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Human Resource Development and the Mobility of Skilled Labour in Southeast Asia: The Case for Nurses

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Introduction

Human Resource Development and the Mobility of Skilled Labour in Southeast Asia: The Case for Nurses

Yuko Tsujita*

Movement of people is the key component deepening regional integration. In the ASEAN countries, the AEC Blueprint 2025, places particular emphasis on facilitating the movement of skilled labour, while it is silent about unskilled labour. However, there is a wide gap between policy aspiration and reality; the overwhelming majority of intra-ASEAN migrants are still confined to low- and middle-skilled labour, heavily concentrated in a few corridors in terms of the flow of labour (Sugiyarto and Agunias 2014). Notably, a large part of such labour migration in the region continues to be irregular (ADBI et al., 2014). A lack of legal status exposes undocumented workers to a wide range of abuses in terms of wages, employment conditions, housing, and so on. Therefore, the existing literature in this area of research tends to be policy-oriented, based on a legal and rights-based approach.

In contrast, the mobility of skilled labour, mainly professionals, but not limited to them, is still restricted. Some countries, such as Singapore, have exemplified the economic benefit of foreign skilled labour to their economy, including brain gain, enhanced productivity, economic growth, reduction of labour shortages, etc. Therefore, skilled migration enables the countries of the workers' origin to reduce the numbers of well-educated unemployed people, gain from remittances home, the transfer of technology and/or knowledge, and achieve accelerated productivity thanks to returning migrants (so-called brain circulation) etc. (e.g. OECD 2001). The aim of facilitating the seamless movement of skilled labour in ASEAN was started by Mutual Recognition Arrangements (MRAs) for eight professions, including engineering, architecture, medical services, and so on that would allow practitioners to practice in other ASEAN countries through mutual recognition of their qualifications. In this research project, nursing is used as the example of a professional service in the ASEAN region, for the

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following reasons.

As developed countries, some East Asian and ASEAN countries are facing the progressive ageing of their populations, a shortage of 'home grown' nurses that limits a family's ability and availability to take care of their dependents under the current demographic, economic, and social transformation; therefore, the demand for nurses has grown rapidly. This high demand has accelerated in recent years due to the increasing demand for quality healthcare in the developing countries, and there is an urgent need for nurses. Therefore, it is important and urgent to investigate how the ASEAN countries can respond to the global and regional shortage of nurses under the current demographic changes and the increasing the demand for better quality healthcare.

Specifically, this research project extends and deepens Fukunaga (2015) that assessed the progress of ASEAN MRAs concerning professional services. He observed that while the MRAs in architectural and engineering services had made steady progress, the MRA for nursing services, which was signed and came into force in December 2012, has facilitated nurses' mobility in only a few countries. The cost of skilled migration tends to be lower, as the cost of migration seems to rise as the level of skill falls (UNDP 2009). Moreover, in some ASEAN countries nurses are in great demand. This raises questions as to why nurses, as skilled labour, do not move across borders in the ASEAN countries when the global mobility of nurses has increased significantly, whether the quality of nurses is high and good enough to work overseas, whether qualified nurses are willing to work in other ASEAN countries, and to what extent the ASEAN countries promote the 'export' and 'import' of nurses, and so on. Indeed, the situation and changes in terms of human resource development and the mobility of nurses are still under-researched. Therefore, it is important to analyse comprehensively the education, employment, and migration for nurses in ASEAN.

This research project studied three countries. On the one hand, the Philippines and India are considered as nurse-dispatching countries. It is reported the Philippines and India account for the largest share of migrant nurses in the OECD countries and flows from these two countries have increased in recent years (OECD 2015). As most ASEAN countries do not distinguish between foreign nurses from ASEAN and non-ASEAN countries, the number of foreign nurses in some recipient countries in the ASEAN region is likely to be dominated by these countries. At the same time, there is expected to be a difference by these two countries in terms of human resource development and mobility. How these two

countries educate their nurses and push them to work overseas is compared and contrasted.

On the other hand, Thailand is taken as the example of a potential nurse-receiving country. Thailand promotes medical tourism and gears its healthcare industry towards international services. Moreover, the country is facing the rapid ageing of its population. There is a shortage of trained nurses in the country. However, the country has a restrictive policy on recruiting foreign trained nurses. An attempt has been made to illustrate Thailand's latest policies and institutions that recruit foreign-trained nurses, and investigate some details of the foreign-trained nurses and other foreigners engaged in providing health care services in that country.

The implications of the MRA on nursing services from Thailand and the Philippines are as follows.

From the perspective of Thailand, knowledge of the MRA concerning nursing services is limited to registered nurses and nursing students. In fact, they tend to have a slightly negative attitude against an open labour market for nursing services. Comparatively, nursing students have a better knowledge about the MRA than the registered nurses. Both students and registered nurses worry about the fact they may be less competent in English proficiency than nurses from other ASEAN member countries, and that the labour market would be more competitive given their notion of nurses from ASEAN member countries that come to provide such services in Thailand. Students, nursing school administrators, and the Thailand Nursing and Midwifery Council recognise the need to improve foreign language proficiency and foreign culture literacy, particularly in English, and the language and culture of the ASEAN member countries. Basically, many registered nurses in Thailand lack the interest in migrating to work abroad.

The chapter on the Philippines argues that the MRA can benefit the Philippines in two ways: Firstly, Filipino nurses will be allowed easier access to the labour market of the host (potential) countries within ASEAN, such as Singapore, Malaysia, and Thailand. Secondly, and perhaps more feasibly and more importantly, the MRA will allow students from other ASEAN countries, especially those who wish to work in English-speaking countries, to study in the Philippines. However, a possible disadvantage is that the students from other ASEAN countries may compete with the Filipino nurses in the international labour market. The benefits are based on the assumption that ASEAN MRAs will be fully implemented by the member countries. As it is, this is rather a tall order and a great challenge, especially

as it requires a consensus on the core training and education standards as well as the quality assurance standard by the member countries.

As major nurse-dispatching countries, there are differences and similarities regarding migration of nurses from the Philippines and India. The Philippines promote overseas employment, while emigration is regarded as an individual choice by India. Both countries currently suffer from a shortage of nurses partly due to the increasing international demand for trained nurses. In the Philippines, the growing demand for nurses in the non-nursing sector vis-à-vis the decreasing supply in recent years, has also contributed to the shortage of nurses. By contrast, India suffers from a chronic shortage of supply, particularly in some parts of the country. As for nursing education, the growing international demand has increased the number of educational institutions attracting younger nursing candidates. The career choice of becoming a nurse is the means to access overseas employment opportunities from both countries. The quality of nursing education is uneven across the educational facilities in the Philippines and India. Although nurses are educated in English in both countries, the quality of nursing education is considered to be one of the reasons why a degree from these countries is not automatically recognised by developed English-speaking countries.

This research project describes a wide range of aspects concerning nursing education and mobility. The reader may determine whether or not some parts of each chapter, if not all the chapters, are interesting and useful.

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Chapter 1

Human Resource Development and International Mobility of Professional Nurses: The Philippine Perspective

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Abstract

The Philippines is known to be one of the largest 'exporters' of nursing professionals in the world, topping the list of Filipino skilled workers overseas. Registered nurses (RNs) also comprise the biggest category of health workforce in the country. Analysis of available statistical data implies that the labour market for Filipino RNs is characterized by three important and interrelated features: nursing is a popular course in Philippine colleges and universities; it is highly dependent on the demand-led international labour market; and that the country needs to "manage" its nurse labor market to address international and domestic demand appropriately and in a timely manner.

It is against these backgrounds that we examine the trends and issues in the nursing education system and labour market for nurses in the country and describe how the country has become heavily dependent on the demand-led international labour market. We also explained how the nurses, through their coping mechanisms, and the Philippine government, through its policy interventions, address the market. Moreover, we argue that the ASEAN mutual recognition arrangement (MRA) on nursing services may ease mobility not only of Filipino nurses but also nursing students and, by uplifting the quality of nursing education, raise the international competitiveness of Philippine RNs.

Our analysis will be based on the market demand-supply framework utilizing both quantitative (from surveys and public file statistics) and qualitative (from interviews and literature review) data. Interviews with nurses working both overseas and in the Philippines, nursing students, deans of nursing schools and nurse administrators of a private and a government hospital were conducted in August, 2016. Moreover, a survey of nursing students (n=315) and nursing graduates (n=110) and nursing schools (n=6) were also administered to understand the trends and issues in the mobility of nurses in the country.

Introduction

The Philippines is known to be one of the largest 'exporters' of labour in the world. The number of Filipino workers deployed overseas tripled in the last 15 years, and in 2015 alone, the total number based on type of hiring (new hires and rehires) has reached 1.84 million, of which 22 per cent, or 406,531 is sea-based (for example, seafarers and service staff in cruise ships) and the rest, 77 per cent or 1,437,875, is land-based (Figure 1.1). Of this, nursing professionals[1] make up the biggest number of skilled overseas Filipino workers (OFWs). Data for 2015 show that they occupy five per cent (22,175) of the total annual deployment (new hires); exceeded only by less-skilled workers such as the household service workers at 38 per cent (194,835), and manufacturing labourers at about eight per cent (41,038).[2] In terms of stocks, OECD (2015) estimates that about 221,000 Filipino nurses work in its member countries. Available data from POEA shows that a total of 256,487 nursing professionals left the country as new hires from 1992 to 2015.

At the same time, nurses also comprise the biggest category of health workforce, with the estimated stock of registered nurses (RNs) reaching 864,757 in 2016.[3] The Philippine Nurses' Association (PNA) in 2015 claimed that of this number, there were only a total of 42,000 RNs working in both government and private hospitals, while over 200,000 RNs are jobless and 300,000 were reported to be taking up non-nursing jobs (Philippine Nurses Association, 2015). The rest are likely to have gone to work overseas.

Based on these data, the labour market for Filipino professional nurses is characterized by three important and interrelated features: first, that it is a popular course for students in college; second, that it is highly dependent on the international labour market; and third, that the country is struggling to keep a balance between labour supply and demand for nurses. Keeping these three features in mind, we examine the trends and issues in the labour market for nurses in the country and describe how the country can

[1] The term that the Philippine Overseas Employment Administration (POEA) uses for those who left to work as nurses overseas, regardless of whether they pass the National Licensure Examination. Since most destinations require or prefer those who passed (the registered nurses or RNs), and there is only one category of professional nurses (the RNs) in the country, the terms "nurses" and "RNs" will be used to refer to the same thing, unless specified.

[2] This statistical data excludes those who initially left the country as tourists, students, immigrants and others. Therefore, the data presented on nurse migration are generally underreported. Neither does POEA take data on those who have returned permanently or returned overseas but hired by a new employer.

[3] The total number of those who passed the National Licensure Examination for nurses from 1951 to 2016, as calculated using data from Professional Regulation Commission (PRC). This number is unadjusted for deaths and retirements.

address or "manage" the demand-led international labour market. Of the various policy interventions, we focus on the ASEAN Mutual Recognition Arrangement (MRA), an example of Asian Framework Agreement and evaluate its impact on the nurse labor market. The MRA, if fully implemented, can potentially benefit the Filipino professional nurses who will have more opportunities to work overseas and more choices of destinations. It will also encourage mobility of students within ASEAN and uplift the quality of nurse education in the Philippines, which in turn will contribute to the competitiveness of Filipino nurses.

This chapter is organized as follows: In section 1, we briefly explain the analytical framework and methodology of the paper. In section 2, to better understand the human resource development in nursing in the country, we will describe the history of nursing education and also the current education system for nurses in the country. In section 3, we will present the trends in the supply of nurses and analyze the factors affecting its changes, citing particularly personal preferences of nursing students and graduates towards the nursing profession and working as a nurse. In section 4, we turn our attention on both the domestic and international demand side, and emphasize how the labour market for nurses in the country is highly influenced by international demand which is, in turn, guided by unpredictable migration and labour policies of the destinations. In section 5, we attempt to show the extent of imbalance in the labour market and identify the factors affecting the gap between demand and supply. We emphasize that the Philippines is highly dependent on the unpredictable international demand and "managing" such international demand-led market is a big challenge. Taking the example of nurse migration and production in 2004-2014, we also describe the ways in which nurses, through their stepwise migration and employment in non-nursing sectors, as well as the government, through its policy interventions that affect both demand and supply, address these gaps. In the last section, we take up the ASEAN Mutual Recognition Agreement (MRA). We end this chapter with a summary and conclusions, as well as topics for future research.

1. Analytical Framework and Methodology

In this chapter, we employ the simple labour market demand-supply analysis as our framework. Using Figure 1.2, we illustrate the case of the Philippines.

On the supply-side, we begin our analysis with the issues concerning nursing schools, which, as Ortiga (2014) argues, are "embedded" in the global nursing care chain as they

produce professional nurses for deployment overseas. Nursing schools produce graduates who need to pass the National Licensure Examination (NLE) and register with the Professional Regulatory Board (PRC) to be able to practice the profession. They are called the RNs, the only category of professional nurses in the country. One feature of this labor market is that the supply of RNs for overseas deployment is only a subset of the RNs produced in the country. This is because most overseas destinations require adequate experience which can only be gained by working as staff nurse in hospitals and healthcare institutions.

Meanwhile, there are four kinds of demand for RNs, in the nursing and non-nursing sectors within and outside the country. RNs who work within the healthcare systems in the Philippines and in the destinations can be found in government or private hospitals and in other health care facilities such as private clinics, local government unit health stations, and school infirmaries. Because it is difficult to estimate the actual demand, we will use data for employed RNs in this study. Working in sectors other than in the hospitals and other health care facilities as professional nurses, within and outside the country, has also gained popularity in recent years. They are engaged in education, business process outsourcing (BPO) as call center agents, elderly care services as caregivers and financial industries, which the PNA considers as "underemployed." The rest of RNs who cannot find job within or outside the country, and in nursing or non-nursing sector, comprise the pool of unemployed nurses.

