthermore, she contended that the new nursing graduates who passed the board examinations should already possess the basic nursing skills, which they will hone as they gain at least three years of hospital experience. Declaring that "*Not all colleges of nursing are decaledad*" (*Not all nursing schools are of good quality*) (Transcript of interview, Chief of LGU Hospital, p. 4), she opined that the lack of skilled nurses is a result of the deteriorating quality of nursing schools and the lack of experienced nurse professors who can teach the necessary skills to nursing students.

#### **4.3.5.2. The "Politics" in Health**

When asked for the possible reasons for the inadequate nurse staffing at the LGU Hospital, the nurses pointed to the City Hall because the City Mayor is the appointment officer - the one who makes the final decision on the hiring of all employees under the City government: "*Hindi naming alam kasi sila sa City Hall ang may choice. Ilalagay nila yong vacant pero depende pa rin sa kanila. (We do not know because the City Hall makes the choice; they may fill the vacant position but it all depends on their decision)*" (Transcript, FGI I- LGU Nurses, p. 3). When probed further, one of the nurses stated, "*Actually, there is no shortage of nurses; in fact a lot of nurses are not being hired*" (Researcher's field notes/journal).

The nurses' testimonies gave different facets to the unique set-up of hospitals that are under the management of local government units (LGU), which are consequences of the vast powers bestowed upon the local

government units and their local chief executives. Although the LGU nurses did not expressly say it, their statements conveyed undertones about the influence and effects of “politics” in the management of the LGU Hospital. According to one LGU nurse, this has affected their work climate especially their relations with other staff members, “*Hindi masyado makapagsalita or complain kasi we are just appointed by the Mayor (We cannot talk or complain openly because we are just appointed by the Mayor)*” (Researcher’s field notes – FGI III-LGU Nurses). This might explain the nurses’ prudence when asked about the reasons for the many unfilled nurse positions in the LGU Hospital.

- ***Hiring, Promotion and Security of Tenure***

The organizational set-up of the LGU Hospital affects the hiring, promotion and security of tenure of the nurses. Since it is the Mayor who has the decision-making powers and has overall supervision and control over the LGU Hospital (see Figure 1 – Organizational Structure), the hiring, promotion and tenure of its employees are practically in the hands of the City Mayor. The Local Government Code of 1991, which granted autonomy to the local government units (LGU), conferred to the local chief executives the power to appoint all employees paid out of the local government funds. This means that the Chief of the LGU Hospital or the Chief Nurses have minimal or no involvement at all in the hiring of new nurses. To cite an example, one LGU nurse mentioned that the nurses and nursing attendants detailed to the offices in the City Hall had set foot in the Hospital only once and that was when they presented to the Nursing Service Office their signed appointment papers (Researcher’s field journal). Furthermore, because the appointing powers reside with the Mayor, the recruitment process is circuitous, which delays the hiring of new nurses. One LGU nurse contrasted their Hospital’s application procedures with the more straightforward process in hospitals that are under the national government:

- Unlike sa national, pag nag-apply ka sa PGH, doon mo rin malalaman kung pasado ka o tangap ka. Sa City Hall mag-apply at dito lang mag-exam. Dito magbibigay ng application, pero ang item sa taas, kasi may HR doon. (Transcript, FGI I-LGU Nurses, p. 3)

Unlike in national [government hospitals], if you apply in PGH, for example, you will know from them directly whether you are accepted. In our case, you apply at the City Hall but you take the examination here at the Hospital. You get your application forms here at the Hospital but the position item belongs “up there” at the City Hall because they have their own HR [Human Resource office] there.

One nurse, the only one who explicitly criticized the “politics” involved in the hiring of nurses, recounted his own difficulties in applying at the LGU Hospital. He recalled how politics got in the way of hiring:

- Kaya lang medyo mabagal talaga ang hiring. Maraming nag-apply sa ngayon. Ang main reason talaga, ang daming processo ng hiring, kailangan pa ng politika. Nagpakahirap talaga ako para makapasok. Talagang mapolitika, hindi yong tamang process. Dumaan din ako sa tamang process – nag-exam ako, na interview pero nakatambak lang mga papers. Pag di mo pina-follow-up, di talaga tatakbo yong mga papers. So bago ako ma-hire, kailangan ko ng isang tao para makapasok. Mabilis na yong four months. Kasi talagang pinilit kong makapasok. Pag wala kang taong backer, mabagal yon. (Transcript FGI II – LGU Nurses, p. 3)

The hiring is really slow. There are many who are applying right now. The main reason really is that the hiring involves many processes; it involves politics. I endured many difficulties just to get inside the Hospital. It is really mired in politics; it is not the right process. I went through the correct process – I took the exam, I was interviewed but my application papers were just among the pile of papers. If you do not follow-up your application papers, it will not be processed. So, before I was hired, I needed somebody with political connections to back me up so I will get the position. Being hired in four months is already considered fast. I really did everything just to get inside. If you do not have a “political backer,” being hired will not be easy.

Continuing his tale, he disclosed that he needed to get a political backer when he applied for a permanent position (i.e. Nurse III), after finishing the two years of training as a Nurse I in the LGU Hospital <sup>21</sup>

- Ako nag-apply right after the Board in 1995. My papers were signed after two years as casual and not permanent position. Naghanap uli ako ng tao para i-recommend ako for permanent position. And it took me almost a year para lang ma-permanent. Actually, may tao lang akong nakilala at it took only one week. Talagang nakaka-depressed kasi ilang beses ka mag-follow up ganito sinasabi tapos walang nangyayari. Di lumalakad mga papers ko hangang sa may bago naman pumasok at natabunan yong ibang papers. (Transcript, FGI II-LGU Nurses, p. 3)

I applied right after I took the Board exam in 1995. My papers were signed after two years as a casual and not a permanent position. Again, I looked for somebody with connections. Moreover, it took me almost a year to get a permanent position. Actually, I met somebody who was close to the powers-that-be, so it took only a week to have my permanent appointment signed. The hiring process is really depressing because you follow-up your application countless times, they tell you one thing and then nothing happens. My application papers were not moving forward until they were buried under a pile of so many other applications.

The LGU nurses also need political patronage to increase their chances of getting a promotion at the LGU Hospital. The nurses said their supervisors have encouraged them to apply for promotion, which they had done a few times in the past but to no avail because the mayor decides on the promotion of Hospital employees.

- Yes, lalo na pag matagal ka na. Nag-aapply din kami. Naka-ilang application na kami, ni-revise pa namin, but still wala pa rin because it will depend on the appointment officer, which is the mayor. But

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<sup>21</sup> The entry-level position of Nurse I in the LGU Hospital is a contractual position, which requires the new nurse to undergo training in the Hospital for two years, after which he/she can apply for a permanent position (Nurse III). In his account, the nurse recalled that he needed a political backer when he applied for a Nurse III position.

kung may magba-back up sa amin, most likely mapromote kami.  
(Transcript FGI II – LGU Nurses, p. 4)

Yes, we are encouraged to apply for promotion, especially if you have been working here for a long time. We applied. In fact, we applied several times but nothing happened because it depends on the appointment officer, which is the Mayor. But if we have someone who will back us up, then most likely, we will be promoted.

A nurse who has been with the LGU Hospital for many years disapproved of the practice of applying for a promotion, “*Ang sa akin lang, ang promotion ay binibigay sa iyo at hindi ina-applyan (In my view, a promotion is given to you; you do not need to apply for it)*” (Transcript FGI II – LGU Nurses, p.4). Despite her opinion, the nurse thought she could not do anything about it, “*Nakakalungkot kasi mas qualified ka for the promotion. Pero sabi nga nila, kung ayaw mo, di umalis ka (It is sad because you know that you are more qualified for the promotion, but as they say if you do not like it, then you get out)*” (Transcript, FGI II-LGU Nurses, p. 5).

The nurses explained that the LGU Hospital actually conducts a performance appraisal of the nurses every six months and if their evaluation is satisfactory, their nurse supervisors can recommend them for promotion, but as another nurse noted, “*...we do not know when it will be approved*” (Transcript, FGI III-LGU nurses, p. 5). The nurses recalled a mass promotion of nurses who have served the LGU Hospital for more than five years, which occurred several years ago when the now outgoing mayor had just begun his administration. However, no similar promotion of nurses has occurred after that. Earning a postgraduate degree can be a plus factor but not a guarantee for promotion, which is contrary to what is provided under the Magna Carta for Public Health Workers that a public health worker who has finished a postgraduate degree shall be entitled to an equivalent upgrading in position or raise in pay. An LGU nurse pointed out:

- Hindi sa dahil may master ka, automatic kang i-promote. Minsan, pag malakas ka, kahit wala kang master, ma-promote ka...

still the promotion will be dependent on the appointment officer. But kung may magba-back out sa amin, most likely mapromote kami. (Transcript FGI II-LGU Hospital, p.5 )

Having a master's degree does not automatically give you a promotion. Sometimes if you have strong political connections, even if you do not have a master's degree, then you will get promoted... still the promotion will be dependent on the appointment officer. However, if there is somebody who is going to back us up, then most likely we will be promoted.

In contrast to the situation at the LGU Hospital, the National Nurses indicated that they do not have a problem with promotion. A nurse who has been with the National Hospital for at least two years and has a very satisfactory performance appraisal can be promoted to the next higher position as long as the Hospital management has declared that position vacant.

- ***Filling up of Vacancies***

Aside from the power to appoint employees, the Local Government Code also gave local chief executives the extensive authority to allocate financial resources to programs and services, to supervise and control all local government projects, and to enforce laws and ordinances required for the implementation of programs and projects. This means that the allocation of funds for programs and services, including the hiring of personnel and filling up of positions, are subject to the discretion of the incumbent local chief executive. The nurses are aware of the implication of the state of affairs at the LGU Hospital as indicated by the following remark: "*May budget yan. Maybe the Mayor has a reason kung bakit hindi pa niya i-fill up (There is a budget for that. Maybe the Mayor has a reason for not filling up the positions)*" (Transcript, Interview, Asst. Chief Nurse- LGU Hospital, p.1). This statement was a reply to the researcher's question whether the City government has allocated a budget for the nurse positions at the LGU Hospital. In my view, the nurse's reply hinted at the possibility that the previous city administration may have realigned the budgetary allocation for the personnel services of the LGU Hospital for other

priorities. However, the researcher was not able to gather documentary evidence to support this supposition.

Consequently, plans and programs in the local government unit (LGU) become hostage to the priorities of the mayor or governor currently sitting in power (Franco, 2006). The delivery of health care services is only one of the many responsibilities borne by the LGUs, thus, it has to compete for funding with other programs and projects deemed by local officials as more politically rewarding because they are tangible to voters, such as the construction of roads and buildings (Furtado, 2001). The Philippines holds the election<sup>22</sup> of local government officials every three years and a local chief executive can only serve for a maximum of three terms (equivalent to nine years). More often than not, a new incumbent would have another set of priorities and implement programs that are different from his predecessor. Nevertheless, the nurses have observed that whenever a new mayor sits in office, there would be a mass promotion of employees and based on this, some nurses forecasted that the newly elected Mayor would fill up the nurse vacancies.

- Actually, bago ngayon ang administration. Now that the local government administration is new, siguro ma-fill up na yan. (Transcript FGI I - LGU Nurses, p.1)

Actually, there is a new administration. Now that the local government administration is new, maybe these would be filled up.

Indeed, as of September 2007, the new Mayor of the City of Manila approved the appointment papers of 18 newly hired nurses. Moreover, the new Mayor finally designated the acting Chief Nurse to the position who has been assuming the responsibilities since 2005 and who has been serving the LGU Hospital for 20 years. Also promoted were nursing staff who have served the LGU Hospital for more than five years, which included 27 nurses and one nursing attendant. A number of the promoted nurses were participants in the focus groups. The new mayor also appointed a new Chief of Hospital, replacing the Chief of Hospital whom I interviewed for this study. The “politics” involved in

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<sup>22</sup> The Philippine local elections were held in May 2007, a month before this study was conducted and the newly elected officials assumed office in July 2007.

the hiring, promotion and security of tenure of the nurses as well as in the allocation of resources are only some of the effects of the devolution of health services, which have been documented in more than a few studies (see Lariosa, 1999; Grundy, Healy, Gorgolon, & Sandig 2003; Del Prado, et al., 1999; Lakshminarayanan, 2003).

#### **4.3.5.3. Decreasing Budgetary Allocation for Health**

- There is no shortage of nurses in terms of its absolute number. Granting that there are available skilled workers in the country, still they cannot be placed in the hospitals because of the lack of nursing positions. (Transcript, Interview, HHRDB-DOH, p.1)

The above statement was how the Director of the DOH Health Human Resource Development Bureau summarized the problem of inadequate nurse staffing in many government hospitals. For DOH-retained hospitals like the National Hospital, the creation of additional nurse positions requires the approval of the Department of Budget and Management (DBM) because it necessitates an infusion of large amount of funds from the national government. Ironically, instead of increasing the budget of the National Hospital to match the upgrading of its bed capacity, the national government has slashed the Hospital's annual appropriations. The Chief of the National Hospital explained:

- You know, actually, in year, I think year 2000, the MOOE, 'no, 'yung Maintenance and Other Operating Expenses... was more than 100 million mark, 'no, it was 113, I think and every year [it] keeps decreasing by 5 percent of the total budget. So, you can just imagine that last 2000, our budget was almost PhP113 million. Now, it is already 2007, and with inflation rates and whatever there are, the budget decreased to PhP94 million. And we got news that by 2008, it will be decreased to about PhP92 million. (Transcript of Interview-Chief, National Hospital, p.4)

The total annual budget of the National Hospital as reflected in the General Appropriations Act (GAA) has decreased from PhP305.17 million (NZ\$9.2 million) in 2003 to PhP297.71 million (NZ\$9.02 million) in 2004<sup>23</sup> and PhP287.65 million (NZ\$8.7 million) in 2006. In 2007, it slightly increased to PhP295.5 million (NZ\$8.95 million) but it is still lower than its 2003 budget<sup>24</sup>. The DBM allows government hospitals to retain their income, which they can use for capital outlay and operating expenses. However, as the Chief of Hospital pointed out, the National Hospital cannot generate much income because 90% of its patients are charity or non-paying patients and only 10% are paying patients. The National Hospital's declining budget merely mirrors the national government's resource allocation for health care services. As a proportion to the Philippine national budget, the total allocation for the health sector has been on a downhill trend – from 2.53% in 1998 to 1.4% in 2004 and 1.1% in 2005 (National Statistical Coordination Board, 2005).

- ***Lack of Equipment & Supplies***

The insufficient funding for government hospitals is also glaringly evident in the Hospitals' old dilapidated buildings, outdated facilities and equipment, and in the limited supplies and equipment that are not enough for their large volume of patients. In the National Hospital, the nurses wryly laughed at the rusty scissors and equipment that they were using. The Emergency Room (ER) of the LGU Hospital has only one defibrillator, a vital life-saving machine and one ECG machine for the almost 200 patients that go to the ER daily.

The scarcity of supplies in the Hospitals has tapped into the ingenuity of the nurses. They made measuring cups out of dextrose bottles, recycled used bond papers and contributed money among themselves to buy masks, batteries, medicines, and other supplies just so they can continue with their duties of providing care for their patients. It was also apparent that the nurses

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<sup>23</sup> The 2005 General Appropriations Act (GAA) was a reenacted budget, meaning the entire 2004 GAA was approved as the 2005 GAA.