In this study, we utilize both quantitative (from surveys and public file statistics) and qualitative (from interviews and literature review) data. Three sets of surveys - for nursing graduates of a nursing school (n=110), current enrollees of nursing schools (n=315) and nursing schools (n=6) - were conducted from October 2016 to January 2017 (see attached Appendix for the questionnaire) in Central Luzon and Metro Manila. In addition, six group interviews (for current nursing students, nursing instructors, deans of nursing schools, nurses working overseas, parents of nurses who are currently working overseas, nurses working in the Philippines) and two individual interviews to chief nurses, one each in a government and private hospital. The interviews were executed in August, 2016 in the province of Bulacan and in Metro Manila.

2. Brief History and Current Trends in Nursing Education in the Philippines

To set the stage, first, we describe the history of nursing education and also the current education system for nurses in the country. Before nursing education was formalized, human resource development in nursing consisted of on-the-job training or apprentice method for those who wanted to work as nurses. Nursing education and profession were formally introduced by the Americans. The profession is guided by nursing laws that had been periodically revised to attain the standards set by the domestic and international nursing institutions. Currently, there is only one basic nursing professional program, the four–year Bachelor of Science in Nursing. This is the only pathway to qualify for the Nursing Licensure Examination (NLE), which is the requirement to practice nursing in the country. The current curriculum has incorporated subjects that are intended to prepare students to become professional nurses who are able to meet the health care needs of the Filipinos and that of the global clients. Moreover, the education system is currently undergoing important restructuring to keep up with international standards, particularly in the light of the ASEAN integration process (discussed in detail in Appendix A.1).

2.1. History of Nursing Education in the Philippines

Nursing education in the Philippines, as narrated by Wayne (2015), has evolved from the context of simple nutrition, wound care, and taking care of an ill member of the family, to caring for sick individuals in the hospital, usually rendered by male assistants, during the Spanish regime. During the war with Spain, however, many women have assumed the role of nurses in order to assist the wounded soldiers. Prominent women who volunteered and did nursing services during the revolution brought about the development of the Philippine Red Cross.

After the American occupation of Manila in 1898, the American nurses began to train women to work as nurses. The formal training to become a nurse started with the opening of several nursing schools in the country in early 1900s but it was in 1907 that the first organized system of instruction began at the Philippine Normal School (Tupaz, 1961, p.20-21). It was also around this period that the *Pensionado* Act of 1903 (or Act No. 854) was implemented to allow Filipino nursing students to study in the United States. About the same year, Mary Coleman Masters, an American educator, advocated to train women for the profession of nursing. From the apprenticeship cycle, the expansion of hospital schools of nursing provided training of nurses at bedside towards the completion of a three-year course leading to Graduate in Nursing (GN). While there were many subjects similar to those taken up in the US, it also included those that were relevant to the Philippine setting.

2.2. Laws Regulating Philippine Nursing Education and Profession

Up to this date, several laws and guidelines have been put in place to regulate nursing education and practice in the country.

The first attempt to regulate the practice of nursing in the Philippines was in 1915, when the Act No. 2493 that amends the Medical Law (Act No. 310) relating to the practice of medicine was promulgated. In this Act, there were only two sections that referred to the practice of nursing. Section 7 of this Act prescribes the requirements to practice as registered nurse, while section 8 prohibits the practice of any person as a nurse without the certificate of registration (Sand & Robles, 1988, 243-245).

The Laws Governing the Practice of the Nursing Profession (1919-1953) that was promulgated in 1919 is considered as the true and the first nursing law in the Philippines. It was intended to regulate the practice of nursing and to raise its standard of practice by establishing the Board of Examiners for Nursing (BEN), which conducted the first Nursing Board Examination in 1920 (Sand & Robles, 1988, 244). In addition to the said Law, Act No. 2808 as amended by Acts No. 3025, 3438, and 4007 and Republic Acts No. 465 and 546 governed the practice of nursing profession from 1919 to 1953.

In 1953, the Congress of the Philippines enacted the Republic Act No. 877, known as the "Philippine Nursing Law". The Act includes the organization of the Board of Examiners for Nurses, provisions regarding nursing schools and colleges, examination, registration of nurses, including miscellaneous provisions relative to the practice of nursing. It also stipulates that the practice of nursing in the Philippines without holding a valid certificate of registration issued by the BEN is unlawful and will be subject to penalty.

Later on in 1976, Department Order No. 42, s. 1976 provided for the revision of the three-year Graduate Nursing (GN) and the four-year BSN programs, which was approved and implemented in staggered school terms effective school year 1976-1977. The old Graduate Nurse course was phased-out, producing the last batch of graduates in 1979. On the other hand, the first graduates of the four-year BSN program were in 1980, which eventually became the only existing program in nursing in the country (ADPCN, 2011).

The law experienced an overhaul with the passing of the Republic Act No. 7164, known as the "Philippine Nursing Act of 1991," which codified and revised all laws regulating the practice of nursing in the country. Eleven years later, the "Philippine Nursing Act of 2002" was enacted to provide for nursing profession that is more responsive both to domestic and international concerns and "integrates nursing education

in the overarching state policy on labour export for economic development." (Cabanda, 2017). In the design process leading to the passing of this Law, the state was able to regulate the nursing profession by engaging the higher education institutions and the PRC to produce excellent quality nurses that are able to better compete overseas (Cabanda, 2017; Ortiga, 2014).

In 2010, the 15th Philippine Congress proposed and deliberated the amendment of the 2002 Nursing Act, but was not acted upon by the Senate. The Bill proposed to: (1) provide a holistic, safe and quality care to clients in various health settings; (2) create a healthy working environment, humane staffing patterns, rational compensation and benefits; and (3) promote professional growth and career advancement and opportunities for certification and recognition locally and abroad (Association of Deans of Philippine Colleges of Nursing (ADPCN), 2011). It was re-filed and approved in the 16th Congress (2013-2016), but was vetoed by then President Benigno Aquino. Currently, there is again a proposed nursing bill in the 17th Congress drafted and fully supported by the Professional Regulations Commission Board of Nursing (PRC-BON) and members of the Technical Working Group (TWG) from different nursing organizations. Once enacted by both the Senate and House of Representatives of the Philippines, the Act will be known as the "Comprehensive Nursing Law of 2016."

2.3. The Development of the Philippine Nursing Curriculum

The Philippine nursing curriculum has undergone several changes over the years. For 42 years (1906 to 1948), there has only been one training program for the nurses, the Graduate Nurse Program. In 1948, it was revised into a five-year integrated program leading to Bachelor of Science in Nursing degree (Sotejo, 1985), administered by university-based College of Nursing. The course had a balanced distribution of technical and cultural subjects intended to enhance the personal and professional development of students (Tupaz, 1961).

In 1976, the curriculum was again revised to include two programs: the three-year Graduate Nursing (GN) that was phased-out in 1979; and the four-year BSN program, which was approved and implemented in staggered school terms effective school year 1976-1977. After the phase-out of the GN program, nursing started to be recognized as a profession. Schools offering the three-year GN program converted to the BSN program, resulting in the notable increase in the number of schools (see Table 1.1).

The BSN curriculum was again revised with decrees and orders from the Ministry of Education, Culture and Sports (MECS) in 1984 and from the Commission on Higher

Education (CHED) in 2001. Based on the latter's amendment, the two-year Associate in Health Science Education (AHSE) was integrated into the BSN curriculum as entry to any health course. This was followed by CHED Memorandum Order (CMO) No. 14, s. of 2009, superseding CMO No. 30, s. 2001, which outlines the policies and standards for the four-year BSN program. It aims to "rationalize nursing education in the country to provide relevant and quality health services locally and internationally" (CHED, 2009:1, emphasis provided by authors) and designed within the context of Philippine society, with caring as its core and foundation. The curriculum takes a trans-disciplinary approach with strong liberal arts and sciences education. (For details, see Appendix A.1).

2.4. Salient Features of the Current Philippine BSN Curriculum

At present, the country has only one basic nursing professional program, the four–year Bachelor of Science in Nursing (BSN), consisting of general education and professional courses. From the first year, students are already introduced to professional courses until fourth year to gradually develop the required competencies. One example is the intensive nursing practicum undertaken by students, which aims to refine their clinical skills from the first-year level to ensure that they have developed the basic clinical competencies required of a beginning nurse practitioner. The program is a competency-based, community-oriented curriculum, with the nursing practitioner having a trifocal role: client care, management and leadership, and research (CMO 14 s. 2009).

The BSN curriculum includes 87 units of general education and health sciences subjects and 115 units of professional courses, for a total of 202 units. The minimum number of units/hours of the Related Learning Experiences (RLE)/clinical duty totals 46 units, equivalent to 2,346 hours. (For details about the current BSN curriculum, see Appendix A.1)

In order to maintain the quality of nursing education, the CHED Policies, Standards and Guidelines should be complied with by the institution in terms of the qualifications of the deans and faculty, the availability of adequate physical facilities and nursing laboratories, updated library collections, the presence of health facility (base hospital) for the related learning experiences of students, and an NLE passing percentage of not lower than 30 percentage for three consecutive years. Concerned nursing schools who failed to comply with the given requirements shall be subjected to immediate phase-out or involuntary closure (CHED CMO 18 s. 2011). As of April 2014, there are 301 nursing schools in the positive list given by CHED, out of the 491 nursing schools listed by ADPCN. Moreover, the nursing schools existing for a period of five years are encouraged

by CHED to undergo program accreditation (CHED CMO 5 s. 2008). At present, accreditation, as a quality assurance measure, is a voluntary initiative, and schools may choose from existing accrediting agencies.

With the reforms in the Philippine Educational System such as the shift to outcomes–based education (OBE), the four-year BSN Curriculum is now undergoing transformation and innovations on how to achieve the best learning outcomes (For details, see Appendix A.1). The CHED Technical Committee for Nursing Education is now in the process of drafting the OBE BSN curriculum, which will be implemented in school year 2018-2019. In the process of transforming the current curriculum, a series of workshops and public hearings led to the addition of the general education courses like Health Care Ethics (Bioethics), and Clinical Reasoning and Decision Making (Logic and Critical Thinking). Moreover, Pharmacology, Nursing Research, Decent Work Employment and Transcultural Nursing are being offered as nursing major courses. These courses aim to develop the competencies for global health care standards needed by the nursing graduates to be aligned with the mutual recognition arrangements with other countries.

Looking back at the history of nursing education and profession in the Philippines, it can be said that while initially it was influenced by the United States, they have progressed through times with consideration for domestic needs, and later on, as proactive response to international demand for professional nurses. These were undertaken through amendments in the laws governing nursing profession and education as well as revisions in the nursing curriculum aimed at raising the competence of the nurses and their competitiveness locally and globally. Keeping these in mind, we will analyze the trends and issues in the production of nurses in the country in the next section.

3. Production and Supply of Nurses in the Philippines

In order to provide a more realistic assessment of the supply of RNs in the country, we first describe the trends in the nursing education industry and the factors affecting the decision of students to take up nursing. We then look more closely on the trends in NLE, the passing of which is the entry point to work as professional nurses in the country. Finally, we also look at their retention and the factors affecting it, particularly their working conditions, attitudes and preferences towards the profession.

3.1. Nursing Enrolment and Graduates

Nursing has emerged as one of the most popular courses in Philippine universities.

Records from CHED reveal that nurse enrolment experienced dramatic changes in the past 15 years. As shown in Figure 1.3, enrolment rose rapidly from school year 2000-01 until 2006-07 at a rate of around six to seven per cent annually. At its peak around 2006, the 460 nursing schools had 452,793 enrollees, comprising 17 per cent of the general enrollees in universities (Arends-Kuenning, Calara & Go, 2015:8) and registering a 1,459 per cent increase in a span of 6 years.

From 2007-08, however, the number of enrolment began to decline rapidly. This can be largely attributed to developments in the international labor market, such as the retrogression policy in the US and expansion of nursing schools in the UK. With the continuing strict nurse recruitment and employment regulations in popular destinations, the enrolment in 2010-2011 slid to about half of that in 2006-2007. Enrolment further decreased in 2016-2017 because of the implementation of the K to 12 program[4] in which high school students will need to spend two more years in senior high school before qualifying to enter college. This forced some nursing schools to close down or field its instructors to non-teaching jobs within the college or university temporarily until the time regular college enrolment resumes in 2018-2019.

The popularity of nursing course in circa 2000s resulting from the opening of foreign markets, particularly the preferred destinations, led to the mushrooming of nursing schools in the same period. In Table 1.1, we can see that in the 1990s, there were only 125 schools, but beginning in 2000-2001 until 2007-2008, the number gradually ballooned reaching more than three times as many after eight years to 466; and in 2013, it was reported that there are 491 all over the country (Manzala, 2013).

While such proliferation of nursing schools absorbed the increasing demand for nurse education, it also imposed serious burden to the sector, especially in terms of qualified clinical instructors, classrooms and laboratory facilities as well as base hospitals, which resulted in the marked deterioration of its quality. In one of the big universities in Manila, the number of sections (of about 50 students per section) ballooned to three times as many as the number of available classrooms, forcing the faculty to reduce the number of courses or compress their contents. One clinical instructor recalled how difficult it was to teach practicum courses because students were not able to learn the fundamentals in their lecture courses. In this way, the nursing schools and the students bore the burden of adjusting the nursing education curriculum and instruction system to meet the demands

[4] The Philippines was among the three countries (the other two being Angola and Djibouti) in the world that require only 10-year pre-university schooling. The K to 12 program is aimed at aligning the Philippine educational system with the international standard of 12 years.

of the international labour market.

The decline in the passing rate in the NLE (see below) is a proof of the marked deterioration in the quality of nursing education. A number of schools even failed, in a period of five years, to produce even one graduate who had passed the examination (Alave, 2009). This prompted CHED to take up measures to curb the number and improve the quality by issuing a memorandum order that all BSN programs that had average passing rates of 30 per cent and below for a three-year period starting in 2008 would be issued orders for immediate closure (CHED, 2011). In 2013, it ordered the closing down of 218 nursing schools and programs nationwide that did not perform satisfactorily in the NLE and satisfy faculty and facility requirements (Cueto, 2013; Pazzibugan, 2013). [5] The government also imposed moratorium in the opening of new nursing schools in mid-2000s (Carlos, 2013; Arends-Kuenning, Calara & Go, 2015). However, despite this temporary stop order, the number continuously increased because of political and business pressures on CHED to allow even schools with pending application to operate (see Table 1.1) (Bagaoisan & Ching, 2009).

In addition to the "marked" deterioration in the quality of schools, the declining demand overseas for foreign nurses, particularly the USA and UK, was also cited as a reason for the regulatory board to attempt to curb its number. The demand for Filipino nurses "plateaued" in 2006 because of policies initiated by these two destinations. The resulting high unemployment and underemployment rates for RNs, which was estimated to be around 400,000 at that time, prompted the PNA to discourage enrolment in nursing (IOM Institute of Medicine, 2011). For its part, ADPCN urged students to choose schools with high standards. Schools were also strongly encouraged to get accreditation for quality assurance in order to attract and produce high quality nurses.

Crucial in understanding the dramatic changes in the number of enrollees and RNs in accordance with the developments in the international labour market is the motivation on why Filipino students take up nursing in college. When students participating in the survey were asked to what extent the various reasons impacted on their decision to take up nursing, it appeared that factors related to international migration play an important role, not only directly influencing it but also via its economic impact on the family (Table

[5] These schools have 30 percent and below passing rate in the licensure exams for the past three years. Some of the schools also failed to meet government standards in terms of the quality of their faculty and facilities. These schools were no longer allowed to take in first year students and many have transferred their current students to other nursing schools. The names of these schools, however, were not announced because 77 of them have appealed their case (Cueto, 2013).

1.2). Topping the list is “To help support the family financially.” Considering that salary of nurses in the Philippines is low, this motivation can be considered as strongly tied to overseas employment. On the other hand, working abroad per se, which means more than economic rewards and include the desire to travel and experience working and living in another culture, ranked fourth. Further statistical testing, however, is needed in order to establish to what extent economic, social and other clusters of factors influence the choice of nursing as a course and profession.

The same trend is also detected in the case of nursing graduates in the survey as shown in Table 1.3. The top four reasons were the same, but “to provide service to the sick and needy” rather than “to help support the family” proved to be the strongest motivation. This suggests that in contrast to current students, for the graduates, dedication to the profession, rather than economic motivations, generally came first when they decided to take up nursing. It was also interesting to know that when the respondents were categorized based on their year of graduation (1980, 1990, 2000-) and their means were tested for differences, it was only the mean values for “to work abroad” that were statistically significant, with the graduates in 2000s having the highest score. This implies that the graduates of 2000s~ were most highly motivated by international migration when they took up nursing. This period coincides with the time when overseas demand for nurses was high, especially in highly preferred countries.

It was also interesting to see the influence of the family in the choice of course in the Philippines. About 74 per cent of the students had a nurse in the family, and 34 per cent had aunts who most probably work overseas and pay for the students’ education, as many of the students interviewed attested to. Moreover, when asked about their preference regarding destination country, family and friends in the destination topped the reasons for their choice. This finding suggests that nurse migration in the country is sustained by the international network of families and friends that does not only provide easy access to information on the conditions in the destinations and provide support to make resettlement easier but also facilitates the “production” of succeeding generations of nurses through their remittances.

3.2. Professional Nurses (or Registered Nurses)

The RNs form the biggest group of healthcare professionals in the Philippines (Lorenzo et.al. 2007). Based on the records of the PRC, the number of those who passed the NLE from 1951 to 2016, or the cumulative stock of RNs in the country is 864,757 (unadjusted for deaths and retirement), with more than 80 per cent produced in the last 25 years from

1991-2016 (see Table 1.4).

Focusing on the period 1994-2016, the annual production of nurses, based on the number of takers and passers, displays a "roller coaster"-like trend. In Figure 1.4, we can see that the number of both takers and passers gradually decreased from a "low" peak in 1994 until 2001, then steeped off from early 2004. It again peaked at a higher point in 2009 and 2010, then tapered off to reach the 1996 level in 2016, with passers declining at an average of 17 per cent annually in the past six years. Considering that the peak of enrolment was in 2006-2007, it comes as no surprise that the biggest cohort took the NLE sometime in 2009-2010.

The number of those who passed the NLE, however, was not in uniform proportion with the number of those who took it. At the time when the takers were many, the passing rates were alarmingly low. Data from 1994 (Figure 1.5) reveal that while the average passing rate prior to 2002 was 54 per cent, it went down by 10 points to 44 per cent between 2002 and 2016, and registered a record low of 37.12 per cent in 2013. It is also worthy to note that the lowest passing percentages of about 40 per cent were concentrated in the years 2009 to 2012, which was also the peak period in the number of graduates. The quality of nursing graduates could have been affected by the lack of preparedness of higher education institutions to handle a large population of students and a large number of poor-performing schools. Moreover, although the performance after 2013 appeared to be rising up until 2015 when it breached the 50 per cent mark, it again plunged to 45.67 per cent the following year. Based only on these figures, it cannot be said that the recent steps by the government to curb schools and put quality assurance programs in place have shown its impact on the quality of recent graduates of nursing. The supply of RNs is expected to increase at a very low rate in the next five years or so; not only because of the graduates' poor performance in the NLE, but also because there is a smaller number of graduates who will take it.

3.3. Retention of Nurses

In examining labour supply, the retention or turn-over issue is more often set aside especially when there is a surplus in the market. In the case of the Philippines in circa 2000s, the increasing and frequent resignations of nurses were immediately covered by a ready pool of nurses who were willing to assume the job and endure hard work in hospitals even as volunteers with minimal or no salary at all. These nurses were keen to work preferably in tertiary hospitals, only in order to acquire the hospital experience required to work overseas so that once the required number of years of experience is

acquired, they applied for a job overseas.[6] Since experienced and specialized nurses were in demand overseas, sometimes, several, or even the entire team of nurses in the same specialty ward would quit and work together in the same hospital overseas. While such high turn-over created skills and geographical imbalance (since many tertiary hospitals were in cities), these were not priority issues that were immediately addressed because of the ready pool of nurses (Carlos & Sato, 2010, 2011).

The poor working conditions of RNs in the Philippines is a strong motivation for them to leave the country. Nursing, both as a college course and as a job, is physically and mentally demanding and stressful. Both students and graduates in the survey were aware of the hardships of the profession in the country, such as the high ratio of patients to nurses, low salary and few benefits, and poor working conditions such as long working hours, night shifts and health hazards. The ratio of nurses to patients ranges from about 15 to 40+ patients assigned to one nurse per shift, exceeding the ideal ratio of 1:12 suggested by the Department of Health (DOH). This ratio also varies considerably based on whether the hospital is private or public, or is in an urban or rural setting. Especially in government hospitals, the number of patients normally exceeds the bed capacity, so that the ideal ratio is not met even if the prescribed number of staff based on the bed capacity is followed. In one district hospital in Bulacan province that has a 75-bed capacity, there are usually 120 patients confined every day, increasing the load of nurses by about two-thirds of the volume of their work. The lack of medical supplies and instruments, as well as the inability of indigent patients to buy the necessary medicines or supplies force the nurses to improvise and be resourceful and puts strain in the performance of nurses. The difficult condition for staff nurses is further aggravated in recent years of low enrolment in nursing schools as fewer student trainees are available to perform basic tasks such as assisting the patient or checking vital signs.

The situation for nurses who remain to work in the country is exacerbated by their low salary, which is deemed by many to be incommensurate with the heavy work load. In national government hospitals, the entry-level salary is pegged at Salary Grade 11, with an equivalent of P18,549.00 (about US$375) as fixed by the "Salary Standardization Law" of 1989. However, hospitals under local government units are allowed to determine their own salary scale depending on its class and financial capability, thus creating gaps in

[6] There are destinations, such as Saudi Arabia, UAE and Singapore, which do not formally require hospital experience and Philippine nursing license. However, having these qualifications is preferred; and often becomes a requirement to obtain the license in the destination and work as staff nurse. Prior to that, they can only work as nursing aide or assistant nurse.

salary even among government-funded hospitals. Even then, salary in public hospitals is considered "high" compared to those working in small, private hospitals, who receive as low as P9,000.00 (about US$190). From mid 2000s to early 2010 when there was a large pool of nurses eager to gain experience to be able to work overseas, there were even registered nurse apprentices who only received very minimal "allowance" instead of a salary.

The Philippine Nursing Act of 2002 mandates a minimum Salary Grade 15 (P24,887.00 or about US$500) for nurses working in government, but this has not been implemented because the Aquino administration claimed that doing so will strain the finances especially of local government units and "undermine the existing government salary structure and cause wage distortion, not only among medical and health care practitioners but also other professionals in the government service" (Adel, 2016). [7] The government also argued that it will have serious implications on the viability of private hospitals and non-government health institutions, which would be compelled to raise the salaries of their nurses as well. Given these serious constraints and since many nurse graduates and nursing students consider "helping the family financially" as a leading factor in taking up the course, many of them opt to work as nurse overseas, or in other industries within the country which offer higher salary.

In summary, in the Philippines, the production and supply of nurses depend on the capacity of the nursing education industry to attract students and produce quality graduates, the motivations of nursing students and nurses to take up the profession, and the working conditions including economic remunerations of those who practice the profession. The behavior of the major supply-side stakeholders such as the students and their families, the nursing education sector, the regulators of the profession and the nurses themselves are in response to the demand situation in the international labour market for nurses, in which the Philippines has become a key player as the major exporter of nursing manpower. To illustrate the role of the country in the international labor market, we discuss the demand for nurses in the next section.

4. Demand-side Trends and Issues in the Philippine Labour Market for Nurses

In this section, we look closely at the demand for nurses domestically, internationally, and

[7] While there was a general increase in the standard salary for government workers in 2016, nurses argued that it only amounted to P500 per month and was not applicable to nurses on contract and "job orders."

specifically in the ASEAN region. Due to limited data on demand projections for foreign nurses, as well as the lack of systematic collection of data regarding nurse recruitment both for local and overseas positions, we will utilize data on actual deployment/employment and show how these figures are strongly influenced by the immigration and labour policies of destination countries.

4.1. Domestic Demand for RNs

According to records of the DOH Health Human Resource Development Bureau (HHRDB), [8] in 2014, the estimated required number of nursing staff to run the hospitals (based on bed capacity) and other health facilities all over the country is 42,000, with 21,750 (50.76 per cent) assigned to private health facilities and the rest, to government health facilities, of which all positions are currently filled up. Of the employed nurses population, 57.48 per cent are hired on a full-time basis, while less than one per cent work part-time and the rest (35 per cent) in other forms of employment categories such as contractual, "job-orders", [9] casuals, volunteers and others. These data do not fully reflect the actual or real demand for RNs in hospitals because nurse staffing requirement, especially in public and rural facilities, is far from the ideal ratio prescribed by DOH.

There are various reasons why health facilities are not able to substantially absorb new nurses. First, health facilities are limited in number. In the Philippines, elderly homes are not common; small and medium scale companies are not required to hire a company nurse; and *barangay* (village) health centers are not required to employ RNs by law. Thus, they are mostly employed in hospitals, infirmaries, and government-run rural health units (RHU). Like in many countries, staffing, especially in public facilities, is highly dependent on the annual budget of the local government and other administrative restrictions such as cap on personnel salaries, so that the number of RNs that can be hired permanently (called the *"plantilla"* in local term) has not seen significant increase in many years. Instead, many are hired on a temporary under the "job order" system, in which the number employed tends to increase before elections and the contract of the nurses hired is co-terminus with the politicians that appointed them. The "*palakasan*"

[8] Caution is necessary in interpreting these data which are derived through voluntary registration at the DOH website. As such, small health facilities with limited access to the website may be excluded in the data.

[9] A "job-order" is a form of hiring in the Philippines in which the worker who has special or technical skills not available in the government agency is employed for piece work or intermittent job of short duration of less than six months. The worker is paid on a daily or hourly basis and the services rendered are not accredited as government service.

system in which appointment depends on family affiliation and friendship and not on merits is also common and has become one of the major difficulties encountered by respondents in the survey. In some cases when there are no available positions, either permanent or temporary, RNs even settle for appointment under a different job title, such as sanitary inspector, which receives lower salaries and less benefits.

These are some of the outcomes of the devolution of the health system in the country in 1992 in which the management of health personnel and other resources, running of hospitals and other medical facilities and decisions regarding budget to be allotted to the health sector and its use, including salaries of personnel, are mostly left at the discretion of local government units (LGUs). Another result of the devolution is the notable maldistribution of health professionals among LGUs as discussed earlier. Given these serious budget constraints, political interventions in hiring personnel, and growing population, the employment data for RNs in the health care facilities, as reported, do not fully mirror the actual demand for nurses in the country.

Realizing the need to ease the actual demand of RNs in the health care system and to provide experience and training to RNs, the government has implemented through DOH the Registered Nurses for Health Enhancement and Local Service (RNHEALS) program in 2011-2013; and later on the Nurse Deployment (NDP) Program (from 2014 to present) in which RNs are sent to remote or underserved hospitals or public health offices to serve its people. Under these programs, RNs are hired on a short-term contract, usually six months to one year, but some are eventually hired in permanent positions. They get paid the same amount as the starting salary for government-employed nurses (P18,549). However, they are required to stay in the country for two years from the start of their deployment. Based on the total number deployed under the program as shown in Table 1.5, it can be said that this program has significant contribution in providing jobs to unemployed RNs. Another potential source of demand for nurses in the country according to DOH is the opening of facilities for the treatment and rehabilitation of drug dependents in 2017, which is projected to offer 10,000 positions for nurses. While these programs may only provide temporary work for these nurses, these are also advantageous for nurses who need the experience required to land a job later, either within or outside the country.

4.2. International Migration of Professional Nurses

In the following three subsections, we will discuss the developments and current trends in the overseas deployment of Filipino nurses, and later show how the labour migration policies for foreign-educated nurses of several destination countries have affected the

RNs in the Philippines. We argue that the international demand for Filipino nurses largely depend on the "whims" of these receiving countries. Their often changing and highly unpredictable policies make the Filipino RNs highly vulnerable in the international labour market.