<sup>24</sup> The 2007 budget for the LGU Hospital was PhP265 million (NZ\$8 million). Data on the previous annual budgets of the LGU Hospital was not readily accessible, unlike the National Hospital's budgets, which can be easily gleaned from the GAA.

have learned to live with the situation, judging by the nurses' demeanor as they recounted stories on how they managed to get by. Nonetheless, the nurses underscored the gravity of the situation as they pointed out that the lack of equipment is a major contributing factor to their heavy workload, because it prevents them from doing their work efficiently.

- Like suction machine. If you have 10 patients you have to suction every now and then, and you only have one or two suction machines, so you have to pull and transfer that and that is another workload, i-transfer mo pa yan... So sana matatapos mo na lahat ng trabaho mo, one at a time kasi marami kang gamit...masarap sana yun. Yun ang nakakadagdag, marami ka pang pasyente, wala ka pang gamit, mag-iisip ka pa, mag-hahanap ka pa. Eh yun ang problema (chuckling). (Transcript, Interview, Chief Nurse-National Hospital, p.4.).

Like for example, you have 10 patients who need a suction machine every now and then. However, you only have one or two suction machines so, you have to pull out a machine and transfer this to where the other patient is. If you have enough equipment, you would be able to accomplish all your tasks one at a time... that would be nice. This is how it adds to the nurses' burden: you do not only have many patients to attend to, you also do not have enough supplies and equipment, then you still have to think where and how you are going to get the needed supplies and equipment (Chuckling). This is the problem.

#### **4.3.5.4. Summary - Factors to Inadequate Nurse Staffing & Other Work Conditions**

The nurses' narratives on the causes of inadequate staffing has demonstrated how the lack of nurses in the two Hospitals interfaced with other work-related conditions (e.g. low salaries, heavy workload) and how these issues are connected to the long-standing problems that have been troubling the Philippine health care sector. Specifically highlighted were the migration of nurses, the political set-up in the LGU Hospital, the underinvestment in health and their impact on the workload of the nurses.

The National and LGU nurses perceived the migration of nurses to be contributing to the lack of nursing staff in their Hospitals. However, the evidence from the National & LGU Hospitals has shown that the actual number of nurses who have resigned in 2005 and 2006 is less than 20% of the total number of nurses employed in the Hospitals, indicating that inadequate nurse staffing are pre-existing problems even without the migration of nurses. All the same, the resignation of nurses exacerbates the inadequate nurse staffing in the Hospitals and the heavy workload of the nurses. Finding replacements for the nurses who resigned is not difficult but administrative procedures delay the hiring of new nurses. Consequently, the nurses who stayed behind takes on a heavy burden as they not only assume the duties of the nurses who have resigned, but they also train the replacements who are new graduates with limited hospital experience.

In the LGU Hospital, the LGU nurses perceived that politics has affected the recruitment of nurses, which have caused snags in the filling-up of nurse vacancies. Because it is the mayor who appoints all LGU employees, the LGU nurses perceived that political influence is necessary in the hiring, promotion and retention of nurses. Furthermore, since the local chief executive has also the power to allocate resources in the LGU, the decision to fill up the vacant nurse positions ultimately resides with the mayor who may chose to hire or not to hire additional nurses to address the inadequate nurse staffing in the LGU Hospital.

Lastly, the annual budget for the National Hospital has been falling in the past few years, which merely reflects the declining resource allocation for the entire health care sector. The situation is ironic because the creation of additional nurse positions to solve the inadequate nurse staffing necessitates the infusion of supplementary financial resources for the National Hospital. The underinvestment in health is also evident in the lack of equipment and supplies in the LGU and National Hospitals, which is a contributory factor to the heavy workload of the nurses.

#### **4.3.6. The Nurses' Working Hours and Coping Mechanism**

The nurses in the focus group interviews described in specific details the consequences of the twin problems of inadequate nurse staffing and large volume of patients on their working hours, which merit a discussion of this topic. This subsection focuses on the extended working hours and the lack of overtime pay for nurses, which serve to reiterate the preceding discussion on the dismal working conditions of nurses. Also discussed are the nurses' coping strategies in dealing with their situation.

##### **4.3.6.1. *Extended Working Hours***

The insufficient nurse staffing and the large volume of patients in the National and LGU Hospitals compel nurses to work 16 hours, instead of the regular eight hours of duty in a day. A nurse supervisor from the LGU Hospital elucidated the situation when she shared her difficulty in the scheduling of the nurses' assignments:

- It is really a headache to make the nurses' schedules because you have to see to it that the nurse staffing is adequate per shift. Sometimes, it cannot be avoided that they have to render 16 or 24 hours of work. But the 24-hour duty only happens in times of calamity/typhoons. As nurse supervisor, I perform managerial functions, but sometimes if there are toxic patients, I also help the nurses. (Transcript, FGI III-LGU Hospital, p.4)

The nurses frequently go on 16 hours of duty that it has become part of their weekly work schedule. It is usual for a nurse who has just finished an eight-hour duty to go straight to another eight-hour second shift. This is a typical schedule of a nurse on a 16-hour-duty: she works in the afternoon shift (from 2:00 p.m. to 10:00 p.m.), then continues on to the late night shift, which is from 10:00 p.m. to 6:00 a.m. of the following day. Once her shift of the previous day ends, she goes home and then, comes back again to the Hospital to do her afternoon shift for the day (2:00 p.m. to 10:00 p.m.). It also happens quite frequently that the Nursing Service Office will recall a nurse enjoying her scheduled day-off for the week (which is two days per week) to report for duty.

The LGU Hospital documented the number of nurses who rendered 16 hours of duty. In April 2007, a total of 61 nurses or two nurses a day rendered 16 hours of duty for the entire month. There were even days when four or five nurses had to go on double shifts (Letter from the Chief Nurse dated May 11, 2007). As far back as 2003, the Nursing Service Office had already documented this problem when they conducted a six-month study, which found that four to five nurses extended their working hours everyday to cover the wards. For instance, in February 2003, the Nursing Service reported 94 nurses who worked for 16 hours straight (Letter from the Chief Nurse dated February 19, 2003). The Assistant Chief Nurse explained that they often ask nurses from one clinical area to work a second shift in another department that needs additional nurses.

- Katulad sa Operating Room, nag-increase kami ng number of operations, so we have to increase also the number of nurses. So kung ano yong area na lesser and census nila, doon kami nagbabawas. (Transcript, Interview, Asst. Chief Nurse – LGU Hospital, p.4)

[Like in the Operating Room, we had an increased number of operations, so we also had to increase the number of nurses. So, we get the nurses from clinical areas that have lesser patient census.](#)

The National Hospital has a general policy requiring one or two nurses to render 16 hours of duty once a week. However, in many occasions, nurses often do double shifts twice or thrice a week especially when there is a “crisis” in the nurse staffing (Transcript FGI Ward & DR-National Nurses, p.6). These situations include occasions when nurses who were due to report in the next shift called in sick or went on emergency leave. The most common is when there is a surge in the number of patients admitted in the Hospitals. One nurse pointed out that even if all the nurses come to work, the three or four nurses assigned in one clinical area simply cannot cope with the sheer volume of the patients.

The Magna Carta for Public Health Workers, the Philippine law that defines the rights, benefits and privileges of public health workers stipulates that the regular working hours of health care workers are work eight hours a day, 40 hours per week. Apparently, the National and LGU Hospitals has violated this stipulation out of necessity to ensure the provision of 24 hours of continuous medical care to their patients.

#### **4.3.6.2. No Overtime Pay**

Even though working for 16 hours has become part of the nurses' regular weekly routine, they do not get financial remuneration for the extra eight hours of duty. Instead of monetary payment, nurses who worked double shifts get an extra day off, which the National nurses aptly called as "time back" (Transcript FGI DR-National Nurses, p.6). "Time back" is a day off that the nurses can supposedly use the next day or anytime within the week to offset the personal time they have used when they went on double shift. Ironically, the nurses are not able to use their "time back" because the absence of one nurse would seriously hobble the already inadequate nurse staffing. As a result, the nurses have accumulated unused "time back" and although its validity lasts for a year, it is impossible for them to use all their "time back", prompting a Delivery Room nurse to remark to her nurse supervisor, "*Dapat, ma'am, perahin na lang (Ma'am, these should just be converted into to cash)*" (Transcript FGI DR-National Nurses, p.6).

Even when they are not on double shifts, the nurses often extend their working hours for two to three hours because they have to serve many patients or they need to accomplish their tasks before they can go home. However, unlike the 16-hour-duty, a two- or three-hour extension is not considered an overtime, so the nurses do not get a "time back".

- ...Kasi kulang yong eight hours sa dami ng trabaho. Nagla-log pa kami gaya ngayon, magcha-charting pa, so extended talaga yong oras pero hindi considered overtime. Just to finish lang noong work. (Transcript FGI II-LGU Nurses, p.2)

...Because eight hours is not enough, with so many things we have to do. For instance, right now we have to log and do charting, so we really have to extend our hours just to finish our work, but this is not considered overtime.

The nurses also do not receive “night differential” (i.e. additional pay) for taking graveyard shifts. A nurse lamented that she cannot even go home immediately after her night shift ends because she often has to extend her duty and yet she is not paid for doing the night duty or for working extra hours.

- Kasi sa ibang country mayroon silang mga night differential. Kami, hindi namin na-e-enjoy iyon... lalo na pag night duty ka, 11 to 7, dapat 7 o'clock uwi ka na kasi pagod na pagod ka na, puyat ka pa. Kung minsan umaalis kami dito 9 o'clock na ng umaga, 9:30, wala kaming nakukuha maski isang sentimo. (Transcript FGI, DR-National Nurses, p. 17)

In other countries, they get night differential. We do not enjoy that here when we are on night duty from 11 p.m. to 7 a.m. At 7:00 in the morning, I should be going home because I am already very tired and lack sleep. Sometimes, we only get to leave the hospital at 9:00 in the morning. We do not even get a cent for this.

The Magna Carta for Public Health Workers mandates the payment of overtime pay and night differentials, but as noted earlier, the implementation of these provisions depends on the availability of funds of the concerned agencies. The LGU and National nurses expressed a common opinion that they should get overtime pay and night shift differential as mandated by law.

- At saka sana kung mayroon kaming overtime [pay] gaya halimbawa 7:00 to 3:00 ang duty mo, uwi ka ng 5 o'clock, 6 o'clock, kung minsan inaabot ng ganoon dahil sa dami ng pasyente. Kasi parang imposible na makuha namin ang time-back since understaffed kami. (Transcript FGI DR-National Nurses, p.16)

In addition, I hope we get an overtime pay, like for example we are on duty from 7:00 to 3:00 but we go home only at 5:00 or 6:00

because there are so many patients. I think it is not possible for us to use our time-back since we are understaffed.

#### **4.3.6.3. Nurses' Coping Mechanism**

Considering that many of the nurses who participated in the focus groups have been working in the National and LGU Hospitals for more than five years and several others for more than 10 years, this researcher found it remarkable how they are able to persevere for so long. Highlighting the nurses' professionalism and commitment to their work despite poor working conditions should not undermine their arguments and feelings about the issues they have raised. On the contrary, this subsection should serve to bolster their arguments for better pay and better working conditions.

When I asked how they are able to cope with their heavy workload and long working hours, the nurses gave the following replies. I interpret the nurses' statements as an indication of their commitment and devotion to their work.

- Imagine mag-o-overtime ka everyday two hours, three hours wala namang bayad...devotion mo na lang sa trabaho, committed. (Transcript, FGI DR-National Nurses, p.7)

Imagine, you work overtime everyday for two hours, three hours without pay. ..devotion to our work, we are committed to our work.

- Commitment na lang sa work mo, ganoon. Kasi parang hindi mo rin maiwan iyong pasyente ng ganoon na lang. Kailangan talaga tapusin mo para at least makita mo naman iyong – para mabigyan mo ng lunas iyong kanilang nararamdaman. (Transcript, FGI II-LGU Nurses, p.5).

It is really just commitment to our work. Because you cannot leave your patients, just like that. You need to do your duties and accomplish your tasks so you can at least alleviate the patients' conditions.

Their commitment is rooted in the nature of the nursing profession, which is to help and care for sick people. Interestingly, the nurses often used the term "service" when they referred to their work, which was revealing of how

they viewed their profession. Thus, one nurse rationalized their perseverance with their love for the nursing profession. She said, “...*Pero it's okay kung talagang love mo ang nursing, you love to give care to patients, siguro parang masaya ka na rin (But I guess it is okay if you love the nursing profession, if you love caring for patients, then, maybe you are happy too)*” (Transcript, FGI DR – National Nurses, p. 7). Others see the long working hours as a necessity to accomplish their workload. Most nurses though have gotten used to the situation because they see it as “*part of the service*” (Transcript, FGI DR – National Nurses, p. 17).

Another vital coping strategy is teamwork. Nurses rely on one another to manage the heavy workload. A National nurse illustrated how they apportion the tasks among themselves:

- Dito may samahan kami. Ina-anticipate kasi namin ano ang gagawin. So habang ginagawa ng isang nurse ang trabaho na to, yong isa naman siya yong mag-carry out para tingnan kung may patient na for transfer, may bibigyan ng kailanganin ng patient... Tapos kung sabay-sabay yong patient nakaka-toxic, tapos wala kang kasama, dun ka mag-kakaproblema. (Transcript, FGI, Ward II-National Nurses, p.4)

*We have teamwork here. We anticipate the things that need to be done. While one nurse is doing her work, another nurse carries out other tasks such as transferring patients, or attending to the needs of the patients. When there are so many patients, it is “toxic<sup>25</sup>” especially when you are all alone, then you have a big problem.*

Teamwork means collaborating with other members of the group to get a work done. A typical example is an ER nurse who has a lighter workload assisting the nurses in another area who are loaded with work. An LGU nurse explained:

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<sup>25</sup> Toxic – a Filipino slang commonly used by nurses & other health care professionals to refer to a situation wherein the Hospital has so many patients, which puts many demands on the nurses, resulting in nurses feeling overburdened and stressed out.

- Tulong-tulong kung ano yong kailangan nila...Makatulong ka lang sa pag-log ng patient, at kung may emergency. Para din bumilis yong trabaho namin, kung hindi naman “toxic” ang isang area, pumupunta yong isang naka-assign doon sa area na yon para tulungan yong “toxic” area. (Transcript FGI LGU Nurses, p.2)

We help the other nurses need with whatever they need, like we help in logging the patients and whenever there are emergencies. To speed up our work, if one area is not “toxic”, a nurse assigned in this area will go and help in the other areas that are “toxic”

The above accounts have shown that the nurses draw on their own resilience, dedication and commitment to their profession to cope with the demands of their work. They also help one another to manage the heavy workload, a coping mechanism that is common to both the LGU and National nurses.

#### **4.3.6.4. Summary - Extended Working Hours & Nurses' Coping Mechanism**

The nurses often work beyond the regular eight hours of duty, so that the Hospitals can provide 24 hours of continuous medical care to patients. Nurses frequently go on 16 hours of duty that it has become part of their regular work routine. The nurses do not get financial remuneration for working overtime. Instead, they get a day in lieu or “time back”, which, ironically, they are not able to use because of the shortage of nurses in the Hospitals. To cope with the demands of their job, teamwork is vital for the National and LGU nurses. To have endured poor working conditions characterized by inadequate nurse staffing, heavy workload, insufficient supplies and equipment, and extended hours of work without pay, the National and LGU nurses cannot be other than highly committed, dedicated and hard working health care professionals.