4.2.1. Fluctuating Number of Nurse Migrants

There are several estimates on the stock of Filipino nurses overseas. OECD (2015:180) reports that the Philippines is the top source of nurses in its member countries, reaching 221,344 in 2010-11 and comprising around half of all foreign-born nurses, with India ranking at second (see Figure 1.6). UK and Germany completed the top four. The figures for the Philippines doubled in only a span of 10 years, reflecting the conditions that promoted the demand for, and thus the export of, Filipino nurses in these destinations such as relaxing of rules in issuing working visa, active recruitment, the growing of the graying population, as well as poor retention of local nurses due to poor working conditions and also to take up jobs in non-nursing sectors.

Meanwhile, the Philippine Overseas Employment Administration (POEA) also keeps a record of Filipino nurses who exit the country using labour visa, both as new hires and returning workers and mostly on contractual basis. Based on their data, the Philippines deployed a total of 256,487 nurses as new hires, mostly women, between 1992 and 2015. After experiencing a glut in 2006-2007, the number has recovered (see Figure 1.7), with the number shooting up to about three times (at 22,302) between 2006 and 2015. This number excludes those who initially left the country using a visa other than labour visa, such as tourists, students, as well as permanent migrants who do not need to report to POEA before departure. According to the Commission on Filipinos Overseas (CFO), which keeps data on permanent nurse migrants, their number is very small compared to those holding labour visa. Their number reached the peak in 2006 and dramatically fell until 2009 when it again showed an increasing trend (see Figure 1.8). Furthermore, the statistics also do not cover those who move between destinations, i.e. stepwise migration (see below, Carlos, 2013).

We can also find some trends in the distribution of newly hired nurses in the major destination countries as shown in Table 1.6 and Figure 1.9. Except Saudi Arabia where deployment almost steadily increases, it appears that the number going to the same destination fluctuates considerably every year (in some years, there is even no deployment at all), reflecting again the unpredictable and always changing policies of these countries. Moreover, the destinations for permanent and temporary workers are essentially different;

temporary workers are usually deployed in Middle East and Asian countries, while permanent workers go to USA, Canada, EU countries, Australia and New Zealand.

Saudi Arabia is by far the largest host for Filipino nurses as temporary workers, making up 65.71 per cent of the total in the last 15 years. Together with UAE, Qatar, Oman and Kuwait, they make up a whooping 78 per cent of the total deployment of new hires in 2001-2015. This suggests that for the Philippine temporary nurse export industry, the Middle East region and particularly Saudi Arabia is a stable market, and that these countries are highly dependent on Filipino health care workers to run their healthcare facilities.

However, to what extent the deployment will be affected by recent economic and political developments in these Middle East countries is uncertain. The labour market is highly dependent on oil revenues that have been on the decline due to lower oil prices and international competition. Due to financial difficulties, there have been reports of non-renewal of contracts of Filipinos engaged in other professions in Saudi Arabia; and even some cases of non-payment of salaries. Middle East countries have also taken action to "nationalize" the labour force by imposing foreigner-local employee ratio schemes. For example, in UAE, "Emiratization" requires a certain percentage of the workers in one company to be an Emirati, although this general rule is hard to follow in the case of nurses as locals are not keen on taking up the job because of its low social standing. Many Emiratis in UAE's nursing sector are not engaged in bedside care but are assigned to administrative and supervisory positions (Carlos & Sato, 2011).

Political instability and safety of Filipino workers are also a source of concern in some destination countries. For example, Libya, a relatively economically affluent country in Africa, has been recruiting nurses regularly from the Philippines. In 2011, when political crisis befell the nation, its Ministry of Health heightened its nurse recruitment campaign in the Philippines. Many nurses defied the government's warning and took advantage of high salary and better benefits compared to Middle East countries. In 2012, the number increased tenfold. As civil war continued in 2014, many of them were repatriated, only to find themselves jobless again in the Philippines. By 2015, going to Libya was only possible via non-formal routes.

In recent years, Filipinos have set their eyes also in other destinations such as Australia and New Zealand. Data from POEA, however, do not reflect their numbers accurately as many left the country as students and dependents of family and relatives already settled there. POEA announced in 2011 that there was a nurse shortage in Australia of 40,000 nurses until 2015. This came at a time of political turmoil in the

Middle East, retrogression in the US and economic recession in Europe and North America so that many Filipinos were attracted to go. The procedure also was rather easy and fast. Many RNs went through a "bridging course" to obtain the status of registered nurse under the Australian Health Practitioners Registration Agency (AHPRA). After working on a regular employment contract for two years, they could already apply for permanent residence in the country together with the family. However, in recent years, it has become difficult and expensive to take this pathway as the country began to impose higher standards on the level of English language proficiency. Noting the burden of looking after permanent migrants coming under family reintegration programs, it has also shifted its policy focus to skilled worker migration so that it is no longer easy to bring the family early on in the nurse's migration to this country.

4.2.2. The UK as Destination for Filipino Nurses

While Saudi Arabia consistently took the biggest chunk of newly hired nurses in most years, UK and USA also became major destination for new hires in some years (Figure 1.9). For these countries, when there was immediate need to fill in shortages in hospitals, the fastest solution to the problem was to take in foreign nurses with basic experience in nursing care. Once the shortage is filled, they close the doors to nurses by imposing strict regulations on labour and migration.

In the UK, the Philippines ranks first in terms of number of nurses with foreign nationality, which is estimated at 8,301 in 2016 (Baker, 2016). However, this number is highly underestimated as many Filipino nurses have already obtained UK citizenship. From early to mid-2000s, there was a serious shortage of nurses, and in just one year (from 2000 to 2001), the number of foreign-educated nurses registered at the Nursing and Midwifery Council increased by 41 per cent due to the large-scale targeted recruitment programs, notably by the National Health Services (NHS), the largest employer of nurses (Royal College of Nursing, 2005:3) which made various trips to the Philippines to screen applicants. Newspapers were filled with recruitment advertisements, attracting numerous applicants. It was also in 2002 when more than half of the new nurse registrants were from outside UK, with 44 per cent of the 16,155 new registrants from overseas recruited from the Philippines (Aichen et al., 2004). The entire processing of applications took place in record time of about three to six months, and Filipino nurses were able to initially work (for a few months) as assistant nurses before obtaining their license from the Nursing and Midwifery Council (NMC). It was also relatively easy for them to convert their labour visa into permanent residence, and later, UK citizenship, in as short as four

to five years within arrival. However, UK was criticized for "poaching" nurses from Africa, and ethical recruitment became an issue. Around 2001, a bilateral agreement intended for ethical recruitment was signed between the Philippines and UK, but it was never fully implemented as UK stopped active recruitment in the years that followed.

Recruitment from the Philippines trickled down due to the increase in the number of commissioned student places in its own nursing schools and recruitment of nurses from EU countries. Active recruitment by UK ended sometime in 2004 and stricter immigration and licensing regulations were imposed, such as higher scores in the English Proficiency Examination (IELTS). Because it became more difficult to obtain labour visa, going to UK on student visa became an easier option, although more expensive because nurses themselves have to pay for their bridging program and training. There were also cases of exploitation in which nurses were forced to work in nursing homes for minimum wage and employers refused to release papers necessary for registration with NMC. In 2011, the UK began to impose rigid requirements for labour visa renewal and extension as well as conversion to permanent residency and citizenship in order to curb permanent migration. In 2016, a new salary threshold for non-European nurses of at least 35,000 pounds annually was also imposed. A Filipino nurse who fails to earn this much after six years will be forced to leave the country for good. This immigration policy is criticized to be "illogical" in the light of the current "major nurse shortage" that the Migration Advisory Committee (MAC) admitted in 2015. Currently, UK is said to have a critical shortage of RNs pegged at 24,000 in 2017 (BBC, 2015; MAC, 2016). In the case of NHS Hospitals alone, it was reported that 96 per cent and 85 per cent reported that they were not able to meet the planned staffing level at daytime and nighttime, respectively (Lintern, 2017); and these are brought about by several recent developments. On the demand side, the increase in the staffing ratio is in response to the 2013 Francis Report[10] that recommended safe staffing levels and issued guidelines on nurse-patient ratio for NHS hospitals. Moreover, the changing demographics raise the demand for nursing and care services and require the nurses to assume more advanced, complex and varied practices.

There are also factors from the supply side that contributed to the current shortage in UK. The number of commissioned student places in nursing schools was cut down in late 2000 due to fiscal budget constraints, but recently, efforts are being done to raise it. The

[10] This is a report of a UK Public Inquiry headed by Robert Francis, which looked into the negligence and failings of the Mid Staffordshire Foundation NHS Trust towards its patients, and emphasized that appropriate and sufficient staffing is necessary to ensure patient safety and quality of care.

retention of nurses has become more difficult due to the nature of the job and migration to other countries like Australia. The ageing of the nurse population is expected to further aggravate the shortage in the future as the current average age of the nursing workforce has hit beyond 50 years old. Furthermore, nurses from EU countries seemed to have lost interest in working in UK after the Brexit referendum in July, 2017. Six months after the referendum, EU applicants for UK registration went down by 90 per cent; while the number of EU nurses who left the NMC Registration doubled (Donnelly, 2017). As a major employer of EU nurses (about 21,000 in 2016) and with one out of five new recruits in recent years coming from EU, this is a disturbing development (Baker, 2016).

In response to the current and projected shortage, NHS for its part has taken steps largely focused on increasing domestic supply, through programs related to education and training (expansion of nurse training places), retention, return to practice and promotion of the profession. In addition to these domestic efforts, although still in small scale, NHS hospital managers have resumed its active recruitment from the Philippines, which resulted in an increasing trend in nurse (new hires) deployment to UK from 2013. NHS and other stakeholder groups have also intensified its campaign to encourage the government to relax foreign labour rules so that more nurses from overseas can be recruited and retained.

Indeed, in a span of 20 years, nurse migration from the Philippines to UK had seen a series of highs and lows owing to the changing immigration and labour recruitment policies of the country as well as domestic economic and demographic conditions. It remains to be seen, however, to what extent this country will turn to foreign-educated nurses, particularly from non-UE countries like the Philippines, to fill its needs for nurses in the light of intensified anti-immigrant sentiments and growing financial difficulties haunting the NHS system.

4.2.3. The US as Destination for Filipino RNs

Meanwhile, the US migration policies in 2000s have become major references to explain how the unpredictable immigration policies can affect the international mobility of nurses. The USA is a very popular destination for Filipino nurses, and Brush and Sochalski (2007) maintained that since the early 1950s, the Philippines has been sending nurses in the US. Many have stayed and raised their families there, producing second and third generations of Filipino-American nurses. The Migration Policy Institute (McCabe, 2012) calculated that about 136,000 or 34 per cent of all foreign-born nurses in the USA came from the Philippines.

The most recent wave of foreign nurses migrating to the country resulted from the implementation in 1999 of the H-1C visa program that allowed foreign nurses to fill the shortage as determined by the US Department of Labour (DOL). Based on OECD (2016) data, the inflow of nurses trained in the Philippines who migrated to the United States displayed an average increase of 39 per cent annually, reaching its peak in 2007. In the years that followed, the number drastically decreased because of two major changes in US policies. First, the H-1C visa program for nurses expired in 2009. Second, visa retrogression for nurses began in 2006, resulting in longer waiting time for nurses to obtain the working visa, from one to two years into six to eight years. The retrogression came as a surprise to many employers and foreign nationals because of its unexpected early implementation. Moreover, the Department of State never indicated that the retrogressions would be so harsh. The lack of coordination between the USCIS and DOS also led to the current unpredictability in the priority date system. Because getting a visa became onerous, many hospitals also stopped sponsoring nurses. The situation was further aggravated by the economic recession in late 2000s, which, despite showing signs of recovery, seem to have no impact yet on nurse recruitment.

In 2013, the American Association of Colleges of Nursing (2013) claimed that there is an easing of the nursing shortage in the country brought about by increasing number of placements in nursing schools, and thus less need to recruit foreign nurses. However, such easing is seen as short-term, and it is expected that there will be an upward shift in the demand for nurses in the country mainly due to the wave of retirement of RNs and increasing demand for healthcare services (American Association of Colleges of Nursing: 2013). Whether when and to what extent such domestic conditions will result in the reopening of the US market to Filipino RNs is unknown and largely depends on the policy directions of the new administration in health care and labour migration.

4.3. Filipino Nurses in ASEAN Member Countries

There has been very limited deployment of Filipino nurses to ASEAN destinations. Based on POEA data (Table 1.8), Singapore is the only ASEAN country in the top ten destinations for nurses, ranking fourth in the past 15 years (Table 1.6), with a significant increase between 2014 and 2015.

For Philippine-trained nurses recruited to Singapore, a typical pathway is to initially get employment as a nursing aide in a hospital or healthcare institution. The nurse is granted a “work permit,” that is valid for two years and renewable. After sufficient training (as determined by the employer), and upon presentation of a valid Philippine

nursing license, the Singaporean employer (hospital or healthcare institution) applies for registration with the Singapore Nursing Board (SNB) on the nurse's behalf. If approved, the Filipino nurse receives an "S pass" visa, which entails receiving a monthly salary of at least S$2,200, allowing petition of immediate family members (for salary of S$5,000 and above) and qualifying to apply for a permanent resident visa later on.

Brunei and Malaysia also hired nurses from the Philippines, but only in small numbers and despite the nurse labor shortage in these countries. In the case of Malaysia, one interview respondent mentioned that she worked in a university hospital in Kuala Lumpur for three years in early 1990s. According to her, they were recruited at the time when the three-year Diploma in Nursing Programme started to be implemented in the country (previous to that there was only the Certificate programme) and they were "pioneer" staff nurses in the hospital. The program ended and currently, there are no nurses deployed to this country through POEA. However, there are reports and advertisements of RNs working or offering their services as private nurses in hospitals and private homes. In the case of Brunei, health care professionals like nurses, doctors and dentists from the Philippines are deployed but only in very small numbers. In 2014, a Memorandum of Understanding allowing them to practice in the country for short periods was inked between representatives of the two countries, but the number is still small compared to Singapore and other destinations outside ASEAN.

While official POEA data do not show that there are Filipino RNs deployed in Thailand, the authors' fieldwork in Bangkok in February, 2017 reveals that there are RNs working in call centers of insurance companies, universities and colleges as instructors, in the "backdoor" office of hospitals, as private caregivers and English language school teachers; but not in hospitals as practicing nurses. Although there is a demand for nurses who can speak English in Thai facilities catering to medical tourism, the Filipinos could not be hired because of lack of Thai license and knowledge of Thai language, which is the official language for the Thai NLE. Many of these nurses left the Philippines with tourist visa and then converted it into employment visa upon arrival in the Kingdom, which is why the POEA does not have any record of these nurses.

From the above, we can see that there is limited deployment of Filipino nurses in ASEAN member destinations and there are varied reasons for such. For potential host countries, such as Singapore, Brunei, Malaysia and probably Thailand (for English-speaking nurses), wide variations in cultural practices, language and systems concerning nurse education and profession and labor and migration restrictions have become barriers to Filipino nurses' deployment.

5. Addressing the International Demand-Led Nurse Labour Market

In this subsection, we assess the demand-supply relations in the labour market for RNs and look at the factors that make balancing in this market difficult. We also describe how nurses and the government cope with the uncertainties of this international demand-led market.

5.1. Manifestations of Imbalances in the Labour Market

In order to visualize and capture the extent of imbalance in the market for Filipino RNs, we put together the data on those who passed the NLE and the number of nurses (new hires) deployed overseas (Figure 1.10), which can be considered as rough estimates of the annual "flows" of demand and supply in the respective years.[11] Considering that the number of available positions in the health care system of the country has been stagnant, it is quite safe to say that the annual demand flow is largely from overseas.

Based on Figure 1.10, there were three periods when the number of nurses deployed overseas was more or less equal to the number of newly-registered nurses. From the period 1999 to 2003, and from 2015, the former exceeded the latter. Meanwhile, the gaps between these flows reached its peak in 2009 when there was a surplus of around 55,000 newly-registered nurses. Based only on these data from the period between 2004 and 2014, the country generated an estimated surplus of 358,694 nurses, some of whom settled for jobs in local hospitals, while many became unemployed or employed in other sectors. PNA reports that 200,000 nurses, or about five times as many as those who work in health facilities, are engaged in non-nursing care sectors, such as call centers, banks, schools and other service-oriented jobs and are thus considered "underemployed" (PNA, 2016). Given that many countries are stricken with serious shortage of nurses in health facilities, the situation in the Philippines of large unemployment and underemployment is quite unique.

However, based on interviews, currently there is a significant decrease in the supply of RNs willing to work in the healthcare system. The chief nurse of a tertiary private hospital with current bed capacity of 57 beds, in the suburb of Manila claimed that since

[11] Care should be taken in interpreting these data. The annual "flow" of domestic demand is not considered here because the number of nurse positions in hospitals and other health facilities is fixed at 42,000; and many nurses quit their positions to take up jobs overseas so that the increase in domestic demand is mostly reflected in the number of overseas deployment. Moreover, the data by POEA covers only those who left on labour visa, and exclude those who left using other pathways, such as students, permanent migrants and trainees.

2015, very few have been applying for nursing positions, and the pool of applicants is also getting smaller. Previously, the hospital had the "luxury" to choose the best among many applicants; now it accepts even those without experience. Moreover, it has to take in and retrain RNs who have been away from practice for a while. There are also applicants who returned from working abroad, such as Saudi Arabia, but they just stay for a few months and eventually return overseas. However, nothing can be done because most nurses' goal is only to gain experience to be able to work overseas. The shrinking pool of RNs was also confirmed by several deans and academic coordinators of nursing schools. One dean described the current situation as follows:

> "Actually, the government is saying (that) we have so many nurses but when you look into the field, you don't feel the overflowing nurses. Just like this morning, I passed by one dialysis center and there was an announcement "HIRING DIALYSIS NURSES" to attract walk-in applicants. Then I received letters from two hospitals asking for our graduates."

The current shortage, however, is just beginning to be felt in the country and has not yet turned into a "crisis" (interview with nurse administrator in a private hospital). Yet, the situation has become a serious concern especially among nurse administrators in private hospitals. Given the choice between government and private hospitals, nurses prefer the former where the salary is almost twice as much, even if it is more difficult to get a position and working conditions are hard. To attract nurses, some of the top private hospitals are already adjusting their salaries and ease the requirement for admission like years of experience in hospital care. Although the law has not been passed yet, a leading tertiary hospital already pays its nurses at least P25,000 as suggested in the bill which is yet to be passed.

5.2. Why is it difficult to address the imbalances?

What caused these past large surpluses and current shortages of nurses in the country? This paper argues that there are three interlinked factors: (1) the unpredictable, singlehanded and whimsical migration and foreign labour policies of destination countries; (2) structural imbalance arising from the time lag between demand and supply because it takes at least four years to create new nurses to meet new demand; and (3) the "over reaction" of the Philippine society on the perceived overseas demand for nurses. All these three have resulted in the vulnerability of the Philippines in the international labour.

The unpredictable nature of policies of destination countries, as displayed in the

examples of US and UK (see above) should be understood within the context of their domestic and international conditions at that time. When news broke out about the ease of migrating to the UK as nurses spread in the Philippines in early 2000s, the international migration industry stakeholders reacted swiftly and vigorously. Language review schools were immediately set up to cater to the increasing number of RNs who want to meet the proficiency level requirement in Europe, US and Asian countries. The rush to build schools began and their number increased "exponentially" (see above). In this set-up, the biggest "losers" can be the nursing students who had to endure four years in college, at least six months preparing for the NLE and two years to acquire hospital experience; only to find out when they were ready to leave that the gates were already closed and they had to wait for the next chance to leave, or settle for work in a hospital or non-nursing sector within the Philippines.

Finally, the high propensity of Filipino stakeholders to react to the perceived international demand for nurses can also be largely attributed to the country's "culture of migration" in which going overseas to work or having an OFW in the family has become a way of life. It is also considered as a fast and effective way to achieve social and economic mobility and stability among and between generations. In fact, 92.4 per cent of the 315 nursing students in the survey expressed their desire to work overseas. This is because nursing is highly paid and merits high status in the Philippine society. Internationally, it is one of the most lucrative skilled professions, and finding a job is relatively easy in most destinations countries, even in times of recession.

Filipinos are exposed to the "culture of migration" early on in life as children are raised in a family with parents working overseas and with money from international remittances used to support their daily needs. With the advances in technology, long-distance mothering has become easier with daily online conversations among the members of the transnational family becomes possible via internet or mobile phones. By way of blood or social relations, one is connected with someone living overseas so that fears and anxieties of resettling and working in another country, even for first timers, are somewhat relieved.

The Filipinos, however, do not respond randomly to perceived demand in any destination; rather, they have preferences that are guided by historical relations, networks, economic compensation, and social standards. In the case of the 2004-2014 cycle, the fluctuations in enrolment and new licensees were in response to strong demands at that time from the two highly preferred destinations, UK and USA. The same findings were obtained from the survey of current nursing students and graduates. Such reaction may

not be found in the case of increased demand in the Middle East.

One of the main reasons why these countries are highly preferred is the high salary they offer. We show in Table 1.9 the differences in salary for staff nurses in these destinations. Nurses are most highly paid in the US, followed by Australia. These values are about seven to ten times as much as what RNs in Philippine government hospitals get; and three to four times compared to what is offered tax-free in Middle East countries. Moreover, in these countries, the opportunity to be granted permanent residency and citizenship is much greater than in Middle East countries where residency is based on having an employment permit. Contracts are usually on a two-year basis, the renewal of which depends on the sponsor (employer). Cultural, political and religious restrictions are also prominent in these countries.

These three factors reinforce each other so that addressing the market imbalances becomes much more difficult. Dealing with the highly unpredictable demand and hardly avoidable market imbalance (surplus) is a challenge for all domestic stakeholders. In the next two subsections, we describe how the Philippine government and nurses have been dealing with the problem.

5.3. State Interventions and Nurses' Coping Mechanisms

Given that the market is international demand-driven, there are limited options that nurses, through their behavior, and government, through its interventions, can do to "manage" the market imbalances, as to be explained in this section.We focus on the ASEAN MRA as another way to cope with the issue in Section 6, and illustrate the efforts undertaken by the Philippine stakeholders, particularly the nurse education sector and the benefits to the country when the ASEAN MRA is fully implemented.

5.3.1. Nurses' Behavior

In the 2000s, the number of deployed nurses (new hires) did not decrease dramatically despite the sudden and extreme decline in demand for nurses in the preferred destinations such as the US and UK. Nurses still left for the Middle East and some Asian countries like Taiwan and Singapore that had open and active recruitment policies at that time. Despite being considered inferior compared to US and UK as pointed out in Section 5.2, Filipino nurses went to these destinations because it was a better choice than staying without work or with work but not related to the profession in the Philippines. The recruitment requirements were few and the processing was also faster, taking only weeks from application to deployment. It was also cheaper, with smaller recruitment fees and

visa processing fees. Moreover, at that time, many of these destinations required neither a Philippine nursing license nor a specified minimum score in English proficiency examinations and adequate years of experience.

For many, working in these less preferred destinations is a vital part of their coping mechanism at a time when "whether, when, and how" to migrate for work is singlehandedly decided by stakeholders in the preferred destinations. This "stepwise international labour migration" (SILM) strategy is characterized by moving from one "transit country" (the stepping stone) to the next until migrant workers reach the most preferred or "final" destination. It is a series of rational decision-making migration processes that involve constantly assessing the labour and migration conditions and policies in several destination countries as well as the migrants' own capabilities and resources with the objective of moving to a better or more preferred destination, until the most preferred final destination is reached (For a discussion, see for example Carlos, 2013; Carlos & Sato, 2010, 2011).

An example of the SILM of Filipino nurses is shown in Figure 1.11. This phenomenon has been mentioned as the "stepping stone" issue in UK (see Kingma, 2008; Buchan et al., 2005), and among OECD countries (see Dumont & Zurn, 2007), but few have elaborated on how and why this phenomenon happens. By working first in the transit countries, nurses can accumulate transferrable resources, such as money to fund the next migration, nursing skills that will be counted towards experience required in applying for a job in the next destination, social connections that will allow the nurse and even international recruiters access to information about the next destination, and a passport that will facilitate easier migration to a more preferred destination. The more difficult it is to acquire these resources in the home country (Philippines), the stronger the motivation for the nurses to take up this round-about behavior rather than the usual one-time migration (Carlos, 2013).

Working in non-nursing sectors such as the business processing outsourcing (BPO) industry, pharmaceutical marketing sector, and education and financial sectors in the country and overseas is also another coping mechanism for RNs waiting for the opportunity to work overseas. That there is a high demand for RNs in these sectors is cited as one major reason why there is a perceived current shortage of nurses in the country today. These alternative jobs are attractive because as one of the interviewees said, they pay higher salary, and working conditions are better than in hospitals. The BPO has emerged as a magnet for RNs and the high salary is cited as one of the reasons. The starting salary in this sector is P25,000 (US$500) that can go up as high as P60,000

(US$1,200) after two years. Since 2000s, the BPO has been a leading robust industry that absorbs the nurse surplus by employing them in healthcare information management such as medical transcription, medical encoding, medical billing, insurance claims, among others. That RNs are in demand in this sector was confirmed by the dean of one nursing school interviewed, saying that many BPO providers come to nursing schools "asking not just nurse graduates; they have to be licensed." The education sector is also taking nurses away from the hospitals. In 2016, senior high schools began to hire nurses to teach health and science subjects under the K-to-12 educational system. These schools offer them P25,000 (US$500) even if they have not passed the Licensure Examination for Teachers yet. Nurses can also be found working in banks, in pharmaceutical companies as medical representatives, and in real estate business. Interestingly, the Filipino nurses also find jobs in non-nursing sectors overseas, such as in Thailand. That nurses can work in varied industries, both in health care and non-health care related areas, both in the Philippines and overseas, prove the versatility, flexibility and good training of Filipino nurses that also make them popular worldwide.

5.3.2. Government interventions

The Philippine government, through its regulatory agencies such as CHED, DOH, PRBON and POEA, plays a crucial role in guiding and empowering local stakeholders to deal appropriately, timely and rationally with changes in nurse demand. In terms of curbing supply, CHED is at the forefront of regulating nursing schools, and orders the closing of non-performing schools in the NLE. PRBON regulates the professions and maintains and improves the quality of nurses through the licensure examination and continuing professional development (CPD) of RNs. The DOH, which is in charge of producing the five-year Human Resource in Health Development Plan, makes projections regarding the demand and supply of nurses, and recommends ideal hospital staffing as well as alternative employment schemes for nurses. POEA, on the other hand, negotiates and inks agreements with potential receiving countries of Filipino nurses. Some examples of these bilateral agreements are the Japan-Philippine Partnership Agreement (JPEPA) and the Triple Win Project with Germany in 2008 and 2015, respectively. The agreements are aimed to facilitate a steady and win-win deployment of nurses to Japan and Germany.

What the government can do to raise the domestic demand is limited. Due to lack of budget, it is almost impossible to manipulate the number of nurses hired in government health care facilities. Neither can private hospitals do this because of staffing and cost constraints. Another form of intervention in the market is through providing or

encouraging RNs to take up alternative jobs in the non-nursing sector. It happened in 2012 when the Secretary of the Department of Labour and Employment encouraged unemployed nurses to take up jobs in "non-traditional" non-clinical but medical-related information outsourcing sector such as medical transcription and medical billing.