## **Chapter Five**

### **ANALYSIS OF THE HEALTH HUMAN RESOURCE DEVELOPMENT PROVISIONS**

#### **5.1. Introduction**

This Chapter has two parts: the first part examines the status of the implementation of the health human resource development provisions, the processes that have been undertaken and the factors affecting their implementation; the second part assesses the provisions of the Nursing Act whether these are responsive to the needs and conditions of nurses in government hospitals. The recommendations, experiences and perceptions of nurses in the National and LGU Hospitals and of the key informants are the bases for the assessment of the adequacy and relevance of the provisions of the Nursing Act.

#### **5.2. Implementation**

This section examines the implementation process, the issues and the factors for the non-implementation of the health human development provisions of the Nursing Act, focusing on the two key retention strategies: the nurse salary increase and the nurse specialty program. The ensuing discussion highlights the government's disinclination to implement the salary increase and the lack of support structures for nurse specialty program.

##### **5.2.1. Salary Increase**

The nurses in the National and LGU Hospitals were aware of the salary increase provided under the Nursing Act. This was evident in their common reactions upon learning about the topic of my research. Their remarks "*matagal na yan (That has been approved long time ago)*" and "*sana ma-implement na (We hope that this will be implemented)*" were revealing of the status of the implementation of the salary upgrading in government hospitals (Researcher's field notes/journal).

The Philippine Nursing Act of 2002 mandates the upgrading of the minimum salary of nurses in government institutions to Salary Grade 15. Based on RA 6758, the "*Compensation and Position Classification Act of 1989*"<sup>26</sup>, the entry-level position of a nurse in government health facilities is Salary Grade 10, step 1 but with the approval of the Nursing Act of 2002, it has been raised five salary grades higher. The Nursing Act's implementing rules and regulations do not specify the salary structure for the entire nursing personnel in government institutions; it merely provides the minimum base salary for nurses. Nevertheless, it is presumed that the salaries for higher nurse positions will be correspondingly raised upon the approval of the Department of Budget and Management (DBM).

The Philippine government has not implemented the upgrading of the minimum base salary of nurses working in the public sector. Six years after the Nursing Act had been approved, the entry-level position for nurses (Nurse I) in the National and LGU Hospitals is still Salary Grade 10, step 1, which has an equivalent basic monthly salary of PhP10,933<sup>27</sup> (NZ\$331) (Table 10) at the time of the interview. If the salary upgrading has been implemented, an entry-level nurse with a Salary Grade 15, step 1 would be receiving a monthly wage of PhP14,630<sup>28</sup> (NZ\$443). The discrepancy between what is mandated in the Nursing Act and the actual minimum salary grade of nurses is equivalent to a wage differential of PhP3,697 (NZ\$112) monthly or PhP44,364 (NZ\$1344) annually.

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<sup>26</sup>The prescribed monthly salary schedule under RA 6758 had been increased several times as the national government legislated several across the board salary adjustments for government personnel: Senate and House of Representatives Joint Resolution No. 1 dated March 7, 1994; Republic Act 9336, which increased the monthly salaries of all government personnel (i.e. civilian and military personnel). In March 14, 2007, Executive Order (EO) No. 611 granted a 10% across the board salary increase for all officials and workers of national government agencies and local government units effective July 2007. The amount of PhP10,933 reflects the 10% increase implemented in July 2007.

<sup>27</sup> The amount reflects the 10% increase effective as of **July 2007** mandated under EO No. 611 (Please see Annex B for the Monthly Salary Schedule of Civilian Personnel Effective July 1, 2007). The Philippine government implemented another 10% increase in the salaries of government employees effective **July 2008**, but this was not taken into consideration because the writing of this thesis was almost through by the time the latest round of salary increase became effective.

<sup>28</sup> The amount reflects the 10% increase effective as of July 2007 mandated under EO No.611.

**Table 10. Current Salary Grades of the Nursing Personnel in the National & LGU Hospitals**

<i>Position Classification</i>		<i>Salary Grade</i>	<i>Corresponding Basic Monthly Salary (Step 1)<sup>29</sup></i>
<b>LGU Hospital</b>	<b>National Hospital</b>		
<i>Nurse VII</i>	<i>Nurse VII</i>	24	P22,905
<i>Nurse VI</i>	<i>Nurse VI</i>	22	P21,176
<i>Nurse V</i>	*	20	P19,579
<i>Nurse IV</i>	<i>Nurse IV</i>	18	P17,425
<i>Nurse III</i>	<i>Nurse III</i>	16	P15,508
*	<i>Nurse II</i>	14	P13,801
<i>Nurse I (trainee, contractual)</i>	<i>Nurse I</i>	10	P10,933

\*There is no corresponding position for this salary grade. It is the Department of Budget and Management (DBM) that approves the position classification for the National Hospital and no Nurse V position was created. For the Local Government Unit, they have the autonomy to create the position classification following standards and guidelines set by the DBM and the Civil Service Commission; they do not have Nurse II.

#### **5.2.1.1. Processes Done**

Even though the salary upgrading of nurses has not been implemented, there have been efforts to realize this provision. In fact, most of the processes undertaken to implement the health human resource development provisions were concerted towards the implementation of the salary increase. In 2003, the National League of Philippine Government Nurses (NLPGN), an organization of nurses in the public sector, submitted a proposal entitled “*Proposed Upgrading of Nurse Positions in the Government*” to the Health Human Resources and Development Bureau (HHRDB) of the Department of Health (DOH). The HHRDB is the office within DOH that is responsible for formulating plans, policies, programs and standards related to the production, deployment, utilization and development of human resource for the health sector. The NLPGN developed the Proposal to put into operation the salary increase mandated under the Nursing Act, as well as to provide a career path for nurses in the public sector by specifying the qualification standards for each level of the nurse position.

<sup>29</sup> The salaries presented in Table 10 reflect the 10% across-the-board increase implemented around the time of the interview – in **July 2007**. As explained in footnote #26, the researcher did not include the 10% salary increase implemented in **July 2008**.

Table 11 presents the salary scale with corresponding basic monthly salaries under the “*Proposed Upgrading of Nurse Positions in the Government*”. The Proposal upgrades the entry-level for a fresh nursing graduate from Salary Grade 10 to 15 in compliance with the Nursing Act. A Nurse III or Nurse IV, which are the positions occupied by most of the participants in the focus groups is raised from salary grades 16 and 18 to salary grades 19 and 20, respectively. The highest position is Nurse VIII, with salary grade 26, a position created for nurse clinicians who have training in specialty and subspecialty programs, since at present there are no positions in the government for nurse specialists (see Annex C for the proposed career path formulated by the NLPGN).

**Table 11. Proposed Salary Scale Upgrading for Nurses**

FROM			TO		
Position/ Title	Existing Salary Grade	Corresponding Monthly Basic Salary (step 1) in PhP*	Position/ Title	Proposed Salary Grade	Corresponding Monthly Basic Salary (step 1) in PhP*
Nurse I	10	10,933	Nurse I	15	14,630
Nurse II	14	13,021	Nurse II	17	16,438
Nurse III	16	15,508	Nurse III	19	18,471
Nurse IV	18	17,425	Nurse IV	20	19,579
Nurse V	20	19,579	Nurse V	21	20,361
Nurse VI	22	21,176	Nurse VI	22 (+2 steps)	22,248**
Nurse VII	24	22,905	Nurse VII	24 (+2 steps)	24,065**
			Nurse VIII	26	24,773

\*The amount is the corresponding basic monthly salary for step 1 of each salary grade based on Monthly Salary Schedule for Civilian Personnel effective July 1, 2007.

\*\*The amounts represents step 3 of Salary Grades 22 and & 24.

According to the NLPGN, to upgrade the roughly 12,000 nurse positions in the national government, which includes non-hospital based government nurses, the estimated subsidy needed from the national government is

PhP40,793,809 (NZ\$1,236,176) for the four national specialty hospitals<sup>30</sup> of the DOH and PhP545,644,323 (NZ\$16,534,676) for the rest of the national government hospitals. The costing for the specialty hospitals is separate because their position classifications for their nurses are different from the other government hospitals. Owing to the huge funding requirement to implement the salary increase, the Proposal offers two implementation options: (a) a five-year staggered implementation at 20% annually; and (b) a three-year staggered implementation, starting with 30% during the first year, 30% during the second year, and 40% for the third year. The upgrading of the more or less 8,000 nurse positions in the local government units is not included in the costing because it shall be the individual local government units which will bear the costs of implementation.

#### **5.2.1.2. Reasons for Non-Implementation of Salary Increase**

The key informants' statements gave an indication of the national government's disinclination to implement the nurses' salary increase. According to the former president of the NLPGN, they were "*shuttled back and forth between the DOH and the DBM,*" the national agency that approves all government expenditures (Researcher's field notes/journal). This key informant added that the DBM maintains the stance that the DOH has not submitted its official position on the matter. The key informants enumerated a confluence of factors for the non-implementation of the salary increase, which are discussed below:

- ***Differing Nurse Salary Schemes***

First, the HHRDB Director pointed out the difficulties in operationalizing the salary increase of nurses in government because of the differing nurse salary structure in various government institutions: To quote him:

- There were three salary proposals submitted to DBM as follows: (1) for general nursing sector in government; (2) for specialty hospitals where there is a different salary scale from the

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<sup>30</sup> The four specialty hospitals are: Lung Center of the Philippines, National Kidney and Transplant Institute, Philippine Children's Medical Center and Philippine Heart Center.

other specialty hospitals; and (3) a separate salary scale for nurses in PGH<sup>31</sup>. How can the salary be standardized considering these three (3) different proposals? (Transcript, Interview, HHRDB-DOH Director, p. 5)

- ***Salary Increase for Other Health Care Professionals***

Other government health workers also demand salary increase. More specifically, doctors have complained that the increase in nurses' salary will cause distortion in the existing salary scale of health care professionals working in the government. According to the key informants, government physicians have argued that if the nurses are going to get a salary increase, then they also deserve to get a raise. The Magna Carta for Public Health Workers has upgraded the salary grades of rural health physicians from Grade 20 to 24, but according to reports, there are government physicians under the LGUs who are still receiving wages below the mandated salary grades. Based on their arguments, increasing the doctors' salaries is timely because 80% of government physicians have enrolled in nursing, enticed by the high income that nurses earn abroad in contrast to the low pay that doctors get in the Philippines (Galvez Tan & Balanon-Sanchez in Galvez Tan<sup>b</sup>, n.d.).

The above argument denotes the importance and higher regard given to doctors in the Philippines as compared to the nurses. A conversation with a key informant about the doctors' demand for increased wages conveyed undertones of a hierarchy in the health care profession in the Philippines wherein doctors occupy the topmost position. "*The lowest--lowly paid doctor starts in government at salary grade 18. Yes, so you can just imagine, if the nurses will be increased to grade 15,*" the Chief of the National Hospital declared (Transcript, Interview, Chief, National Hospital, p. 8). This key informant, who is himself a doctor, argued that if the government grants the nurses a minimum base salary of Salary Grade 15, then there would be nurses

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<sup>31</sup> The Philippine General Hospital, popularly known as PGH, which is the biggest government hospital in the Philippines is not under the management of the Department of Health but is under the University of the Philippines-system. It is exempted from the Salary Standardization Law, so their employees receive higher salaries than the other employees of government hospitals.

(i.e. Nurse IV to VII) whose salary grades would be at par with the salaries of government doctors. His contention is that doctors' starting salaries should also be increased to Salary Grade 22 because they completed a higher degree of medical training and as captain of the health care team, doctors carry more responsibilities than nurses.

- Yes, but you know, with the number of trainings, resources and time they have spent also for studies and, of course, the degree of responsibility and pressures that they have, *parang it's not commensurate naman na 18 lang sila (it does not seem commensurate that doctors are only given a salary grade 18)*. The doctors must also have to be increased to a level of grade 22 as a starting point. I think this is also one of the reasons why the doctors are becoming nurses because they opted to have better pay when they go abroad rather than being a doctor here. They start with grade 18 and with a family to feed and with all these... (Transcript, Interview, Chief, National Hospital, p. 8)

To avoid displeasing the other health care professionals, the HHRDB of the Department of Health (DOH) indicated that they prefer to wait for the enactment of several pending legislations in Congress that seek to amend the Compensation and Position Classification Act of 1989. These pending legislations, if approved into law, would institute across-the-board salary increases to all professions in the government sector (Researcher's field notes/journal). The HHRDB's stance is tantamount to saying that the Philippine government will not implement the nurse salary increase anytime soon because, to date, there has been no clear indication that the Philippine Congress will approve the pending legislations revising the existing salary standardization scheme.

Still on the issue of including other health workers in the salary increase, the president of the Philippine Nursing Association (PNA) criticized the exclusion of the nurses in the private sector, especially those working in the small private hospitals who still receive a monthly salary of PhP2,000-3,000

(NZ\$60-90). According to her, the PNA is pushing for a nursing industry wage standard and is now reviewing the different salary schemes for nurses in both government and private hospitals. During the deliberation of the Nursing Act in the Philippine Congress, the legislators decided to exclude the private sector from the mandatory increase because of the incapacity of small private hospitals to give the salary increase.

- ***DOH Reorganization***

Another reason cited for the non-implementation of the salary increase is the reorganization of the Department of Health (DOH). The approval of the nurse salary increase happened in between two major restructuring of the DOH, one is still ongoing and the other is in the pipeline. Through Executive Order No. 102, the DOH, beginning 2000 up to the present, has embarked on a reengineering of its organizational structure, functions and operations to parallel the change of its mandate caused by the devolution of health services to local government units. Then, in 2006, the Office of the President of the Philippines through Executive Order No. 366 instituted a government rationalization program, directing national executive agencies such as the DOH and all its attached health facilities to streamline their organizational structure in accordance with their core functions. Consequently, the DOH has decided to put on hold the plans to upgrade nurse positions while it is in the process of formulating its own rationalization plan (Researcher's field notes/journal).

It is unclear, however, if the DOH rationalization plan tackles the issue of the nurses' salary increase. For instance, the National Hospital's rationalization plan will increase the number of nurse positions to meet the required adequate nurse staffing, but there is no indication if it will raise as well the nurses' salaries. Moreover, the DOH rationalization program only involves the central and regional offices, its attached national agencies and hospitals, and excludes the facilities under the local government units. As of this writing, the DOH and the National Hospital have yet to implement their rationalization programs.

- **Funding**

The big issue regarding the nurses' salary increase is the funding for the cost of implementation. The Nursing Act and its implementing rules and regulations are silent on the financial requirements for the salary increase and the sources of funding. The period after the approval of the Nursing Act of 2002 was an inauspicious time for raising nurses' salaries because the whole government was experiencing a budget deficit and was implementing cost-cutting measures in certain sectors such as health. The national government reduced the DOH budget from PhP11.4 billion (NZ\$34.5 M) in 2002 to PhP9.28 billion (NZ\$28.1 M) in 2003 and PhP9.75 billion (NZ\$29.5 M) in 2005. To increase the nurses' salaries, the national government would have to allocate an estimated PhP586,438,132 (NZ\$17.7 million) for the initial implementation, after which, the costs of the salary increase would have to be included in the budget line items of the respective agencies in the General Appropriations Act.

Another potentially problematic aspect is the implementation at the local level since the cost of salary increase will be borne by the LGUs. As one key informant noted, *"Even if it's a law, once the LGUs declare for non-availability of funds, the upgrading would not be implemented"* (Researcher's field notes/journal). Not all LGUs have the financial capability or are willing to assume the additional cost of increased health workers' wages - a hard lesson learned from the implementation of the benefits under the Magna Carta for Public Health Workers. Notwithstanding this fact, there are LGUs that have the capacity to increase the nurses' salary, but according to the NLPGN, the LGU leaders have stated that they are only waiting for the official national guidelines on the upgrading of nurses' salaries, which the national government has yet to issue. Without such clear actions from the national government, the salary increase of nurses has become one of the many unimplemented and unfunded policies in the Philippines.

- **Lack of Advocacy & Other Issues**

The National League of Philippine Government Nurses (NLPGN) lamented the lack of advocacy by the nursing sector to push for the

implementation of the nurses' salary increase. *"The problem with nurses is that they are submissive. There is a need to advocate with the government on the implementation of the salary upgrading. And it's worth emphasizing the big role of nurses in the delivery of health care,"* as pointed out by the president of the NLPGN (Transcript, Interview, NLPGN president, p.1).

In addition, the DOH has not assigned an office or a person within the HHRDB to focus on the nursing sector or, more specifically, on the implementation of the health human resource development provisions of the Nursing Act. The current and former presidents of the NLPGN are also DOH employees and they are active in advocating for the implementation of the said provisions. However, these two officers of the NLPGN are holding positions in offices outside of the HHRDB and are managing other health programs, so they cannot devote their full attention to the implementation of the provisions of the Nursing Act.

- We help out the Department of Health at nire-recognize din ng Department of Health ang National League as their partner in implementing this. Kaya ang problema talaga namin dito is dahil dito sa Department parang kung hindi mo programa, hindi ka tutok. (Transcript, Interview, former president-NLPGN, p.8)

*We help the Department of Health who, in turn, recognizes the National League as their partner in implementing these provisions. Our only problem is that, here in the Department, if it is not your program, you cannot give it your full attention.*

The officials of the DOH and the NLPGN cited another major issue in the nursing sector that had sidelined the salary increase of nurses. Because of the many issues raised against it, the national government had dragged their feet in implementing the salary increase of nurses until a huge controversy hit the nursing sector in 2007, which totally eclipsed the issue on the salary increase – this is the alleged “leakage” of the examination questions during the 2007 nursing licensure examinations. It is striking to note that the controversy sent top government officials and the Philippine nursing leaders in a scramble to redeem the Philippines in the eyes of developed countries as the US-based

Commission on Graduates of Foreign Nursing Schools (CGFNS) threatened to reject the 2007 Filipino nursing examinees applying for US jobs. The Philippine government quickly resolved the controversy by acquiescing to the demands of the international bodies to let all the 2007 examinees retake the nursing board examinations under strict conditions. The swift and decisive actions to resolve the controversy in contrast with the government's inaction over the salary increase made it plain to see what the government's priorities are concerning the nursing sector.

### 5.2.2. Nurse Specialty Program

The nurse specialty program under the Nursing Act bares the government's underlying intent concerning the Philippine nursing sector. It embodies the government's desire to strike a balance between retaining a sufficient quantity of nurses in the country and developing highly skilled nurses who are marketable abroad. One of the authors of the Nursing Act, declared in his sponsorship speech, "*We need policies to enhance the competitiveness and professionalism of Filipino nurses and at the same time respond to the health care needs our people, particularly those in the rural areas*" (Transcript of Senate Floor deliberations, sponsorship speech of Senator Villar, August 26, 2002, no page number). The Nursing Act wants to address the reported shortage of skilled nurses in the country but at the same time, it seeks to uphold the nurses' right "*to earn a comfortable life abroad*" (Transcript of Senate floor deliberation, sponsorship speech of Senator Flavier, August 14, 2002, no page number). To meet these objectives, Section 31 of the Nursing Act mandates the Philippine Board of Nursing to establish a specialty-training program in critical care, oncology, nephrology, and other areas as determined by the Board to upgrade the skills of selected Filipino nurses, who will serve in government for a minimum of two years after they have received the training.

The main thrust of the specialty-training program is to train at least 10% of the nursing staff of government hospitals as nurse specialists, who shall then be required to render two years of service in the government. In other words, this provision seeks to establish a production line or a replenishing pool of highly skilled nurses who will work in the country for two years before they go

abroad. Through this mechanism, the government can accomplish the twin objectives of producing globally competitive Filipino nurses and ensuring a domestic supply of skilled nurses. The funding for the establishment of a nurse specialty program shall come from the Philippine Charity Sweepstakes Office (PCSO) and the Philippines Amusement and Gaming Corporation (PAGCOR), two state-owned corporations often tapped by the national government as sources of funds for its socio-civic programs since the Charters of the two agencies allocate 20% of their revenues to social programs. The DOH has not accessed the funds from PCSO and PAGCOR nor has it established a nurse specialty program in government hospitals.

#### **5.2.2.1. Processes Done**

The Nursing Act stipulates instructs the Board of Nursing and the DOH to establish a nurse specialty-training program in government hospitals in coordination with the accredited national organization of nurses. In 1999, prior to the enactment of the Philippine Nursing Act of 2002, the Board of Nursing had already approved a Board resolution establishing a Nursing Specialty Training Program and creating the Nursing Specialty Certification Council under the Board of Nursing. The function of the Nursing Specialty Certification Council is to oversee the nurse specialty programs administered by the Specialty Certification Boards. The Board of Nursing created Specialty Boards for four major areas of nursing: community health nursing specialty, medical-surgical nursing specialty, mother and child health nursing specialty, and mental health and psychiatric nursing specialty (Board of Nursing Resolution No. 14, Feb. 18, 1999). Then in 2002, the Board of Nursing issued the guidelines for the implementation of the Nursing Specialty Program, which standardized the processes and requirements for the certification of a nurse as a Nurse Clinician I, Nurse Clinician II and Clinical Nurse Specialist (Board of Nursing Resolution No. 118, series of 2002). Even before the establishment of the Nurse Specialty Certification Council, individual private nurse organizations have already been conducting their respective nurse specialty trainings and issuing certification to the nurses who have completed these trainings. With the establishment of the Nursing Specialty Certification Council, the Specialty Boards accredits private organizations providing the nurse specialty trainings, administers the nurse

specialty examination and certifies the nurses who have fulfilled all the requirements.

The DOH in collaboration with the NLPGN conceptualized the nurse specialty-training program in government hospitals embodied in the Nursing Act as distinct from the nurse specialty program under the Board of Nursing. The DOH and the NLPGN spearheaded the initial talks to set-up this program in government hospitals and gathered the chief nurses of the big government hospitals in the National Capital Region to discuss the mechanisms for implementation. They proposed the idea of creating a comprehensive nurse specialty-training program that utilizes the existing capacities and facilities of DOH-managed hospitals. Examples of the nurse specialty programs they had envisioned are wound care in Jose Reyes Memorial Medical Center, psychiatry nursing in the National Center for Mental Health, cardiovascular nursing in the Philippine Heart Center, orthopedic nursing in the National Orthopedic Center, and so on and so forth. They agreed during the meeting that the DOH would come up with an inventory of the existing facilities and capabilities of government hospitals that can be the springboard for the government's nurse specialty program. There were no follow-up actions after the initial meeting and no coordination with the Board of Nursing or with the Philippine Nurses Association had occurred. The former president of the NLPGN admitted that they have overlooked the establishment of the nurse specialty program in government hospitals because of the many other issues in the nursing sector which claimed their attention, particularly referring to the alleged board examination "leakage" that happened in 2006.

#### ***5.2.2.2. Reasons for Non-Implementation of the Nurse Specialty Program***

The training of nurse specialists in the Philippines as directed under the Nursing Act calls for an assessment of the capacity of the Philippine nursing sector to develop a specialty program and the readiness of the health care system to utilize nurse specialists. Nurse clinicians, nurse specialists, nurse practitioners, nurse anesthetists, and nurse midwives all fall under the umbrella term "advanced practice nurses." They are registered nurses who have

completed advanced education and clinical practice requirements beyond the two to four years of basic nursing education (ANA as cited in Schoeber & Affara, 2006). They are also nurses who have acquired complex decision-making skills and higher level of competencies for expanded practice. The scope of practice of a nurse specialist, clinician or practitioner varies, depending on the country where the nurse is licensed to practice (ICN as cited in Schoeber & Affara, 2006).

Right now, there is no existing regulatory framework in the Philippines delineating the scope of practice and the role of nurse specialists in the health care delivery system. The Philippine Nursing Act of 2002 does not provide such framework as it does not even define what nurse specialists are nor identify their functions. The lack of a regulatory framework that defines and delineates the scope of advanced nursing practice is an obstacle for the full utilization and integration of nurse specialists in the country. Without a regulatory framework, nurse clinicians and specialists do not have a place in the public health care system. To illustrate, the current position classification system for nurses in government health facilities do not have positions for nurse specialists, so nurses with advanced training do not get the compensation and the position that is commensurate to their level of expertise.

The HHRDB Director cited the case of nurses who have undergone training<sup>32</sup> in anesthesiology but could not practice as nurse anesthetists<sup>33</sup> because of objections from doctors who are anesthesiologists. A policy delineating the scope of practice of nurse anesthetists could have addressed the controversy and allowed these nurse anesthetists to practice, especially in areas that do not have enough anesthesiologists.

- There are a lot of nurse anesthetists in the country, but only a few are performing this.... There is a shortage of anesthesiologists... We want to develop a nurse anesthetist, but

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<sup>32</sup> According to the HHRDB Director, the government implemented a pilot training program for nurse anesthetist in the Philippine Heart Center, one of the specialty hospitals.

<sup>33</sup> Nurse anesthetists are nurses trained to assist the anesthesiologists. (Transcript, Interview, HHRDB Director)

there is a resistance from the medical anesthesiologists.

(Transcript, Interview, HHRDB Director, p. 3)

Another concern is the relevance and appropriateness of the nurse training programs on critical care, oncology, nephrology among others to the health care needs of Filipinos and the level of health care facilities available in the country. Clinical nurse specialists are highly skilled nurses who are trained to work in “high-tech environments” (Catalano, 2003, p. 13) typical of the health care settings in developed countries. According to HHRDB, because of limited opportunities to practice in the Philippines, it is not surprising that about 50% of Filipino nurses who have advanced training are working outside of the country. As an alternative, the NLPGN is advocating for the development of a nurse specialty program in public health, which has a wider scope of application and is more relevant to the Philippine setting than the clinical nurse specialties specified in the Nursing Act.

Finally, only a few government health facilities have the capacities to provide specialty-training programs for nurses and mostly these are the big hospitals located in Metro Manila, the National Capital Region. A nurse from Mindanao, a main island in southern Philippines, will have to travel all the way to Metro Manila to avail of the training. Hence, these training programs are not accessible to nurses from other parts of the country. Moreover, the Philippines do not have enough nurse specialists who can give the training nationwide since many of them have already gone abroad. The HHRDB Director enumerated three prerequisites for the establishment of a national nurse specialty program. First is an inventory of the specialties that are currently available in the country. Second is to identify the capabilities of hospitals throughout the country and develop specialty programs based on their areas of expertise, so that nurses instead of going to Metro Manila can readily avail of such training in their place or in nearby cities. Third is to establish a nationwide network of hospitals and develop a pool of trainers who can be tapped to conduct specialty-training programs for nurses in any hospital anywhere in the country.

Advanced nurse practice in the Philippines still has a long way to go before it can be integrated into the country's health care system. The government needs to put in place support structures before it can successfully implement nurse specialty-training programs as envisioned in the Nursing Act. The Philippine nursing sector is looking towards this direction as it formulates the Road Map 2020, the development plan for the Philippine nursing sector in the next 20 years. As the Director of the HHRDB of the Department of Health readily admitted, "*It would take some time before we can say that we are able to operationalize the provision of the Law*" (Transcript, Interview, HHRDB Director, p.5).

### **5.2.3. Other Provisions**

If the two centerpiece provisions, i.e., the salary increase and the nurse specialty program have not been put in place, then, expectedly, the other provisions on non-financial incentives and benefits, such as free hospital care for nurses and their dependents, scholarship grants and other similar non-cash benefits have not been carried out as well.

#### **5.2.3.1. Health Care Benefits**

The nurses have health care insurance through PhilHealth, the national health care insurance system. Moreover, the National and LGU Hospitals give free hospitalization benefits to their employees and their dependents. These benefits, however, have already been provided to nurses even prior to the approval of the Nursing Act.

#### **5.2.3.2. Training and Scholarship Grants**

No scholarship grants have been exclusively set-up for nurses in government hospitals as intended under the Nursing Act. Nurses who want to pursue advanced training or postgraduate studies can apply for national or international scholarship grants that are available to all public sector employees through the Commission on Higher Education. However, many nurses do not have access to information about these scholarships. The situation at the LGU nurses is unique because their nurses can avail of a tuition fee discount if they

study in their “sister” university, a local university owned and funded by the City of Manila, the same LGU that owns the LGU Hospital. In partnership with the local university, the LGU Hospital had previously offered a master’s program for their nurses right within the Hospital’s premises, so that the nurses can attend the classes after their duty hours.

The National and LGU Hospitals also allow their nurses to attend training courses on official time. Occasionally, the Hospitals provide in-house trainings at minimal costs such as intravenous (IV) therapy given to LGU nurses, but most of the trainings are available outside of the Hospitals, which nurses often have to pay from their own pockets. As one nurse pointed out, *“But the problem is it’s the same nurses who attend the trainings; many nurses do not attend trainings usually given outside of hospital, because they pay”* (Transcript, FGI III-LGU Nurses, p. 4).

#### **5.2.3.3. Health Human Resource Development Plan**

The only provision that has been realized so far is the undertaking of a health human resource production, utilization and development plan. In 2005, the Department of Health (DOH) through the funding of the World Health Organization (WHO) embarked on the development of 25-year Human Resource for Health Development Master Plan. The Master Plan, covering the period 2005-2025, discusses the long-term policies for the production and rationalization of health human resources as well as strategies to manage the migration of health care professionals, improve their retention and establish their career paths in the Philippines (Ronquillo, et al., 2005). The researcher was unable to ascertain whether the undertaking of this Master Plan was an aftermath of the enactment of the Philippine Nursing Act. Under the Nursing Law, the Board of Nursing is the main agency mandated to conduct the studies, but the Master Plan is wholly an undertaking of the DOH and covers not only nurses but also all health care professionals in the country.

#### **5.2.4. Summary & Concluding Remarks - Implementation**

Six years after the approval of the Nursing Act, the Philippine government has not implemented any of the nurse retention strategies

espoused under the health human resource development provisions of the Philippine Nursing Act. The starting salary of a nurse in a government hospital is still Salary Grade 10 instead of the Salary Grade 15 mandated under the Nursing Act. Government officials cited as reasons the differing nurse salary schemes in various government hospitals, which make it difficult to implement a uniform salary increase for all nurses in the public sector and the complaints of other health care professionals, particularly the doctors who also demand wage increase. Another major issue is the financial resources required to upgrade the nurses' salaries. The national government has to appropriate an estimated amount of PhP586.4 million (NZ\$17.7 million) and for the nurses in devolved health facilities, the cost will have to be borne by the LGUs, many of which do not have the financial capability to implement a salary increase.