On the other hand, when there is increasing demand overseas, encouraging RNs to return to the profession, particularly those who are engaged in non-nursing jobs is a more timely measure, rather than relaxing regulations on opening nursing schools and the profession, or encouraging students to take up nursing, both of which entail at least four years of study and training. In the study, it was found out that the chance to go overseas is a leading motivation for graduates. Therefore, many nurses employed in other sectors are keen to return to the practice in the hope of getting the experience when there are opportunities to work abroad as nurses. As the dean of one of the leading nursing schools in the Philippines noted, "the only way by which they (nurses) go back to the profession is when there is an opening abroad, and the requirement is a hospital experience. Then, they will be forced to go back to have that experience." The government can encourage hospitals to provide the experience by, for example, using the preceptor system in which senior nurses train the returning nurses. For the scheme not to be exploited like in the case of "volunteer" nurses, it is important that the government regulates it by limiting the number of trainees and creating positions (like for example, as assistant nurses) for them in the hospitals. In this way, the country is able to produce trained and competent nurses at a relatively short time and thus immediately meet the needs in overseas destinations or when their markets are opened. At the same time, it can contribute in alleviating the nurse shortage in hospitals in the country.

In the discussions above, we can see how difficult it is for the Philippine government and stakeholders to cope with the unpredictable international demand-led market for nurses. Over-reaction to such demand and the existence of time lag in the production of nurses also contributed to massive surplus of nurses in the past, leading to their unemployment and drifting to non-nursing sectors within and outside the country. Many nurses have taken the stepwise migration pathway in which they take up work in transit destinations while waiting for the opportunity to go to the most preferred destination. For the part of the government, it put in place mechanisms to curb the quantity and quality of the supply of nurses through regulations in the areas of nursing education and licensing. In addition to these, this paper suggests the importance of hospitals in taking up the role of providing training experience to nurse returnees. In this way, hospitals not only contribute in sustaining and improving the quality of health care system in the county, but

also in meeting the demand-led international market for nurses in a timely manner. By having the capacity to train returnees when international market is open to Filipino nurses, hospitals can act as dynamic stabilizers.

Another scheme that is expected to contribute positively in addressing the demand-led international labour market from the perspective of the sending country is the tying of labour-related agreements and arrangements with destination countries. These can help secure overseas jobs for nurses, either directly (like the JPEPA in which quotas are determined) or indirectly, by making it easier for nurses to work in destinations through, for example, mutual recognition of educational qualification and experiences. Other than raising the quality of education and training in the country, it will also help nursing schools attract foreign students to complement domestic enrolment. In the next section, we will focus on the ASEAN MRA, particularly on its benefits to the country and the efforts taken by the nursing sector in preparation for the implementation of the said agreement.

6. The Philippines' Commitment to and Expected Benefits from the ASEAN MRA in Nursing Services

Recent developments in nursing education and practice in the Philippines are vital responses to the challenges brought about by globalization. Many of them are implemented to express commitment towards social and economic integration in ASEAN, and are guided by the ASEAN Economic Community (AEC) blueprint that was adopted in 2007. Aimed at fast tracking ASEAN integration until 2015, the blueprint envisions a single market and production base characterized by free flow of professionals, free flow of skilled workers, free flow of goods, free flow of investment, and free flow of capital.

In drafting specific programs and guidelines to enhance the mobility and competitiveness of professionals within ASEAN, the conceptual framework presented in Figure 1.12 has been adopted. In this subsection, we focus on the recognition of qualifications under the MRA in Nursing Services, which, of all the targeted professions, was the first to be signed in 2006 in Cebu City, Philippines. Specifically for nursing services, the ASEAN MRA aims to facilitate mobility of nursing professionals within ASEAN; exchange information and expertise on standards and qualifications; promote adoption of best practices on professional nursing services; and provide opportunities for capacity building and training for nurses.

In the course of the preparation, the Philippines hosted the third meeting of the

Southeast Asia Regional Policy Network on Good Regulatory Practices (GRPN) on March 14 to 16, 2017 in Iloilo City to push for initiatives to implement regulatory reforms for improving the business environment.[12] These initiatives aim to update changes or developments in the relevant prevailing laws, regulations and practices of each host country in response to the MRA. The result of this meeting is expected to cascade down to other professional sectors, particularly the nursing sector. It is worthy to note that at the start of the MRA implementation, many ASEAN member states did not have specific regulations or regulatory body for nursing services. The process of implementation of the MRA helped these member states to strengthen their regulations and speed up the process of establishing their Nursing Board/Council (21st ASEAN Joint Coordinating Committee on Nursing, 2016).

Another evidence that shows the extent of the country's preparation in the MRA is the submission of the Philippine Roadmap for Implementation of ASEAN MRA on Nursing Services, which was completed in December 2012 (See Appendix A.2). Congruent with the template suggested by the ASEAN Joint Coordinating Committee on Nursing (AJCCN), the roadmap specifies the objectives and activities to be carried out by them. It also details the web sites where a compilation of required information for recognition and registration of foreign nurses in each country are maintained. In June 2013, the Philippine Nursing Roadmap Committee met to develop harmonized standards of Philippine Nursing education and practice/service anchored on the core competencies; monitor compliance by schools and health care institutions; create nurse-led facilities whose practitioners are accredited by the PRBON for independent nursing practice and basic nursing care.

Below, we examine the potential impacts of MRA on the Philippine nurse labor market and describe the efforts undertaken as well as some difficulties experienced by the country in working towards the implementation of the arrangement.

6.1. Impact of MRA on mobility of professional nurses from the Philippines

In general, MRA is expected to increase the mobility of workers. In the case of Europe, the flows of nurses between member countries are increasing in magnitude and relative

[12] According to Venzon (2017), the National Economic and Development Authority (NEDA), the lead agency responsible for government-wide good regulatory management system, identified the initiatives as modernizing government regulatory processes, institutionalizing regulatory management system, eliminating outdated regulations, institutionalizing Regulatory Impact Assessment (RIA) within government, and pursuing legislative agenda on regulatory reform and seamless service delivery.

importance as flows of nurses from third countries (such as Philippines and India) have been replaced and overtaken. For example, in UK, there have been more nurses from EU than non-EU countries since 2008/09. The same effect may also be achieved in the case of the ASEAN MRA scheme.

However, the impact on the mobility of Filipino nurses may be limited. The MRA does not aim at establishing a regional registration system of nurses (that is, there is no 'ASEAN Nurse' registration to be established) but instead involves a two-step registration process: home country registration and host country registration. This means that a registered nurse in the Philippines may apply to be registered as a "foreign nurse" in any ASEAN host country if the qualifications recquired as stipulated in Article 3.1 of the Agreement, such as a valid professional registration in the country of origin and a minimum three years of experience, are met. Aside from these, the receiving country can establish specific rules in consideration with its own cultural practices and language proficiency. Whether Filipinos will obtain the certification, therefore, largely varies and is heavily dependent on the comparability of the national qualification framework and certification with other ASEAN countries. To this end, the Philippine nursing education sector has been working hard to formulate its framework and certification systems.

Moreover, while the MRA may allow the Filipino nurse to obtain the license upon meeting the requirement for qualifications, it may still be difficult to practice the profession in the destination because of legal and practical limitations faced by an already-registered Filipino nurse in the ASEAN destination. In the case of EU, for example, the enlargements in 2004 and 2007 reinforced the migration of nurses but it is difficult to separate the effects of labour market policies such as quota on the number and salary caps of foreign nurses, previous history of labour mobility and the preferences of nurses to move to a destination with better immigration deals (such as family integration and granting of permanent visas) and more relaxed labour market rules, active recruitment and, of course, the demand for nurses. Similar situations can also happen in the case of Filipino nurses, whose preference for a destination depends on the salary, presence of family and relatives in the destination, family integration policies and ease of communication through English rather than an MRA. It must be understood however that the goal of the MRA is not migration but to facilitate mobility of professional workers who can complement the local workforce in times of need.

Nevertheless, the MRA provides a window of opportunity for those RNs in the Philippines who are already working in ASEAN countries, particularly in Thailand and Malaysia, which apparently have demand for nurses. A Filipino RN in Thailand who

currently works as part time caregiver and high school teacher said that given the chance, he would choose to return to practice because it is more professionally rewarding. Some of the RNs interviewed in Thailand are in favor of the MRA because the scheme can give them a chance to be professionally recognized so that they can get more benefits even if they stay in their current jobs. One interviewee does not plan to avail of the scheme to work in bedside care because it is more physically and mentally demanding and the salary does not differ much with what they currently get.

From the above, it can be said that while the MRA has potential impact on the mobility of Filipino nurses to ASEAN destinations, it is limited because of the varied restrictions concerning labour and migration that are imposed in the destinations and are not covered by the provisions of the MRA. In addition to this, economic and other social and cultural factors, rather than the presence of MRA, can be stronger motivations for Filipino nurses in choosing the destination.

6.2. Impact of MRA on the mobility of nursing students in ASEAN

The harmonization in higher education and enhancement of national qualifications and programs comparative to those of other ASEAN member countries, as required in the MRA, will facilitate student mobility within ASEAN. Once the accreditation system is put in place, a student from one ASEAN country may be able to take up nursing in any ASEAN country and have it recognized in his own country, given that the other requirements are satisfied, such as language proficiency. Based on interviews with some deans of nursing schools, currently, there are Indonesians and Vietnamese enrolled in nursing schools in the Philippines in accordance with special inter-university MOUs. The MRA will thus be advantageous for Philippine nursing schools because they can accept nursing students from any ASEAN country, provided they meet the entry requirements specified by these schools.

On the part of the ASEAN students, studying nursing in the Philippines will widen their career choices to include working outside their country of origin, especially English-speaking destinations which recruits Philippine-educated nurses. It will also cultivate their English language proficiency which can be helpful if they want to work in other countries. For example, an Indonesian nursing student who aspires to be a professional nurse in the US will have a better chance of passing the CGFNS and TOEFL if trained in the Philippines since most courses are taught in English. At the same time, if he decides to work in Indonesia, his educational and career qualifications can be recognized if the ASEAN MRA is implemented. However, MRA can also have some negative effects on

the international mobility of Filipino nurses because those Philippine-educated ASEAN nurses can be potential competitors for Filipino nurses in the international labour market. In this sense, while the MRA raises the enrolment of students from ASEAN in its nursing schools, the MRA can become a double-edged sword as it creates competitors for nurses in labour markets of destination countries in ASEAN and beyond.

6.3. The Commitment and Preparations of the Philippines in the Implementation of MRA and Their Impact on the Quality of Nursing Education and Practice in the Philippines

One of the more evident impacts of the MRA on the Philippines is the uplifting of the quality of nurses through massive reforms being carried out in the Philippine education system, the setting up of qualifications framework and quality assurance mechanism, and provision of career development and pathways for professionals. These steps, which are central and crucial in the Philippines' commitment to comply with and push for the full implementation of the MRA in Nursing Services, are undertaken with the collaborative efforts and initiatives of the country's PRC, CHED, DOH and various professional nursing associations and interest groups.

The starting point for the MRA to be able to facilitate the mobility of Filipino nurses is whether the education, experience, and training of nurses in the country of origin is "almost" equivalent to those in the host country, so that the efforts of the nursing education sector and the government to conform its standards to that of the prevailing standard in nursing education are indispensable.

The following are the specific initiatives undertaken by the stakeholders in nursing education and practice, as preparations for and in compliance to the provisions of the MRA. Although not the sole motivation, it can be said that the following developments in the human resources development for nurses in the Philippines, particularly through reforms in the nursing curriculum, career formation and continuous learning systems, have been strongly influenced by the country's commitment to the ASEAN MRA and ASEAN integration.

6.3.1. Formulation of the Philippine Qualifications Framework (PQF)

The PQF (Figure 1.13) is a national policy that describes the levels of educational qualifications and sets the standards for qualifications outcomes. It is a quality-assured national system for the development, recognition and award of qualifications based on standards of knowledge, skills and values acquired in different ways and methods by

learners and workers. Being competency-based, labour-market driven and assessment-based, it aims to address the persistent critique of the mismatch between educational qualifications and the needs of Philippine-based industries; the fragmented system of qualifications in the country; the impending reality of an ASEAN Economic Community; and issues of comparability for a significant number of skilled workers and professionals working in different parts of the world (Bautista & Taganas, 2016). (For details about the PQF, please refer to Appendix A.3)

At present, the country has already completed the comparison matrices to provide concise information of member states' policies on important information such as temporary licensing for five categories of limited practice, Continuing Professional Development (CPD), registration requirements, licensing period and language requirements. These are in response to one of the goals of MRA to adopt and harmonize standards and procedures, the details of which have been laid out in the PQF.

6.3.2. Design of the National Nursing Career Progression Program Credentialing

In order to align with the ASEAN qualifications in the MRA scheme, PRBON takes the lead role in the development of mechanism in the implementation of the National Nursing Career Progression Program Credentialing. There are three pathways developed (Figure 1.14): one for leadership and governance, another for specialty and independent nursing practice, and the other is for nursing education. Each pathway has the same progression level from PQF 6 to PQF 8, but with different educational qualifications, experiences, roles and responsibilities. Through these initiatives, nurse professionals become well prepared to effectively and efficiently perform their duties and responsibilities, in collaboration with multi- and interdisciplinary teams, and whose qualifications will be recognized and harmonized with ASEAN qualifications (Abaquin, 2015).

6.3.3. Promoting Continuing Professional Development (CPD)

In consideration of the MRA, the Philippines in 2016 put in force the "Continuing Professional Development Act of 2016" (Republic Act 10912) which mandates and strengthens the CPD Program for all regulated professions, including nursing. As stated in this Act, one of the reasons the CPD program needs to be strengthened is to "enhance and upgrade the competencies and qualifications of professionals for the practice of their profession pursuant to the PQF, the AQRF and the ASEAN MRAs" (RA 10912, s. 2016). From July, 2017, RNs are required to complete 60 CPD units every three years as one of the requirements to renew their license. These units can be obtained through attending

seminars, training, and workshops by accredited CPD providers, taking up higher academic qualifications such as master's or doctorate degrees, assuming professional chair appointment, residency, externship, or taking up additional specialty/sub-specialty programs, fellowship grants, and post-graduate diploma or self-directed training offered by non-accredited CPD providers evaluated by CPD Councils; or other such activities recommended by CPD Councils and approved by the Board and the Commission.