Expectedly, the other health human resource development provisions have not been implemented as well. The DOH has not started the specialty training program for nurses in government health facilities. The main obstacle to the implementation of this training program is the limited number of government hospitals that have the capability to undertake a nurse specialty-training program. Moreover, the lack of a policy framework that defines, regulates and delineates the scope of practice of nurse specialists in the country inhibits the integration and utilization of nurse specialists in the Philippine public health care system. There is also the issue of the relevance of nurse training programs in the areas of oncology, nephrology and critical care among others, to the health care needs of the Filipino people. Furthermore, the government has not set-up scholarship grants, health care benefits and other non-financial benefits for nurses, which the Nursing Act stipulates.

The non-implementation of the nurse retention strategies signifies a gap between the policies and intentions enunciated in the Nursing Act and the government's actions. The Philippine government is reluctant to provide the required funding for the salary increase of nurses and it has not established any of the required support structures for the nurse specialty program. It is, thus, clear that the implementation of the health human resource development provisions is not among the top priorities of the Philippine government.

### **5.3. What Do Nurses Want?**

This section is an assessment of the relevance and adequacy of the health human resource development provisions to the conditions of nurses in the two government Hospitals. The running argument in this analysis is that the health human resource development provisions do not adequately address the needs of the National and LGU nurses. The declarations, perceptions and recommendations of the LGU and National nurses are the bases for the analysis presented herein.

#### **5.3.1. Salary Increase**

The nurses in the focus groups unanimously want a salary increase. When asked about how much salary they would like to receive and which they think is adequate for them, the amount of PhP20,000 (NZ\$606) was the common reply. When the interviews were conducted majority of the nurses in the focus groups were staff nurses, i.e. Nurse II and III with salary grades 14 and 15 and were receiving basic monthly salaries of PhP13,801 (NZ\$418) to PhP15,508 (NZ\$470)<sup>34</sup>. The amount of PhP20,000 (NZ\$606) is slightly higher than the salary increase mandated under the Nursing Act. Under the proposal submitted by the NLPGN, staff nurses with salary grades 14 and 15 will be upgraded to salary grades 17 and 19, respectively, which have corresponding basic monthly salaries (for step 1) of PhP16,438 (NZ\$498) and PhP18,471 (NZ\$560)<sup>35</sup>, which are still lower than the nurses' desired salary.

##### **5.3.1.1. Intentions to Migrate**

The logical follow-up question that arises is whether a P20,000 monthly salary or even the salary increase stipulated under the Nursing Act would be sufficient to entice nurses to stay in the country when their potential income if they work overseas is triple this amount. This argument assumes that most nurses want to work abroad because they want to earn higher income. The

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<sup>34</sup> These are the equivalent basic monthly salaries of salary grades 14 and 15, **step 1**. Nurses with salary grades 14 and 15, steps 2 to 8 receive slightly higher salaries (please refer to Annex B). The amounts cited here only reflect the 10% salary increase implemented in July 1, 2007.

<sup>35</sup> For more details about the NLPGN proposal, please see Table 11.

testimonies of the nurses in the focus groups belie this assumption. The focus groups interviews told a different story - that of nurses who chose to remain in the country because of their families. While the prospect of earning a higher income abroad remains attractive, it is outweighed by their desire to stay close to their families. The nurses' statements reflect the value of close-knit families in the Filipino culture. Here is one example:

- Ever since, di ko talaga nai-isip na mag-abroad. I would rather stay here. Bakit ako pupunta doon, samantala nandito nanay at tatay ko na alagaan ko...Although sayang yong opportunity for your career growth. Maganda siya but di gaano ka decisive, parang gusto ko lang for my experience. (Transcript, FGI II-LGU Nurses, p. 3)

Ever since, I have not thought of going abroad. I would rather stay here. Why would I go there when I need to take care of my father and mother who are here? I may be wasting the opportunity for career growth by not going abroad. I think it is good to go but I am not that decisive; maybe I want to go only for the experience.

Some of the nurses have previously gone abroad but have decided to return to the Philippines also for the same reason – to be with their families. The nurses in the focus groups as well as the Chief of the National Hospital pointed out that if given a salary that is enough to support their families, then nurses will likely choose to remain in the Philippines so they can be with their families. The past president of the NLPGN agreed with this view, explaining that while the salary increase is not comparable to the wages paid abroad, as long as the salary increase is sufficient to send their children to school, then the nurses will be content. A few other nurses shared that they attempted in the past to leave the country, but they encountered obstacles in the processing of their papers. A few others said that they do not have the money to pay for the visa screen, CGFNS and NCLEX examinations and other requirements in going abroad. These experiences only underscore that not everyone who desires to work overseas can actually leave. Only a handful of the nurses in the focus groups expressed interest in going abroad – they are the young nurses who

cited career opportunities as well as higher income as the main attraction for going abroad.

### **5.3.1.2. Salary as a Form of Recognition**

Beyond the issue of how much salary is adequate to make the nurses stay in the country, a salary increase holds a deeper significance for the nurses who chose to remain in the country. These nurses see the salary increase as an acknowledgment of their hard work, dedication, commitment and long years of service in government. For these nurses, the non-implementation of the salary increase is akin to a disregard of their sacrifices and perseverance in providing health care to Filipinos despite dismal working conditions. It is their perception that the national government values nurses only as top dollar earners for the country, hence its top priority is to keep sending nurses abroad, neglecting the welfare of the nurses and the health of the Filipinos in general. Below are some of the nurses' comments:

- Kaso nga, ang top priority ni Gloria, 'yung tungkol dyan, eh, parang tuwang-tuwa pa siya na mag-abroad ng mag-abroad ang mga nurses. (Transcript, FGI, DR-National Nurses, p. 26)

*The top priority of Gloria<sup>36</sup> is to keep sending nurses abroad and she seems happy with that.*

- Ang dami ng pasok ng mga dollars. Hindi niya alam na ang nakakaawa ang mga Pilipino dahil napapag-iwanan na 'yung mga tao, wala nang nurses na mag-aalaga sa mga Pilipino. Interesado siya doon sa turn out ng dollar pero hindi niya iniisip 'yung kapakanan ng mga Pilipino. (Transcript, FGI, DR-National Nurses, p. 26)

*There are plenty of dollars coming in. But she (referring to President Macapagal-Arroyo) does not know that the Filipino people are in a deplorable situation because the nurses who provide care to Filipinos are gone. She is interested in the dollar remittances of those working abroad but she is not thinking about the welfare of the Filipinos.*

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<sup>36</sup> Referring to Gloria Macapagal Arroyo, the President of the Philippines

Moreover, they also felt that in giving salary increases, the national government prioritizes other professions over the nursing sector. For the nurses, the doctors' complaints against the nurses' salary increase only served to highlight the government's partiality towards other professions. The nurses argued that the doctors' complaints should have been a non-issue because the government has made a commitment to increase the nurses' salaries when it approved the Nursing Act into law. Below are some of their comments:

- Bakit yung mga pulis at military may increase sa salary? Kasi sila ang priority ni Pres. Arroyo. (Transcript, FGI, DR-National Nurses, p. 26)

Why do the police and the military have a salary increase?  
Because they are the priority of President Arroyo.

- Parang lahat na lang ay naibibigay sa ibang mga profession. Ang nurse palagi na lang sa background. (Transcript, Interview, NLPGN former president, p. 12)

It seems like other professions are given everything but not the nurses. The nurses are always in the "background" (i.e. denoting that nurses are unimportant).

The nurses attributed the government's non-recognition of their importance in the health care system to a lack of understanding of the role of nurses. A key informant elucidated the significant yet inconspicuous contribution of the nurses, likening it to the care-giving role of a mother:

- I don't know kung ano ang nagiging problema talaga kasi ang perception talaga nila is parang napaka-invisible ng -- intangible kasi iyong contribution ng nursing kasi in a certain organization, kasi she's always there. Para siyang nanay. Iyong who gives care everyday, pero parang nate-take for granted... Pero kung mamatay iyong tatay...- nagkasakit iyong mga anak, sino ang nandiyan? (Transcript, Interview, NLPGN former president, p. 11)

I don't know where the problem lies – because the perception is that the nurses' contributions in a certain organization are

invisible, intangible. Maybe because she is always there, like a mother, someone who gives care everyday but is often taken for granted. But when the father is gone and the children are sick, who is there to care for the children – is it not the mother?

Fulfilling the nurses' desire to be valued for their significant contribution to the nation's health care is, therefore, essential to the retention of nurses. Key informants stated that as long as there is an international demand for nurses, the exodus of Filipino nurses, especially the new nursing graduates, would continue, but what is of utmost importance is for the government to focus on the nurses who have opted to stay in the country, "*to keep those who are here*" (Researchers' field notes/journal). This insight is relevant because although these nurses have decided to stay put, they are not entirely closing their doors to the possibility of going abroad. More importantly, the nurses who have chosen to remain or came back after working abroad have long years of professional experience and service in the government as exemplified by the nurses in the focus groups. Recognizing the sacrifices of the nurses who stayed by compensating them well and enabling them to live a decent life is the intent of the salary increase provided under the Nursing Act (Transcript of floor deliberations, Sponsorship Speech of Senator Flavio, August 14, 2002). By failing to implement the salary increase, the government failed in its good intentions.

### **5.3.2. Professional Advancement Opportunities: Additional Income**

To augment their salaries, many of the nurses are engaged in income-generating activities. Some have small business on the side like a *sari-sari*<sup>37</sup> store, others sell stuff to their co-workers, and many others take up teaching jobs as clinical instructors in nursing schools, which they do after their hospital duties. Teaching as clinical instructors is a lucrative job for the nurses. They are paid an average of PhP150-250 (NZ\$4.5-7.5) per hour, with some nursing schools paying as high as PhP400 (NZ\$12) per hour. It is possible for nurses to teach 40 hours per week and with an hourly wage of PhP150, they can earn

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<sup>37</sup> A sari-sari store is a small neighborhood store that sells variety of goods.

as much as PhP24,000 ((NZ\$727) monthly, on top of their regular salaries in the Hospitals. Being a clinical instructor is also a convenient job for the nurses because it usually entails supervising nursing students who are doing their internship in the Hospitals.

Their earnings as clinical instructors constitute a substantial additional income, enough to make some nurses decide to stay in the country where they can be with their families. One LGU nurse's reason for not going abroad is also true for the other LGU nurses: "*I have just finished my masters in nursing. There are opportunities now coming my way so I'm not yet contemplating to go abroad*" (Transcript, FGI III-LGU Nurses, p. 4). Thus, many nurse participants are motivated to pursue graduate studies, because having a master's degree is a prerequisite for clinical instructors. Said one LGU nurse:

- For personal career growth, kasi may opportunity kaming mag-teach clinically pag may master. So iyan ang motivating factor din sa iba na magturo of which the hospital allows naman. (Transcript, FGI II-LGU Nurses, p.5)

For personal career growth, because there is an opportunity to teach clinically if we have master's degree. So, that is the motivating factor of the nurses - to be able to teach- which the Hospital allows.

The health human resource development provisions of the Nursing Act do not give emphasis to opportunities for professional advancement yet as indicated by the nurses' experiences, such opportunities are emerging to be a good nurse retention strategy. In fact, the LGU Hospital has adopted a policy of allowing their nurses to teach and pursue graduate studies under certain guidelines<sup>38</sup>. The LGU Hospital has an in-house master's program done in collaboration with the *Pamantasan ng Maynila*<sup>39</sup> (*University of Manila*), which

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<sup>38</sup> These guidelines include applying for a permit to teach, not allowing nurses to take a leave from their hospital duties just to teach, they cannot teach for 16 hours straight, their capabilities must be assessed and they must perform well before they are allowed to teach, etc. These were formulated to ensure that the Hospital comes first. (Transcript of interview, Chief LGU Hospital)

<sup>39</sup> A local university funded by the City of Manila.

conducts classes in the Hospital's premises after office hours (Transcript of Interview, Chief LGU Hospital). Around 30 LGU nurses are teaching as clinical instructors and a good number are pursuing postgraduate courses in nursing. The National Hospital also permit their nurses to teach as clinical instructors and pursue postgraduate studies on their own but the Hospital does not have a policy similar to the LGU Hospital that explicitly promotes and gives incentives for nurses to undertake advanced studies.

### **5.3.3. Alleviating the Heavy Workload**

Aside from increasing their salaries, the nurses stressed the urgency of alleviating their heavy workload and improving their work conditions. A nurse explained clearly the exigency of this issue, "*So kahit sabihin pang i-increase ang salary at still patuloy yong practice na ganito, walang tatagal talaga dito*" *Even if you increase the salary, but this situation continues, no nurse would last under these conditions*" (Transcript, FGI, Ward II-National Nurses, p.3).

To ease the nurses' workload entails solving the inadequate nurse staffing in the LGU and National Hospitals to improve the existing nurse-to-patient ratios. Yet the provisions of the Nursing Act do not convey the significance and urgency of addressing the low nurse-to-patient ratios in government hospitals. Like an afterthought, the phrase "...*The government and private hospitals are hereby mandated to maintain the standard nurse-patient ratio set by the Department of Health*" is the last line of the last section (Section 34) of the health human resource development provisions of the Nursing Act. Therefore, the legislators did not consider the improvement of nurse-to-patient ratios in hospitals as a key retention strategy. Yet studies have established that workload is associated with nurses' job satisfaction and turnover intentions (Zeytinoglu, Denton & Davies, et. al. 2007). Moreover, the accounts of nurses presented below show that the current nurse-to-patient ratios in the National and LGU Hospitals have serious implications on the well-being of both the nurses and the patients.

### **5.3.3.1. Effect on the Nurses' Well-being**

Improving the nurse-patient ratio is vital to the nurses' welfare and the retention of nurses. Based on studies done in other countries, nurse-to-patient ratio is significantly associated with burnout or emotional exhaustion, job dissatisfaction and turnover intentions of nurses. Nurses in a hospital with a nurse-to-patient ratio of 1:8 would be twice more likely to experience high emotional exhaustion and to be dissatisfied with their jobs than nurses in a hospital with a ratio of 1:4 (Aiken, Clarke, Sloane, Sochalski & Silber, 2002). There is a strong relationship between job satisfaction and job turnover among nurses - nurses who have low job satisfaction are more likely to leave their jobs (Neisner & Raymond, 2002). Furthermore, nurses' job satisfaction is also related with quality of care, improved patient satisfaction and improved patient outcomes (Grindel, 1996 in Neisner & Raymond, 2002).

Based on the nurses' accounts, the combination of inadequate staffing and large volume of patients have negative consequences on their well-being. The nurses feel stressed out from working long hours to serve the large number of patients. Said one nurse:

- It is stressful because we cannot take a short break even if we wanted to because you have to move around the four areas in ER to oversee the work even if there is assigned nurse in the areas. If there are plenty of patients, we cannot take a break until the next shift. And that is the only time that we can eat our lunch if we have not eaten yet. (Transcript, FGI III-LGU Nurses, p. 3)

The Nursing Service of the LGU Hospital documented "the physical and emotional detriment" brought about by nurses frequently doing 16 hours of duty, which has resulted in successive absences among the nurses (Letters of the Chief Nurse May 23, 2002, September 5, 2002 & May 11, 2007). The absences, in turn, aggravate the burden of the nurses because as one nurse takes a sick leave, another nurse takes her place and works for 16 hours. The nurses, therefore, cannot get off the cycle of absences and long hours of work.