6.3.4. Establishment of the National Core Competency Standards (NCCS) 2012

The NCCS is an important step in support of one of the thrusts of the MRA to facilitate the exchange of information on core competencies and scope of practice of nursing professionals in the country. At the core of this standard is the promotion of best practices on professional nursing services, which is another thrust of the MRA.

As early as 2009, PRBON started the journey in conducting a comprehensive review of the nursing core competency standard using the competency-based framework. In 2012, the National Nursing Core Competency Standards (NNCCS) was drafted and promulgated by PRBON in Resolution No. 24 s. 2012. The 2012 NNCCS emphasized the three roles of the nurse: client care; management and leadership; and research, as well as the four types of clients of the nurse: individual, family, population group and community. These roles set expected patterns of professional behaviour for the professional nurse.

The adoption of 2012 NNCCS was used as a guide in the development of the following: the Basic Nursing Education Program in the Philippines; competency-based test framework as the basis for the development of course syllabi and test questions for “entry level” nursing practice in the Board Licensure Examination for Nurses; standards of professional nursing practice in various settings in the Philippines; national career progression program for nursing practice; and all related evaluation tools in various practice settings (PRC, 2012).

6.3.5. Shift to Outcomes-based Education (OBE) Nursing Curriculum

In response to the provisions of the MRA, the Philippine Nursing Education is now in the process of transforming its curriculum into an outcomes-based Bachelor of Science in Nursing (OBE BSN) curriculum (Figure 1.15). This was inspired by the global shift to learning outcomes as the basis of national qualification frameworks and regional common reference frameworks. To this end, a comparative analysis of the nursing curriculum and nursing core competencies with other countries has been embarked on by the Philippines with Australia and Brussels. The International Labour Organization has likewise asked

the Commission on Graduates of Foreign Nursing Schools (CGFNS) to undertake comparative analysis of Philippine nursing curriculum with Norway, Finland and Denmark. Generally, the result of the analysis was found comparable (CMO NO 14 S2009). This finding is expected to facilitate the mobility of nursing professionals within and outside of the ASEAN. Moreover, the development of the competency-based framework and the creation paradigm has been shared with other disciplines and in international nursing conferences to disseminate the information to interested nations who look to the Philippines as a source of nursing professionals (ASEAN Joint Coordinating Committee on Nursing, 2016).

Through these MRA initiatives, Filipino nurses are being prepared to effectively and efficiently perform their duties and responsibilities, in collaboration with multi- and interdisciplinary teams, and whose qualifications will be recognized and harmonized with ASEAN qualifications. More importantly, by conforming to ASEAN and international nursing standards and promoting high quality of education and training, the competitiveness of Filipino nurses, in the labor market of ASEAN and beyond will further improve.

6.4. Issues on the Implementation of the ASEAN MRA

Still, there are many issues that need to be resolved to prepare the country and its stakeholders in the implementation of the MRA. One area that needs to be improved is the dissemination of information among stakeholders regarding the MRA. While the ASEAN had already established the AJCCN, set up the AJCCN Secretariat, collected information and nursing database, and established the AJCCN website during the 2011 assessment of the MRA compliance, it has not conducted dissemination activities related to MRA-related information on nursing services. This could be the reason why in the survey of nursing graduates, 77 per cent said they were not familiar with the MRA. Information dissemination can also be technically challenging given the gaps in the state of information technology among the member countries. Aside from information dissemination, other concerns, particularly in the areas of governance of higher education institutions, research collaboration on nursing curriculum and labour market issues, design of the credit transfer system, still need to be addressed in preparation for the MRA implementation (Manzala, 2016).

On the actual implementation of the MRA in all professions, one concern would be the presence of differing policies and inward labour mobility of ASEAN countries. According to POEA, the “free flow” under the ASEAN Economic Community is not

absolutely "free" since these are rules-based and governed by immigration and labour regulations (Mendoza, Desiderio, Sugiyarto, Salant, 2016). In fact, they claimed that "MRAs rarely, if ever, grant fully unconditional and open-ended rights of access" (Mendoza et al., 2016). Specific to the ASEAN MRA in Nursing, Filipino nurses still go through the usual process of recognition at country of destination based on the eligibility requirements negotiated in the MRAs (see below) so that whether more nurses can be deployed in the ASEAN destination largely depends on how the Philippines can negotiate for these requirements and how these destinations are willing to strike a compromise with the Philippines.

Summary and Conclusions

In this chapter, we attempted to link human resources development in nursing workforce and international migration of Philippine RNs with the integration of the labour market in ASEAN through the MRA scheme. The analyses were based on the market demand-supply framework utilizing both quantitative (from surveys and public file statistics) and qualitative (from interviews and literature review) data.

First, we described how human resources development in nursing, particularly through education and professional regulation, has evolved through the years and how the international mobility and migration of RNs overseas has influenced the shaping of the current nursing system. Based on the analysis, we found out that laws regulating nursing education and practice have been revised to adapt to changes in both local, national and international nursing care needs and circumstances.

Against this background, we examined the current trends and issues in the labour market for Philippine RNs, both from the supply and demand side perspectives, and how the market has become increasingly dependent on labour and migration policies of destination countries. On the supply side, the volumes of enrolment in nursing course and national registry for nurses dramatically fluctuate because of the unpredictable and varied policies and standards of destination countries. On the demand side, given the limitation in expanding the domestic labour market, the country and its stakeholders have relied heavily on demands especially in highly preferred destinations such as the US and UK so that when demand from these countries declined in 2000s, the market produced a huge surplus of nurses who became unemployed and underemployed.

Therefore, the challenge facing the country is how to manage its nurse production and utilization in the light of the demand-led nature of the international labour market,

without sacrificing the health care system of the country. Increasing domestic demand for RNs is bounded by the lack of government budget for health and the size of the domestic health care market. Balancing demand and supply of RNs through regulations on nursing schools, licensure examination and renewal is difficult because nurse supply is guided by preferences of students and their families, as well as their perceptions on work opportunities in preferred destination countries.

Considering the increasing needs for nurses in many countries due to graying of its population and more complex health needs, targeting the international market and being able to immediately respond to its changes are a more practical way to manage the nurse market. To maintain a group of competent and qualified professional nurses who can respond as early as possible to increases in both international and domestic demand for nurses, RNs who are currently not into practice are now required to have some form of training or continuous professional education. The government can also develop a nursing enhancement program or a system similar to the preceptor scheme in hospitals that provide training for those who want to return to the profession. In this way, the hospitals can take the role of providing the required experience to qualify for work overseas while at the same time, alleviate nurse shortage on the ground. Furthermore, it can encourage RNs who cannot find jobs in hospitals to temporarily work in non-nursing but medical-related fields.

Striking mutual agreements with destination countries is also one way to mitigate the negative impacts of the changing labour and migration policies in the destinations. In this paper, we cited the ASEAN Mutual Recognition Arrangement (MRA), which is part of the plan to integrate the ASEAN labour market, and demonstrate the possible benefits it will bring to the country. If fully implemented, MRA is expected to have limited impacts on the mobility of Filipino nurse professionals, but it can raise the number of ASEAN nursing students in Philippine nursing schools. More importantly, this scheme will harmonize the education, qualification and career progression systems in member countries and result in uplifting the quality of nursing education and training in the country. This in turn, may strengthen the competitiveness of the Filipino nurse not only in ASEAN but beyond this region as well. Whether MRA will make the country more dependent on international demand for nurses, however, is not clear and thus becomes a topic for future study.

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Appendix A.1 Features of the Philippine Bachelor of Science in Nursing Program

The following information are based on the Commission on Higher Education (CHED) Memorandum Order (CMO) No. 14, s. of 2009.

a. The Bachelor of Science in Nursing (BSN) Program Curriculum

The goal of the Bachelor of Science in Nursing program is to enable the graduates to cope with the changing patterns in global health care, technological advancement, the varying population demographics and the expectations in the roles of the professional nurse in the present and future work settings. Specifically, courses that intend to improve their communication and interpersonal skills includes Communication Skills both in English and Filipino, Critical and Creative Thinking, Psychology, Socio-Anthropology, World Civilization and Literature, and Nursing Informatics. The professional nursing subjects that build the competencies of the graduates are introduced in the first year and gradually develop up to the fourth level so that nursing graduates can function as general nurse practitioners at PQF Level 6.

Early appreciation of the nursing profession, its historical background, theoretical foundation and professional values are introduced in courses like Theoretical Foundation in Nursing, and Fundamentals of Nursing Practice and Health Assessment at level I. On the other hand, the role of the nurse in the health care delivery both locally and globally, utilization of the nursing process in the care of client, specifically the mother, children, family and population groups, are introduced at level II. Level III gives more emphasis on the more complex role of a nurse in the care of adult clients, which require students to demonstrate higher level of competencies in the performance of duties and responsibilities, teamwork, and multidisciplinary collaboration. This includes subjects like NCM 103, NCM 104, NCM 105 and Research. Towards the end of level IV, the students are expected to demonstrate the competencies in all the key areas of responsibility such as safe and quality nursing care, communication, collaboration and teamwork, health education, legal responsibility, ethico-moral responsibility, personal and professional development, quality improvement, research, management of resources and environment, and records management. In order to achieve these, the following courses are offered; Leadership and Management, Electives courses in Hospice Palliative Care, Critical Care Nursing, Care of the Chronically Ill and Older Person and Quality Health Care and Nursing, among others.

A research proposal is required in Research 1 at level III and continuation of the

research is completed at level IV, which includes collection of data, analysis, interpretation, summary and conclusion and recommendation. The faculty adviser assists them as part of the practicum session. The final research defense process is done for critiquing, and the final research paper is submitted as a requirement at the end of the course.

In order to demonstrate the desired competencies for each year level, the students are exposed simultaneously to clinical and community settings, with carefully planned RLEs. They are given opportunities to take care of actual clients with varied cases, ranging from simple to complex conditions. In these situations, they are required to apply the nursing process in providing primary care to clients in the hospital and community settings. In addition, the classroom and RLE are simultaneously offered within the same level. Moreover, the students are under strict supervision by the faculty from the school they are enrolled, with the following ratio:

BSN Level	Faculty Ratio to Students
II	1: 8-10
III	1: 10-12
IV	1: 12-15

b. Components of the Nursing Curriculum

Curriculum Contents	Units		Hours
1. Courses (units)		202	
1.1. General Education (GE) Courses	87		
Language and Humanities	21		
Mathematics, Natural Sciences & Information Technology	22		
Health Sciences	9		
Social Sciences	15		
Mandated Subjects	20		
1.2. Professional Courses	115		
2. RLE Contact (units/hours)		46	2,346.0
2.1. Skills Laboratory	12.5		637.5
2.2. Clinical Laboratory	33.5		1,708.5
3. Laboratory Courses		10	540.0

c. Suggested Program Outcomes for the BSN Nursing Program

1. Apply knowledge of physical, social, natural and health sciences, and humanities in the practice of nursing.
2. Provide safe, appropriate and holistic care to individuals, families, population group and community utilizing nursing process.
3. Apply guidelines and principles of evidence-based practice in the delivery of care.
4. Practice nursing in accordance with existing laws, legal, ethical and moral principles.
5. Communicate effectively in speaking, writing and presenting using culturally-appropriate language.
6. Document to include reporting up-to-date client care accurately and comprehensively.
7. Work effectively in collaboration with inter-, intra- and multi-disciplinary and multi-cultural teams.
8. Practice beginning management and leadership skills in the delivery of client care using a systems approach.
9. Conduct research with an experienced researcher.
10. Engage in lifelong learning with a passion to keep current with national and global developments in general, and nursing and health developments in particular.
11. Demonstrate responsible citizenship and pride in being a Filipino.
12. Apply techno-intelligent care systems and processes in health care delivery.
13. Adopt the nursing core values in the practice of the profession.
14. Develop entrepreneurial skills in the delivery of nursing care.

Appendix A.2 The Philippine Roadmap for the Implementation of ASEAN MRA on Nursing Services (Source: ADPCN Website)

Objectives and Detailed Activities	Timeline (as of December, 2012)
1 Exchange information and expertise in order to promote adoption of best practices on standards and qualifications	
A. Compilation of required information	
i. Recognized basic qualifications (local)	In place
ii. List of recognized institutions (local and foreign)	In place
iii. Domestic laws and regulations pertaining to nursing education, nursing practice, examination and registration	In place
iv. Requirements for post basic nursing qualifications	In place
v. Requirements for credentialing for specialization in host country	In place
vi. Code of ethics and professional conduct and nursing practice safety guidelines	In place
vii. CPD (Continuing Professional Development) requirements in host country	In place
viii. Registration policy and procedures in host country	In place
ix. Process for license to practice	In place
x. Criteria for recognition of foreign nurses	In place
xi. Number of foreign registered nurses in host country	In place
xii. Contact details of Professional Regulatory Authority of host country	In place
xiii. Information on certificate of good standing, period of registration and verification of registration documents (only upon request of the PRAs of AMS)	In place
B. Publication of the Compiled Information through National and ASEAN Website	
i. Website address of Professional Regulatory Authority	In place
ii. Linking the national websites to the ASEAN Healthcare services website	In place
iii. Regular periodic updates of the national website content for	In place

	AJCCN by the AJCCN representatives	
2	Facilitate Mobility of Healthcare Professionals within ASEAN	
	A. Recognize registration mechanism in all AMS	In place
	B. Adherence to national treatment for foreign registered nurses to ensure equal treatment for local and foreign registered nurses including health and welfare insurance	In place
	C. Mechanism for monitoring foreign registered nurses in compliance with professional and ethical code and standards in the host country	
	D. For foreign registered nurses who fails to practice in accordance with the professional and ethical codes of conduct and standards of practice of the host country, PRA of the host country can provide information upon request of PRAs of AMS	In place
3	Provide opportunities for capacity building and training of registered nurses	
	A. Conferences/Forums	
	i. List of relevant professional websites in host country	In place
	ii. Websites announcing regular conferences/forums for registered nurses	
	B. Visits to Healthcare Facilities/Institutions	
	i. List of facilities/institutions (niche areas)	In place
	C. Attachments Programmes	
	i. List of institutions offering attachments programmes (host countries) for easier referral	
	D. Exchange of Resources among AMS	
	i. Mechanism of exchange of resources (e.g. experts, students) to facilitate capacity building and training among AMS	
	• PRA of the host country provide temporary license upon request	In place
	• List of experts and their areas of expertise made available in the website	
	• List of possible funding agencies/institutions	
	ii. Countries with developed systems assist the other ASEAN countries through various programs	

	• Teaching faculty in the institutions of higher learning to assist other ASEAN countries through various programs initiated by ASEAN
4	Mandatory Malpractice Insurance for Healthcare Professionals in Host Country

Appendix A.3 The Philippine Qualifications Framework (PQF)

With the envisioned free flow of professionals and skilled workers in the region, comparability of qualifications has become a paramount concern. Thus, development and implementation of quality assured national qualifications frameworks (NQF) and regional qualifications reference framework was given emphasis in recent years (Bautista & Taganas, 2016). As a result, the Philippine Qualifications Framework (PQF) was institutionalized on October 1, 2012 through Executive Order No. 83 entitled "Institutionalization of the Philippine Qualifications Framework". As mandated by this Order, the high-level PQF-National Coordinating Council (NCC) was convened to coordinate the formulation of harmonized education and training policies in the country.