### 5.3.3.2. *Effect on the Quality of Care*

Another compelling reason to improve the nurse-to-patient ratio is its impact on the quality of patient care. The less than ideal conditions of low nurse-to-patient ratios and long hours of work in the two Hospitals do not foster an environment where nurses are able to give the ideal patient care. The nurses acknowledged that the nursing care they provide is not the best quality of care, saying that, “*Talagang less yong quality care na napro-provide namin (The quality of care we provide is less)*” (Transcript, FGI II-LGU Nurses, p.1). One nurse went as far as to describe the nursing care they provide as “*ineffective*” because they cannot “*really attend 100 percent to the needs of the patients*” (Transcript, FGI, Ward II-National Nurses, p.1). The National Hospital Chief Nurse explained why:

- Ang mga explanation mo, ang instructions mo sa patients, rush-rush na yan. Tapos ang mga patients mo low-income group, so hindi sila masyadong makaintindi di ba? So parang makulit na sila, when in fact, they couldn’t really understand because of their education. (Transcript, Interview, Chief Nurse-National Hospital, p.2)

*You rush your explanation and your instructions to the patients. But the patients cannot readily understand the instructions since most of them come from the low-income group. So, these patients become annoying to the nurses, when in fact, they just could not really understand because of their [low] education.*

One benchmark to measure the quality of patient care is the amount of time that a nurse allots for each patient. A reduction in the number of hours of nursing care given to each patient indicates a diminution in the quality of care. The Department of Health (DOH) guidelines requires a minimum of 30 minutes to 120 minutes of nursing care per patient, but the three or four nurses assigned in one shift can only manage to give each patient “*4, 5, or 10 minutes*” of nursing care (Chief Nurse letter dated March 26, 2002; Transcript, FGI I-LGU

Nurses, p. 2). The nurses serve the patients “*on a per demand basis,*” meaning they attend to patients only when the patients communicate their needs to the nurses (Transcript, FGI II-LGU Nurses, p. 1). The ER nurses at the LGU Hospital have a system of prioritizing the patients, using the classification “*immediate, urgent, priority, less priority*” (Transcript, FGI II-LGU Nurses, p.2). In this situation, it is inevitable that nurses would neglect the needs of patients whom they have classified as “less priority”. Below are the accounts of nurses illustrating the decline in the quality of care:

- For example: may nilalagnat at sabi ng doctor pakibigyan ng paracetamol o injection. Tapos may dumating hirap na hirap huminga, siyempre uunahin namin yon. (Transcript, FGI II-LGU Nurses, p.2)

For example, one patient has a fever and the doctor has ordered to give him a paracetamol or an injection, then another patient comes in who has difficulty breathing. Of course, we will prioritize the patient who could not breathe.

- Sa buong shift, marami kang patient na hindi mabi-visit kasi nga may isang patient na nano-noxic. Kawawa yong ibang patient. (Transcript, FGI II-LGU Nurses, p.2)

In one shift, there are several patients that you cannot even visit because one patient is more demanding than the others are. I pity the patients whom we were not able to serve.

Another indicator of diminished quality of care is the delay in the administration of the patients’ medications. The Delivery Room nurses at the National Hospital explained that this happens because they often juggle many duties and functions all at the same time. Aside from providing direct patient care, they also assist doctors in surgical procedures, and sometimes they are assigned to other clinical areas.

- Hindi naibibigay sa tamang oras kasi instead na magbigay siya ng gamot, nanduon siya nag-a-assist sa OR. And then pagkatapos nun mayroon pang mga deliveries, normal deliveries, mayroon pang mga raspa, ganoon, admission. Kung minsan isa lang yung

nurse na naiwan dito sa labas. Ang daming admissions...Kulang na lang gawing apat 'yung kamay para magampanan iyong dapat gawin. (Transcript, FGI Ward II-National Nurses, pp.3-4)

Sometimes we are not able to give the medicines on time because instead of giving medications, a nurse is assisting in the OR [Operating Room]. Aside from that, there are normal deliveries, Dilatation and Curettage, and admission of patients. There are so many admissions. If we can only have four hands so, we can carry out all the duties that we need to do.

### **5.3.3.3 Effect on Patient Safety**

The deterioration in the quality of care raises serious concerns over patient safety. The debate over the 1999 California legislation,<sup>40</sup> which mandates a minimum nurse-to-patient ratio for each clinical area in the hospital highlighted the serious consequences of nurse staffing levels on patient outcomes. In the past, there had been conflicting findings on this issue, but in recent years, evidence on the relationship between nurse staffing, workload and patient outcomes have begun to emerge (Stone, Tourangeau, Duffield, Hughes, Jones, O'Brien-Pallas, et al., 2003). One research showed consistent association between the levels of registered-nurse staffing and shorter length of stay of patients and lower rates of complications common to hospitalized patients, i.e. urinary track infections, pneumonia, upper gastrointestinal bleeding, cardiac arrest and "failure to rescue"<sup>41</sup> (Needleman, Buerhaus, Mattke, Stewart & Zelevinsky, 2002). The study of Aiken, Clarke, et al. (2002) showed that substantial increases in the number of patients per nurse result in significant increases in patient deaths. This study showed the odds of a patient dying increased by seven percent for every additional patient in the average

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<sup>40</sup> The California legislation mandates a ratio of 1 nurse for every 5 or 6 patients in medical and surgical general units, 1:1 in trauma centers, 1:4 in pediatric units, 1:4 in emergency rooms, and 1:2 in Obstetrics-Gynecology (Neisner & Raymond, 2002).

<sup>41</sup> It is defined as "the death of a patient with one of five life-threatening complications – pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis – for which early identification by nurses and medical and nursing interventions can influence the risk of death" (Needleman, Buerhaus, Mattke, Stewart & Zelevinsky, 2002, pp. 1716-1717).

nurse's workload. Thus, an increase in the number of patients per nurse from four to six and from four to eight resulted in 14% and 18% increase, respectively, in patient mortality.

The above findings have serious implications for Philippine government hospitals where the nurse-to-patient ratios typified by the LGU and National Hospitals are much worse: one nurse for every 20-30 patients in the LGU Hospital and one nurse attending to 40-50 patients in the National Hospital. The nurses at the National Hospital candidly admitted that under these dire conditions, "*prone ka talaga sa error*" (*one is prone to committing errors*), which can lead to patient deaths (Transcript, FGI Ward-National Nurses, p.4). In the past three years, the Philippine media reported medical errors that occurred in the National Hospital. In one case, a woman died because the National Hospital allegedly transfused her with the wrong blood type and in another case, a nurse administered the wrong injection to a child patient that allegedly caused the child's death. The nurses explained that mistakes like these are bound to happen in a situation where there is only one nurse attending to 50 patients and the nurse is swamped with doctors' instructions for the medications of all these 50 patients.

#### **5.3.4. Full Implementation of the Magna Carta for Public Health Workers**

The nurses advocated for the full implementation of all the benefits mandated under Republic 7305, the Magna Carta for Public Health Workers. The Magna Carta for Public Health Workers covers a wide range of financial and non-financial benefits for health workers working in the government sector. These include the basic monthly salaries of public health workers, overtime pay, night differential for graveyard shifts, salary increase after postgraduate studies, longevity pay, hazard pay, subsistence allowance, laundry allowance, remote assignment allowance, housing benefits, free medical examination, treatment and hospitalization. If fully implemented, the Magna Carta benefits constitute a sizeable supplementary income to the monthly basic salaries of public health workers.

To date, public health workers do not receive all of the abovementioned Magna Carta benefits. Currently they are only receiving hazard pay, longevity pay, laundry allowance and subsistence allowance. The funding for the provision of the benefits comes from the budget of the respective national agencies and the local government units, many of which do not have the adequate financial resources. Consequently, the implementation of the benefits is uneven as the financial capacity of each government agency or local government unit varies. Some government agencies or local government units are able to provide the full amount of the mandated allowances, e.g. hazard pay and subsistence allowance. Others can only give the partial amount while some are unable to give these benefits at all.

The Magna Carta for Public Health Workers is a more comprehensive policy than the Nursing Act in terms of improving the well-being of health workers. It provides not only additional financial benefits but also recognizes the significance of improving the working conditions, the development and retention of a highly competent and motivated workforce. The Magna Carta lays down policies on staffing and workload; the regular working hours of health workers and the compensation for extra hours of work; the security of tenure of jobs; and the rights, privileges and responsibilities of health workers. It also provides guidelines on the development of skills and capabilities, mandating the establishment of career paths and the upgrading of salary scales of health workers who have acquired advanced studies and training.

Enacted in 1992, the Magna Carta needs to be revisited because the essence of this Law and its important provisions on work conditions and professional advancement have been overlooked through the years. The implementation of the Magna Carta concentrated a great deal on the financial benefits for health workers, yet the other provisions of this Law are equally important and relevant to the current situation of Philippine health care workers. More importantly, the government can harness the potential of the Magna Carta as an effective policy for the retention of health care professionals in the country.

### 5.3.5. Funds for the Health Sector

- Sana bigyan ng priority ng gobyerno ang nurse. Napaka-kulang na kulang talaga ang funds para sa nurse. If you ask for equipments, infrastructures ...talagang kawawang-kawawa. Sa dami ng pasyente, kulang talaga. (Transcript, FGI Ward-National nurses, p.23)

I hope the government will give priority to the nurses. The funds for the nurses are so inadequate. If you ask for equipment, infrastructures, these are insufficient because of the large number of patients. The situation is so pathetic.

The above statement indicates the nurses' awareness of the connections between their plight and the state of affairs in the Philippine health care system. Literature shows that nurses' job satisfaction is affected by their perceptions of the external environment, which includes all the important decisions made outside of the hospital such as budget cuts and other policy decisions that limit the quality of care provided in their hospitals (Zeytinoglu, Davies, Denton, et al., 2007). Health care professionals have generally strong professional conscience and they get frustrated when conditions such as lack of supplies and equipment impede their desire to give the best quality of care (Matthauer and Imhoff, 2006). It was evident in the interviews that the nurses are committed and dedicated workers who wanted to provide the best possible care despite the deplorable circumstances. Here is how a National Hospital nurse illustrated the link between the quality of care and the inadequate hospital budget:

- Pag wala kang supply wala ka na rin sa standard of providing quality health care. For instance, dahil sa walang supply ng measuring cup, nag-improvise nalang kami ng suwero to measure the urine of the patient. In effect, may error ka na doon sa measurement kasi hindi tamang instrument ang ginagamit mo...Also, there was a time na hinati naming yong oxygen sa dalawang patients para lang mabigyan din ng oxygen yong isang

patient and which is not a good practice. (Transcript, FGI Ward-National nurses, p. 3)

If you do not have the supplies and equipment, you no longer abide by the standards of providing quality health care. For instance, since we did not have supply of measuring cups, we improvised and used the dextrose bottle to measure the patient's urine. In effect, you have already committed an error in measurement because you did not use the correct instrument. Also, there was a time when we split the oxygen tubes into two so that we can provide oxygen to two patients at the same time, which is not really a good practice.

The nurses were also cognizant that their working conditions will improve only if the government will prioritize the long-neglected health sector by infusing the much-needed dose of funds to revive the ailing public health care system. *“Legislators should allocate more budget for health and not only for the military,”* said another National Hospital nurse (Transcript, FGI Ward-National nurses, p. 5). The National and LGU Hospitals need increased funding to solve the long-standing problems of inadequate staffing, to buy enough supplies and equipment and to give the nurses their long overdue salary increase and Magna Carta benefits. Increased funding for government hospitals can also mean better facilities for the nurses. The nurses' wish list included additional electric fans in the wards, a nurses' lounge where the nurses can rest in between their duties instead of the cramped nurse supervisor's room, and a dormitory where nurses can sleep after their night duty.

#### **5.3.6. Summary & Concluding Remarks - “What Do Nurses Want?”**

This section has presented the experiences, views and recommendations of nurses on how to improve their work conditions and to retain the nurses in the Philippines. Their experiences and perspectives exposed the inadequacies of the health human resource development provisions of the Nursing Act. The health human resource development provisions do not capture the gamut of issues related to the working conditions

of the nurses. There is, obviously, a gap between the retention strategies espoused under the Nursing Act and the actual conditions and experiences of nurses in the National and LGU Hospitals.

First, it fails to address a most important problem raised by the nurses – their heavy workload. The nurses stressed the necessity and urgency of alleviating their heavy workload by improving the nurse-to-patient ratios in government hospitals. Low nurse-to-patient ratios have grave consequences on the well-being of nurses, the quality of patient care and the safety of patients. Improving the nurse-to-patient ratio means solving the inadequate nurse staffing in the two government hospitals, which the Nursing Act does not provide for.

The nurses also want the government to implement the salary increase. For the nurses, the salary increase provided under the Nursing Act holds a deeper meaning than a mere enticement to remain in the Philippines. For them, the salary increase is an affirmation of the nurses' important role in the nation's health care system and a recognition of their hard work, commitment and devotion to their profession. In spite of the thousands of Filipino nurses who leave the country yearly, many Filipino nurses have chosen to remain and continue to work in the public health sector because they do not want to leave their families. For the same reason, nurses who have gone abroad have decided to return to the Philippines and work in government hospitals. By focusing too much on the large out-migration of Filipino nurses, the Nursing Act fails to notice the nurses who have opted to stay and who have been serving the government for many years. These nurses want to feel valued for their contribution and hard work. It is, therefore, integral for any retention strategy to satisfy the nurses' desire to be appreciated and to give attention to the needs of nurses who have decided to stay in the country.

Encouraging nurses to undertake postgraduate studies and allowing them to teach as clinical instructors are good retention mechanisms as seen in the case of the LGU Hospital, which has adopted such policy. These mechanisms not only give the nurses the opportunity to advance professionally,

these also give them a means to earn higher income. The rewarding pay as clinical instructors (PhP150-400 per hour) is a substantial addition to their monthly wages and a significant factor for the nurses' decision to remain in the country. To become clinical instructors, nurses need to finish a master's degree yet providing opportunities for postgraduate studies is not one of the key retention strategies under the Nursing Act.

Lastly, the nurses linked their predicament to the government's continuing underinvestment in health care. They equated their plight with the government's neglect of the health care sector. The nurses advocated for increased budgetary allocation for the public health sector to create additional nurse positions and fill up vacant nurse positions, and thus resolve the long-standing problem of inadequate staffing in government hospitals. Increased funding would enable the full implementation of the Magna Carta benefits and the nurses' salary increase, provide sufficient supplies and equipment, and grant better facilities for the nurses, e.g. additional electric fans, a nurses' lounge and dormitory – all of which are necessary to improve the nurses' work environment.

The nurses' accounts have shown that the health human resource development provisions of the Nursing Act are inadequate to address the existing conditions of the nurses in the National and LGU Hospitals. Therefore, the national government should pay heed to the nurses' concerns and enhance the provisions of the Nursing Act to bring about real change in the working conditions of the nurses in government hospitals.

## **Chapter Six**

### **CONCLUSION AND RECOMMENDATIONS**

#### **6.1. Introduction**

The main purpose of this study was to assess the health human development resource provisions of the Nursing Act and its implementation as a nurse retention strategy. The use of constructionist philosophy and interpretive approach to policy analysis has allowed the nurses and the implementers of the Nursing Act to express their views and experiences, which are important in understanding how these policy communities frame the issues that are affecting them. In addition, the study has also been guided by its pragmatic purpose to generate evidence on how the retention strategies embodied in the Nursing Act are being implemented and experienced by the nurses and relevant organizations tasked to implement the provisions, which are essential inputs to policymaking. This concluding chapter provides a summation of the key findings of the study as well as recommendations to enhance the policy and programs for the retention of nurses in the Philippines.

#### **6.2. Conclusion**

The health human resource development provisions of the Nursing Act are not responsive to the needs of nurses in government hospitals because these do not address the nurses' pressing concerns regarding their working conditions, foremost of which is their heavy workload. Moreover, the provisions do not capture the gamut of workplace issues that are connected to the long-standing problems beleaguering government hospitals and the Philippine health care system in general. The nurses' depiction of their working conditions and the realities of the Philippine health care system presented a much more complex picture than the Nursing Act's conception of the nurses' issues.

The Nursing Act employs the upgrading of nurses' salary as one of its main strategies to retain the nurses in the country. However, based on studies, a salary increase may be a puny attempt to stop the tide of migration amidst a strong international demand for nurses. This is not to say that salary increase is

not important for the nurses because it is. However, a salary increase has a deeper significance than an enticement to stay in the country, particularly for the nurses who have been working in government hospitals for many years. It is important to draw the government's attention to the Filipino nurses who have opted to stay or have decided to return from abroad so they can be with their families. These are typified by the nurses in the focus groups – they are the nurses with long years of professional experience and who continue to work in government hospitals under poor working conditions and low salaries. For these nurses, a salary increase is a recognition of their important role in health care delivery. It fulfills the nurses' desire to be valued and acknowledged for their hard work, sacrifices, perseverance and commitment to their profession. Increasing their salaries will also help these nurses meet the needs of their families, especially during these hard times; otherwise even these nurses who have chosen to stay may eventually be forced to work abroad when they feel they are no longer able to provide for their families. The non-implementation of the salary upgrading is, thus, considered by the nurses as a disregard of their significant contribution to the nation's health care. The non-allocation of funds for the implementation of the salary increase is seen as the government's indifference of the nurses' needs. Furthermore, by not implementing the salary increase because it has incited complaints from other health care professionals, particularly from the doctors merely reinforces the nurses' perception that they are undervalued.

This study has provided the context why the nurses demand a salary increase. Devoid of this context, the government will fail to see the heart of the issues that drive Filipino nurses to seek better employment opportunities abroad. Nurses view their salary in relation to their workload. They feel that their current salaries are low because these do not compensate for their heavy workload. Workload is a central issue for the nurses. Aside from salary, other workplace issues such as lack of equipment and supplies, decreasing hospital budget, the migration of nurses and inadequate nurse staffing were discussed in terms of how these conditions have contributed to their heavy workload. The nurses described their heavy workload through the low nurse-to-patient ratios in the National and LGU Hospitals. An LGU nurse has to care for 20-30

patients and a nurse in the National Hospital attends to the needs of 40-50 patients every day. The nurses often extend their working hours and do 16 hours of duty without overtime pay to provide continuous nursing care to the large volume of patients in the two Hospitals. In spite of this, the Nursing Act hardly reflects the significance of workload and nurse-to-patient ratio. Like almost an afterthought, in the last line of the last section of the health human resource development provisions (Sec. 34), it simply states: “the government and private hospital are mandated to maintain the standard nurse-patient ratio set by the DOH.”

Inadequate nurse staffing has always been a perennial problem in the two government Hospitals. Hence, the basic premise of the Nursing Act that the nursing shortage in government hospitals is brought about by the migration of nurses needs to be re-examined in the light of the evidence from the National and LGU Hospitals. Data from the two government Hospitals indicated that while the most common reason for the nurses' resignations was to work abroad, the actual number of nurses who resigned constituted only a small proportion of the total number of the nursing staff. What the evidences have shown is that the shortage of nursing staff stems from the lack of nurse positions in the National Hospital and from the many unfilled nurse positions in the LGU Hospital. The National Hospital has only 50% of the required nurse staffing because the national government does not provide the Hospital with additional funds to create the needed nurse positions. In the LGU Hospital, the hiring and promotion of nurses are affected by its organizational and “political” set-up. When this study was conducted, 40% the nursing staff positions in the LGU Hospital were unfilled or vacant because the decision to hire and promote nurses rests solely on the city mayor who has the direct supervision and control of the LGU Hospital. The case of the LGU Hospital provides a preview of the problems and issues that are unique to health facilities under the management of local government units.

Although there is not enough evidence to link inadequate nurse staffing in the two Hospitals to the migration of nurses, the turnover of nurses has an impact on the nurses who stayed behind. The resignations exacerbate the

heavy workload of nurses who remained since they assume the duties of the nurses who left and at the same time, train the newly-hired nurses who have limited hospital experience. Finding replacements for those who resigned is not difficult since many new nursing graduates are eager to fill their place, but administrative procedures delay the hiring of these new nurses. The Hospitals, specifically the National Hospital, also feel the impact of nurse migration through the loss of their skilled nurses and the resources they spend on the constant training of new nursing graduates who would eventually leave after gaining two years of hospital experience.

The loss of skilled nurses as a consequence of migration is a debatable issue because it raises related issues on the quality and regulation of nursing education in the Philippines. The lack of skilled nurses might be an indication of the deteriorating quality of nursing education in the country caused by the unregulated proliferation of nursing schools rather than as a consequence of nurse migration. Furthermore, a good number of nurses in the focus group interviews were nurses with long years of professional experience and who have been working in the two Hospitals for several years, which casts reservations to the prevailing view about the shortage of skilled nurses in the country. There are no available evidences yet to establish the loss of skilled nurses and to determine their causes, highlighting the need for a database of Filipino nurses and their areas of expertise, in order to generate vital information for policy formulation.

The other key retention strategy adopted by the Nursing Act – to establish nurse specialty training programs in government hospitals - could not be implemented because the government's rudimentary health care facilities do not have the capacities to train and utilize advanced practice nurses. Developing nurse specialists in oncology, critical care, nephrology and other specialty areas presumes the availability of sophisticated health care facilities and the existence of support systems and structures that are not yet in place. Establishing a national nurse specialty program is a grand vision for the Philippine nursing sector, but to realize this ambitious goal, the government needs to undertake the following enormous tasks: (1) establish a network of

training hospitals nationwide, which entails modernization and upgrading of government health care facilities, especially those located outside of the National Capital Region; (2) provide a career path for nurse specialists in the public health care delivery system by creating positions for certified nurse specialists; and (3) lay down a regulatory framework for advanced nurse practice in the Philippines. The first two requirements involve the infusion of large amount of funds from the national and local governments, but other than naming two government-owned corporations as sources of funds, the Nursing Act does not allocate any amount for the implementation of the proposed program.

The nurse specialty training program was conceptualized as a mechanism for the retention as well as for the professional advancement of nurses, but as shown in the experience of the National and LGU Hospitals, allowing nurses to pursue postgraduate studies and to teach as clinical instructors better serve the two above-mentioned objectives. By the nurses' accounts, teaching as clinical instructors is emerging to be a good retention mechanism because it provides the nurses a good income as well as professional growth. Teaching as clinical instructors is a lucrative sideline that has become a main source of supplemental income for the nurses. Nurses teach after their duty hours in the hospital, which usually involves supervising and instructing nursing students who are training in the LGU and National Hospitals. To become clinical instructors, nurses must have a master's degree, or at the very least, they must have completed a considerable number of units of postgraduate courses. The substantial earnings and professional advancement they get from teaching have played an important part of the nurses' decision to remain in the country. Seeing this as a good retention mechanism for its nurses, the LGU Hospital has instituted a policy expressly allowing nurses to pursue postgraduate studies and to teach as clinical instructors subject to certain guidelines. Like the provision on nurse-to-patient ratio, incentives for nurses to pursue graduate studies are the least highlighted provisions in the Nursing Act, in contrast to the focus given to salary increase and nurse specialty training program. It is ironic that the marginal provisions on

nurse-to-patient ratio and educational scholarships correspond to the issues that are vital to the nurses.

The inadequacies of the Nursing Act as a retention policy stem from the conflicting objectives served by the health human resource development provisions. The legislators formulated these provisions to serve twofold objectives: one is to provide incentives for nurses to stay in the country, and the other is to upgrade the skills of Filipino nurses to enhance their global competitiveness. The second objective is revealing of the government's inclination to sustain the sending of Filipino nurses abroad. In the marriage of two incompatible objectives, it is the latter objective that prevails. The government's support for the continued export of Filipino nurses is the very reason for the non-implementation of the nurse retention strategies provided under the Nursing Act.

Despite the limitations and the non-implementation of the health human resource development provisions, the significance and potential of these provisions cannot be underestimated. These provisions signify the government's recognition of the need to implement nurse retention strategies amidst the continuing exodus of Filipino nurses. These retention strategies, however, should be re-crafted to reflect the perspectives and experiences of Filipino nurses so that these provisions will be more responsive to their needs and conditions. Given the chronic global demand for nurses, the government's retention policy must acknowledge that Filipino nurses will likely continue to leave and work abroad. At the same time, it should recognize that there are nurses who have opted to stay and who have returned from working abroad. In addition, not all nurses who aspire to work abroad can actually leave for many reasons that include financial constraints on the part of the nurses and migration restrictions in destination countries among others. Thus, the government's retention policy must shift its focus and give importance to the nurses who have stayed and who have continued to work in government hospitals in spite of the poor working conditions. Finally, the objectives of the nurse retention policy and strategies must be redefined to strengthen the

motivation of nurses in the public health sector, thereby, keeping a highly motivated nurse workforce who can provide quality health care to Filipinos.

### **6.3. Recommendations for Policy Directions**

This section discusses specific recommendations for policy directions to enhance the retention of nurses in the Philippines, based on the key findings of this research study.

#### **6.3.1. Create Additional Nurse Positions in Government Hospitals**

The national government should create additional nurse positions in government hospitals to address the problem of inadequate nurse staffing. Since the inadequate nurse staffing is attributed to the lack of nurse positions, the logical solution is to add more nurse positions in government hospitals to improve the low nurse-to-patient ratios. From a nurse retention standpoint, it is crucial to ease the heavy workload of nurses because studies have found it to be related to nurses' job dissatisfaction and intentions to resign. Another equally important reason is the serious consequences on the nurses' well-being, the quality of patient care and the safety of patients. Since the findings of this study on nurse-to-patient ratio are limited to the National and LGU Hospitals, there is a need for a critical assessment of the nurse staffing in government health care facilities vis-à-vis benchmarks for patient safety, quality of care and nurses' workload. Such assessment should examine how many of the nursing staff positions are actually filled, especially in health care facilities located outside of Metro Manila<sup>42</sup> and the impact of nurse migration on the nurse staffing of these health facilities.

Given the assumption of overproduction of nurses in the Philippines, creating additional nurse positions in government hospitals with insufficient nurse staffing will provide employment to the thousands of nursing graduates; otherwise, these nursing graduates could not be absorbed into the health care delivery system because of the lack of nursing positions. This will also ensure

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<sup>42</sup> Health care professionals are unequally distributed in the country. More than one-third of doctors and nurses working in the government sector can be found in the National Capital Region; 10% in Region 4, another urban region; and the rest are distributed in the different rural areas in the 14 regions of the country (Ronquillo, et al., 2005).

the maintenance of an adequate supply of nurses who are essentially part of the health care workforce, which is the rationale for the health human development provisions in the Nursing Act. Alongside the creation of additional nurse positions, a career path for nurses must also be provided as the NLPGN had proposed. A career path is an indispensable mechanism to encourage nurses to pursue advanced training and to retain the highly skilled nurses in the public health care system.

Adding more nurse positions in government health facilities will require huge amount of funds from the national government. The national government has already set a precedent when Congress approved in 2002 a PhP1.98 billion supplemental budget for the creation of 20,000 new teacher positions in public schools and increase in the teachers' salaries (State of the Nation Address 2002). Then, in 2006, Congress allotted in the General Appropriations Act (GAA) PhP95.63 million for 5,300 new teaching positions to achieve the ideal ratio of 45 students to one teacher in public schools (Manila Bulletin, 2006). If this was accomplished for the education sector, then there is no reason that the same cannot be done for the equally essential public health care sector.

The proposal to add more nurse positions, however, cannot be forced upon the local government units (LGU), unless the national government provides the required funding to the LGUs. Hence, there is a need for a review of the existing regulations on hospital licensing with the end in view of formulating mechanisms to closely monitor and strictly enforce the DOH standards for nurse-to-patient ratio in all hospitals, including those that are under the management of the LGUs.

### **6.3.2. Mix of Financial and Non-Financial Incentives**

It is crucial and high time to actualize the intent of the provisions of the Nursing Act and to give the long overdue and well-deserved recognition to the nurses in the public health sector through a combination of financial and non-financial incentives.

First on the agenda is the allocation of funds for the salary increase of nurses and to work out the mechanisms for its realistic implementation, particularly at the LGU level, learning from the pitfalls in the implementation of the Magna Carta for Public Health Workers. To address the concern that the nurse salary increase will have a domino effect on the salaries of other health workers, it is recommended that the Department of Health (DOH) include as part of its rationalization plan, a study on the rationalization of the salaries of health care professionals in the public sector. Such study can specifically look into the corresponding salary increase to be given to other public health care professionals if the mandated nurse salary increase is going to be implemented, the total costs required, the sources of funds and the mechanisms for implementation.

Second is to focus on providing nurses with opportunities for educational and professional advancement. The DOH can formulate guidelines for government hospitals enabling nurses to teach as clinical instructors. The basic purpose of this policy is to foster a “culture” or an environment where nurses are encouraged to seek professional advancement and which supports the nurses’ endeavor to earn additional income. Naturally, such policy has to be complemented with a mechanism that will operationalize one of the marginal provisions of the Nursing Act, i.e. the provision of scholarships to nurses. Giving scholarships to nurses will fulfill twin objectives: to provide nurses with the means to pursue advanced training/studies and to retain highly skilled nurses in the country. Under existing government regulations (i.e. Executive Order No. 129), government employees who obtained scholarship grants can go on leave with pay for the entire duration of the study in exchange for a contract of service with the government for a specified number of years. In this way, the objective of the Nursing Act to maintain a pool of highly skilled nurses who will serve in the country for a number of years will be realized. This is the same concept behind the nurse specialty training program, but the scholarship program should extend beyond the nurse specialties indicated under the Nursing Act. This proposal goes hand in hand with the earlier recommendation to create a career path for nurses in government service. The DOH should also look into the possibility of replicating their program called

“Doctor to the Barrios” for the nursing sector. This program sends physicians to rural areas in the Philippines, giving these doctors incentives such as good compensation, postgraduate studies, trainings and allowances.

The nurse specialty training program in government hospitals is a good concept, which may need to be adjusted to the existing capacities of the Philippine public health care sector. For instance, instead of training programs in renal care, critical care or oncology as envisioned in the Nursing Act, wherein only few government hospitals offer this kind of specialty service, the government can focus on developing public health nurse specialists as proposed by the NLPGN. Public health nursing is deemed to be more viable given the current capacities of the health care system and more relevant to the health care needs of the Filipino people.

Another way of recognizing the nurses’ valuable contribution to health care is through the giving of annual awards to outstanding nurses in public health service. Although giving awards may be considered cliché, it can boost the morale of nurses who have been quietly serving in the government for so many years and affirm their commitment to public service. A similar program is being undertaken for the outstanding nurses in the private sector, and last year, the DOH gave out an award for the outstanding government doctor - it is timely for the government to give one for the nurses in public health service.

Non-financial benefits can be extended to the nurses’ families who are the main reason for the nurses’ decision to remain in the country. As recommended by the nurses in the focus groups, these incentives can be in the form of scholarship grants or tuition fee discounts in schools for the nurses’ children.

### **6.3.3. Review of the Magna Carta for Public Health Workers**

The Magna Carta for Public Health Workers is a policy that articulates the vital role of public health workers in the delivery of health care services. In recognizing health workers as valuable assets that needs to be developed and utilized, the Magna Carta specifies various financial and non-financial

mechanisms to promote the socio-economic well-being of health workers, to improve their working and living conditions, to enhance their capacities in delivering health care services by developing their skills and abilities, and to encourage health workers with high qualifications to remain in public service. As compared to the health human resource development provisions of the Nursing Act, the Magna Carta provides a more comprehensive policy framework for the development and retention of health care professionals in public service. In fact, the Magna Carta basically addresses all the issues raised by the National and LGU nurses regarding their working conditions: workload, nurse staffing, salaries and benefits, overtime pay, career and professional advancement and career path.

After its enactment in 1999, several efforts had been done to evaluate the implementation of the Magna Carta, but these mostly focused on the financial benefits provided under the Law. There is a need to revisit several key provisions in the Law particularly on workload, nurse staffing, overtime pay, professional development and career path, which have not been given enough attention but are vital to the improvement of the working conditions of public health workers. This research study, therefore, recommends a review of the Magna Carta for Public Health Workers, concentrating on the implementation of the provisions on work conditions and professional advancement, to fully tap this Law's potential as an effective and comprehensive retention strategy.

#### **6.4. Final Remarks – Nurses and the Philippine Health Care Sector**

As a concluding remark, it is clear that a retention strategy that adequately addresses the needs and conditions of nurses requires a bevy of interrelated policies and implementing mechanisms that are beyond the scope of the health human resource development provisions of the Nursing Act. A laundry list of retention strategies can be proposed but for the nurses, the link between their predicament and the prevailing conditions in the health care sector is unmistakable. The nurses who are in the country and have remained working in government hospitals do not ask much for themselves; they want their deplorable working conditions to get better so that they can provide better

quality of care to their patients. However, to improve the working conditions and address the needs of the long-ignored nurses, it is inescapably essential for the government to give priority to the long-neglected health care sector by providing the much needed resources to improve the health care system in the country. It is high time for the Philippine government to actualize its good intentions articulated in the Philippine Nursing Act of 2002 because the nurses are their most valuable partners and assets in fulfilling its responsibility of delivering affordable and quality health care services to its citizens.

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Global Health Workforce Alliance. <http://www.ghwa.org>

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International Council for Nurses. <http://www.icn.ch>

International Center for Human Resources in Nursing. <http://www.ichrn.org/>

International Center for Nurse Migration. <http://www.intlnursemigration.org/>

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### **Transcripts of Focus Group Interviews & Key Informant Interviews**

Transcript FGI I, II & III - LGU Nurses

Transcript of Interview – Chief Nurse - LGU Hospital

Transcript of Interview – Assistant Chief Nurse – LGU Hospital

Transcript of Interview – Chief of Hospital - LGU Hospital

Transcript FGI Ward II & DR – National Nurses

Transcript of Interview - Chief Nurse - National Hospital

Transcript of Interview - Chief of Hospital - National Hospital

Transcript of Interview – HHRDB-DOH Director

Transcript of Interview – President, NLPGN

Transcript of Interview – Former President, NLPGN

Transcript of Interview – President, PNA

Transcript of Interview – Former President, PNA

Transcript of Interview – Chairperson, Board of Nursing

Transcript of Interview – (2) Former Board Members, Board of Nursing

**ANNEX A –  
Section 2 and Sections 30-34 of Philippine Nursing Act of 2002**

**Republic Act No. 9173**

AN ACT PROVIDING FOR A MORE RESPONSIVE NURSING PROFESSION,  
REPEALING FOR THE PURPOSE REPUBLIC ACT NO. 7164, OTHERWISE  
KNOWN AS “THE PHILIPPINE NURSING ACT OF 1991” AND FOR OTHER  
PURPOSES

Be it enacted by the Senate and the House of Representatives of the Philippines  
in Congress assembled:

**ARTICLE I  
Title**

Section 1. Title. - This Act shall be known as the “Philippine Nursing Act of  
2002”.

**ARTICLE II  
Declaration of Policy**

Section 2. Declaration of Policy. — It is hereby declared the policy of the State  
to assume responsibility for the protection and improvement of the nursing profession  
by instituting measures that will result in relevant nursing education, humane working  
conditions, better career prospects and a dignified existence for our nurses.

The State hereby guarantees the delivery of quality basic health services  
through an adequate nursing personnel system throughout the country.

**ARTICLE VII  
Health Human Resources Production, Utilization and Development**

Section 30. Studies for Nursing Manpower Needs, Production, Utilization and  
Development. - The Board, in coordination with the accredited professional  
organization and appropriate government or private agencies shall initiate undertake  
and conduct studies on health human resources production, utilization and  
development.

Section 31. Comprehensive Nursing Specialty Program. - Within ninety (90)  
days from the effectivity of this Act, the Board in coordination with the accredited  
professional organization recognized specialty organizations and the Department of  
Health is hereby mandated to formulate and develop a comprehensive nursing specialty  
program that would upgrade the level of skill and competence of specialty nurse

clinicians in the country, such as but not limited to the areas of critical care, oncology, renal and such other areas as may be determined by the Board.

The beneficiaries of this program are obliged to serve in any Philippine hospital for a period of at least two (2) years and continuous service.

Section 32. Salary. - In order to enhance the general welfare, commitment to service and professionalism of nurses the minimum base pay of nurses working in the public health institutions shall not be lower than salary grade 15 prescribed under Republic Act No. 6758, otherwise known as the "Compensation and Classification Act of 1989": Provided, That for nurses working in local government units, adjustments to their salaries shall be in accordance with Section 10 of the said law.

Section 33. Funding for the Comprehensive Nursing Specialty Program. – The annual financial requirement needed to train at least ten percent (10%) of the nursing staff of the participating government hospital shall be chargeable against the income of the Philippine Charity Sweepstakes Office and the Philippine Amusement and Gaming Corporation, which shall equally share in the costs and shall be released to the Department of Health subject to accounting and auditing procedures: Provided, That the department of Health shall set the criteria for the availment of this program.

Section 34. Incentives and Benefits. - The Board of Nursing, in coordination with the Department of Health and other concerned government agencies, association of hospitals and the accredited professional organization shall establish an incentive and benefit system in the form of free hospital care for nurses and their dependents, scholarship grants and other non-cash benefits. The government and private hospitals are hereby mandated to maintain the standard nurse-patient ratio set by the Department of Health.

**ANNEX B**  
**MONTHLY SALARY SCHEDULE OF CIVILIAN PERSONNEL**  
 Effective July 1, 2007

Salary Grade	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6	STEP 7	STEP 8
1	5,590	5,730	5,873	6,020	6,171	6,325	6,483	6,645
2	6,094	6,246	6,402	6,563	6,725	6,894	7,066	7,244
3	6,643	6,808	6,977	7,153	7,330	7,515	7,701	7,895
4	7,174	7,352	7,536	7,724	7,918	8,116	8,318	8,526
5	7,747	7,941	8,139	8,342	8,551	8,765	8,984	9,209
6	8,367	8,576	8,791	9,010	9,236	9,467	9,703	9,946
7	8,953	9,175	9,405	9,640	9,882	10,128	10,382	10,643
8	9,580	9,819	10,064	10,316	10,573	10,837	11,109	11,386
9	10,250	10,506	10,769	11,039	11,315	11,596	11,888	12,183
10	10,933	11,207	11,486	11,774	12,068	12,371	12,680	12,997
11	11,589	11,878	12,175	12,478	12,792	13,112	13,440	13,774
12	12,284	12,591	12,906	13,229	13,559	13,899	14,245	14,601
13	13,021	13,347	13,680	14,022	14,372	14,732	15,101	15,477
14	13,801	14,147	14,500	14,863	15,235	15,616	16,006	16,405
15	14,630	14,995	15,370	15,754	16,148	16,553	16,965	17,391
16	15,508	15,895	16,292	16,701	17,117	17,546	17,985	18,434
17	16,438	16,849	17,270	17,701	18,146	18,599	19,064	19,540
18	17,425	17,861	18,307	18,765	19,235	19,714	20,208	20,713
19	18,471	18,932	19,405	19,891	20,389	20,898	21,420	21,955
20	19,579	20,068	20,569	21,085	21,612	22,152	22,705	23,274
21	20,361	20,871	21,393	21,927	22,475	23,036	23,614	24,203
22	21,176	21,705	22,248	22,804	23,375	23,959	24,558	25,171
23	22,022	22,573	23,139	23,717	24,308	24,917	25,540	26,179
24	22,905	23,477	24,065	24,665	25,284	25,915	26,563	27,227
25	23,821	24,417	25,026	25,653	26,293	26,951	27,624	28,316
26	24,773	25,392	26,028	26,678	27,345	28,028	28,730	29,448
27	25,764	26,409	27,070	27,745	28,438	29,150	29,878	30,626
28	26,795	27,465	28,152	28,855	29,576	30,315	31,074	31,851
29	27,866	28,564	29,277	30,009	30,760	31,529	32,317	33,124
30	31,763	32,557	33,372	34,205	35,060	35,937	36,835	37,755
31	44,468	45,580	46,718	47,886	49,083	50,311	51,568	52,857
32	50,820	52,091	53,393	54,728	56,096	57,498	58,936	60,409
33	63,525							

**ANNEX C**  
**PROPOSED CAREER PATH FOR NURSES IN GOVERNMENT**  
**(National League of Philippine Government Nurses)**

<b>Position</b>	<b>SG</b>	<b>Level</b>	<b>Gov't Sector</b>	<b>Education</b>	<b>Experience</b>	<b>Training</b>	<b>Eligibility</b>
Nurse I (Staff Nurse)	15	2	National/ Local	Completion of Bachelor's degree in Nursing	None required	None required	RA 1080
Nurse II (Head Nurse)	17	2	National/ Local	Completion of Bachelor's degree in Nursing and six (6) units of management in post graduate level	One (1) year relevant experience	6 hours of relevant training specific to supervision	RA 1080
Nurse III	19	2	National/ Local	Completion of Bachelor's degree in Nursing and nine (9) units of management in post-graduate level	Two (2) years relevant experience	8 hours of relevant training specific to supervision	RA 1080
Nurse IV	20	2	National/ Local	Completion of Bachelor's degree in Nursing and twelve (12) units of management in post-graduate level	Four (4) years relevant experience	16 hours of relevant supervision and management	RA 1080 Career Service (professional) Second level eligibility
Nurse V	21	2	National/ Local	Completion of Bachelor's degree in Nursing and and eighteen (18) units of management in post-graduate level	Five (5) years of relevant experience	24 hours of relevant training specific to supervision and management	RA 1080 Career Service (professional) Second level eligibility
Nurse VI	22	2	National/ Local	Completion of Bachelor's degree in Nursing and	Six (6) years of relevant experience	32 hours of relevant training specific to	RA 1080 Career Service (Professional) Second level

**ANNEX C**  
**PROPOSED CAREER PATH FOR NURSES IN GOVERNMENT**  
**(National League of Philippine Government Nurses)**

				completion of Master's degree in Nursing or degree related to the job		supervision and management	eligibility
Nurse VII	24	2	National/Local	Completion of Bachelor's degree in Nursing and completion of Master's degree in Nursing or degree related to the job	Eight (8) years of relevant experience	40 hours of relevant training specific to supervision and management	RA 1080 Career Service (Professional) Second level eligibility
Nurse VIII	26		National/Local	Completion of Bachelor's degree in Nursing and completion of Master's degree in Nursing or degree related to the job	Twelve (12) years of relevant experience preferably on nursing specialty programs	80 hours of relevant training specific to supervision and management preferably on nursing specialty and subspecialty programs	RA 1080 Career Service (Professional) Third level eligibility

ANNEX C - continuation  
**PROPOSED CAREER PATH FOR NURSES IN GOVERNMENT**

**REALLOCATION TO UPGRADED POSITIONS**

<b>Position Title</b>	<b>Salary Grade</b>	<b>Description</b>
Nurse I	15	Staff Nurse (DepED, Hospital)
Nurse II	17	Head Nurse (Operating Room Nurse) Public Health Nurse I Division Nurse in Charge (DepED)
Nurse III	19	Nurse Supervisor (Hospital Departments, Senior OR Nurse) Senior Public Health Nurse (Municipal Health Offices) Training Nurse (Hospitals and City Health Offices) Division Nurse Supervisor (DepEd)
Nurse IV	20	Chief Nurse (District Hospitals) Nurse Supervisors (Hospitals and Local Health Offices)
Nurse V	21	Chief Nurse (District Hospitals, Secondary Hospital)) Assistant Chief Nurse (Regional Hospitals) Nurse Program Supervisor (City Health Offices and Regional Nurse Supervisor (DECS), National Agencies health programs) Supervising Public Health Nurse Regional Nurse Supervisor (DOH)
Nurse VI	22	Chief Nurse (Regional Hospital) Assistant Chief Nurse (Medical Center or Nursing Division of big city health departments) Nurse Program Supervisor (Public Health Program Supervisor of NGAs like DepEd)) Nursing Adviser (DOH)
Nurse VII	24	Chief Nurse (Medical Center or Nursing Division of big city health departments)
Nurse VIII	26	Specialty Nurse Clinicians Nurse Researchers Chief Nursing Officer (DOH)

ANNEX C – continuation

**EXISTING CAREER PATH**

<b>Position</b>	<b>SG</b>	<b>Level</b>	<b>Gov't Sector</b>	<b>Education</b>	<b>Experience</b>	<b>Eligibility</b>
Nurse I/Public Health Nurse I (Staff Nurse)	10/12	2	National/Local	Completion of Bachelor's degree in Nursing	None required	RA 1080
Nurse II/Public Health Nurse II (Head Nurse)	14/16	2	National/Local	Completion of Bachelor's degree in Nursing	One (1) year relevant experience	RA 1080
Nurse III/Public Health Nurse III	16/19	2	National/Local	Completion of Bachelor's degree in Nursing and twelve (12) units of management in post-graduate level	Two (2) years relevant experience	RA 1080
Nurse IV	18	2	National/Local	Completion of Bachelor's degree in Nursing and 18 units of management in post-graduate level	Four (4) years relevant experience	RA 1080 Career Service (professional) Second level eligibility
Nurse V	20	2	National/Local	Completion of Bachelor's degree in Nursing and 18 units of management in post-graduate level	Five (5) years of relevant experience	RA 1080 Career Service (professional) Second level eligibility
Nurse VI	22	2	National/Local	Completion of Bachelor's degree in Nursing and 24 units of management in post-graduate level	Six (6) years of relevant experience	RA 1080 Career Service (Professional) Second level eligibility
Nurse VII	24	2	National/Local	Completion of Bachelor's degree in Nursing and completion of Master's degree in management in post-graduate level in Nursing or degree related to the job	Eight (8) years of relevant experience	RA 1080 Career Service (Professional) Second level eligibility