The PQF started in 1998 when Technical Education and Skills Development Authority (TESDA) began implementing reforms for a quality assured competency-based technical vocational education and training (TVET) system (Bautista & Taganas, 2016). The system was formally established in 2004 through the National Qualifications Framework for TVET called the Philippine TVET Qualifications Framework (PTQF), with four levels of qualifications.

PQF serves to change the mindset of stakeholders and the public at large that graduates of four-year college degrees are more qualified and therefore have a greater chance of being employed, particularly in other countries. The widespread bias against technical and vocational training vis-à-vis college education, coupled with the lack of alignment between education and industry, poses a key challenge to PQF substantiation and implementation. Because even employers prefer to hire college graduates for jobs that do not require educational attainment, the implementation of the PQF would then level the playing field and give vocational and technical skills equal footing with college education.

According to Bautista and Taganas (2016), the objectives of the PQF are the following:

(1) Establish national standards and level for outcomes of education, training, specialization, skills and competencies.
(2) Provide national regulatory and quality assurance arrangements for education and training.
(3) Support the development and maintenance of pathways and equivalencies which provide access to qualifications.

(4) Support individual lifelong learning goals by providing the basis for individuals to progress through education and training.
(5) Align the PQF with international qualifications framework to support the national and international mobility of learners and workers through increased recognition of the value and comparability of Philippine qualifications.

On the other hand, the International Labour Organization (2015) states that qualification standards and level of outcomes are based on three domains:

(1) Knowledge, skills and values (the kind of knowledge, skills and values involved)
(2) Application (the context in which the knowledge and skills are applied)
(3) Degree of independence (refers to responsibility and accountability)

Despite the institutionalization and implementation of PQF in different higher institutes of learning (HEIs) since 2012, almost 70 per cent of nursing students surveyed are not familiar with the PQF. This is understandable since most nursing graduates surveyed belong to batch 2013 to as far back as 1979. The EO was executed in 2012, and thenceforth the implementation could not have been cascaded to HEIs a year or two later. It is the responsibility of the HEIs to cascade the information on PQF to familiarize students and help them plan for the future, especially those who want to work abroad.

Familiarity with PQF, particularly its components, will help graduates, especially those who have plans to go abroad, to work in a foreign country. One of the PQF components is the career pathways for nurses. It aims to support the development and maintenance of pathways and equivalences which provide access to qualifications and assist people to move easily and readily between the different education and training sectors and between these sectors and the labour market (Philippine Qualifications Framework, 2013). Although this has been in place already through the Philippine Roadmap for ASEAN MRA on Nursing, almost 60 per cent of the nursing graduates surveyed were not familiar with this component.

With the implementation of the PQF, national qualifications will be aligned with international qualifications framework to support the national and international mobility of workers through increased recognition of the value and comparability of Philippine qualifications with the rest of the ASEAN member countries. However, 72 per cent of the nursing graduates surveyed were not familiar with credential and credit transfers. Familiarity with this component may help BSN students who want to pursue his/her studies in other ASEAN member countries to easily transfer education credits with an HEI of choice.

One important feature of PQF is the development of postgraduate qualifications or

specialization tracks/career progression as shown in Figure 1.14. All nursing practitioners must have the same level of General Nursing Practice (GNP) and basic educational background in nursing, the Bachelor of Science in Nursing. The career pathway for nursing leadership moves from GNP to middle/supervisory level at PQF Level 7 based on the acquired experiences, knowledge, attitudes and skills and educational qualification of at least a masteral degree. Practitioners in the PQF level 8 must have significant level of expertise as an executive, with highly specialized knowledge, attitude and skills. The minimum educational background is at least a doctoral degree, who can demonstrate professional leadership for innovations, research and in working with multidisciplinary team in a complex setting. The same pathways will be undertaken by the specialty and independent nursing practice and for nursing education.

Another area that is explored in the PQF is the lifelong learning aspect of the profession. The Philippine Constitution recognizes the role of professionals in nation building and provides for the sustained development of a reservoir of professionals under Section 14 of Article XII of the Constitution. Towards this end, the Professional Regulation Commission promotes a program for Continuing Professional Development (CPD). The objectives of the CPD are to provide continuous improvement of the quality of registered professionals through updates on the latest scientific/technological/ethical and other applicable trends in the local and global practice of professions; provide support to lifelong learning in the enhancement of competencies of Filipino professionals towards delivery of quality and ethical services locally and globally; and deliver quality Continuing Professional Development (CPD) activities aligned with the Philippine Qualifications Framework for national relevance and global comparability and competitiveness.

In 2016, Republic Act 10912, known as the "Continuing Professional Development Act of 2016" came into force. It mandates and strengthens the CPD Program for all regulated professions. In this Act, the CPD program needs to be strengthened in order to enhance and upgrade the competencies and qualifications of professionals for the practice of their profession pursuant to the PQF, the AQRF and the ASEAN MRAs; ensure international alignment of competencies and qualifications of professionals through career progression mechanisms leading to specialization/subspecialization; ensure the development of quality assured mechanisms for the validation, accreditation and recognition of formal, non-formal and informal learning outcomes, including professional work experiences and prior learning; ensure maintenance of core competencies and development of advanced and new competencies in order to respond to national, regional

and international labour market needs; and recognize and ensure the contributions of professionals in uplifting the general welfare, economic growth and development of the nation (RA 10912, s. 2016).

The Act likewise creates the CPD Council and appropriates funds for its implementation. Each CPD Council shall be composed of a Chairperson and two members. The CPD Council for Nursing has three members: the Chairperson, who is a member of the PRBON; the president or representative duly authorized by the accredited professional organization; and the president or representative duly authorized by the organization of deans from universities offering the nursing program.

One of the challenges ahead is the alignment and strengthening of CPD provider activities considering developments in PQF, AQRF, MRAs, lifelong learning, and self-directed learning. Another is the mechanics for the monitoring and evaluation of CPD programs offered, capacity building for CPD providers; development of the database for verifications of CPD units earned; adequate qualified staff as secretariat for the CPDC council; and financial and logistic support to the CPD program to ensure effective and systematic implementation.

Finally, the most important feature of the Philippine Qualification Framework (PQF) is the shift to outcomes-based education (OBE) and use of learning outcomes. It has been a global shift to learning outcomes as the basis of national qualification frameworks and regional common reference frameworks. Learning outcomes emphasize the results of learning rather than focusing on inputs. This also supports the transfer of qualification, credit transfer and recognition of non-formal and informal learning. This is very specific and describes exactly what a student will be able to do in some measurable way.

In OBE, institutions must begin with the articulation of desired quality outcomes within the context of the vision, mission and goals of HEIs (See Figure 1.15). Crucial to this is the formulation of internal quality assurance (QA) systems that focus on programs and institutional processes. These should also look into the cycle of planning, implementation, assessment, and transformation. Moreover, QA can be carried out with the help of external agencies, like CHED and the accrediting bodies. The role of CHED is to oversee a rational and cohesive system that promotes quality according to the typology of HEIs (CHED, 2014, p.10)

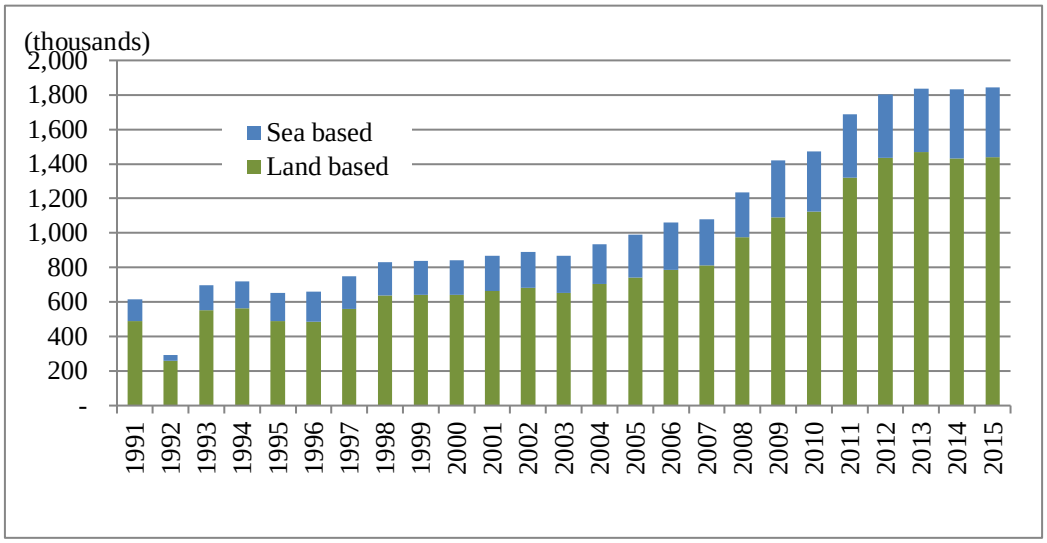
The OBE BSN program aims to develop a professional nurse who is able to assume entry-level positions in health facilities or community settings. The professional nurse is capable of providing safe, humane, quality and holistic care to individuals of varying age, gender and health-illness status; healthy or at risk families; population groups; and

community; singly or in collaboration with other health care providers to promote health, prevent illness, restore health, alleviate suffering and provide end of life care. As a nurse generalist, they can assume the three major roles of the professional nurse as stated in the National Nursing Core Competencies Standards of 2012: direct client care, leadership and management, and research. (Draft CMO OBE BSN Curriculum, 2016)

Public orientation on the draft CMO OBE BSN curriculum was conducted to present the proposed curriculum and to listen to comments and suggestions to make the curriculum more relevant and responsive and to facilitate the program outcomes intended for the nursing profession. The final draft will be presented to CHED for approval and for the issuance of CHED memorandum order for implementation of the Policies, Standards and Guidelines for the Bachelor of Science in Nursing for adoption by School Year 2018-2019.

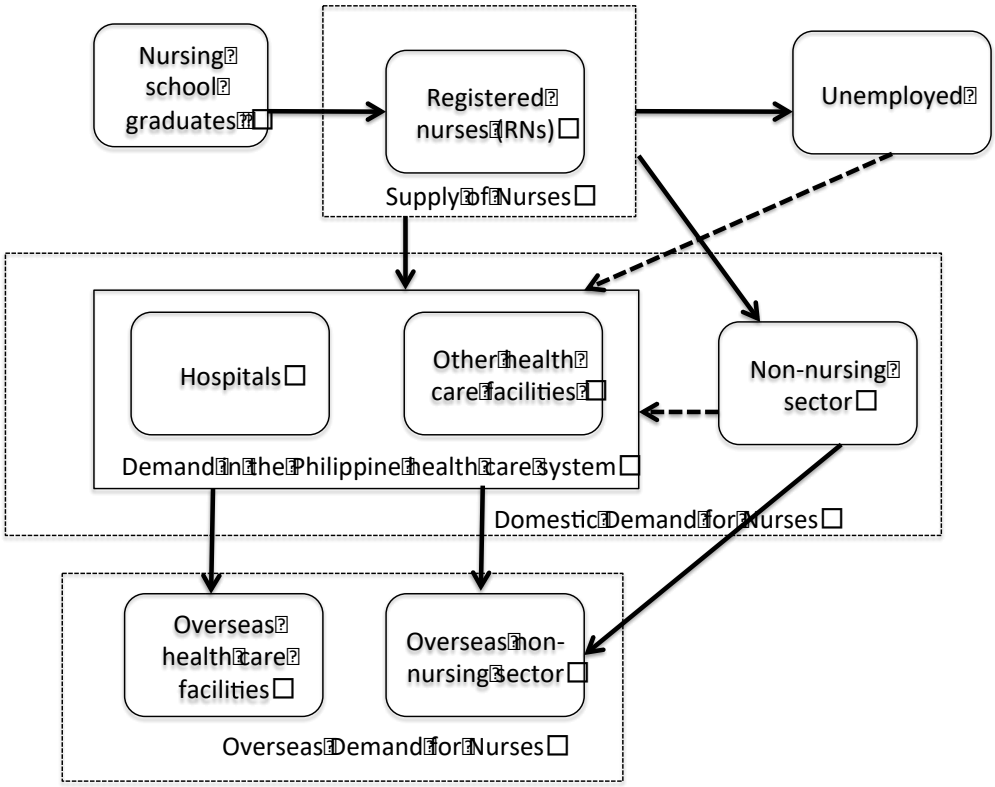
Figures and Tables

Figure 1.1: Deployed overseas Filipino workers (OFWs) (New hires, 1991-2015)



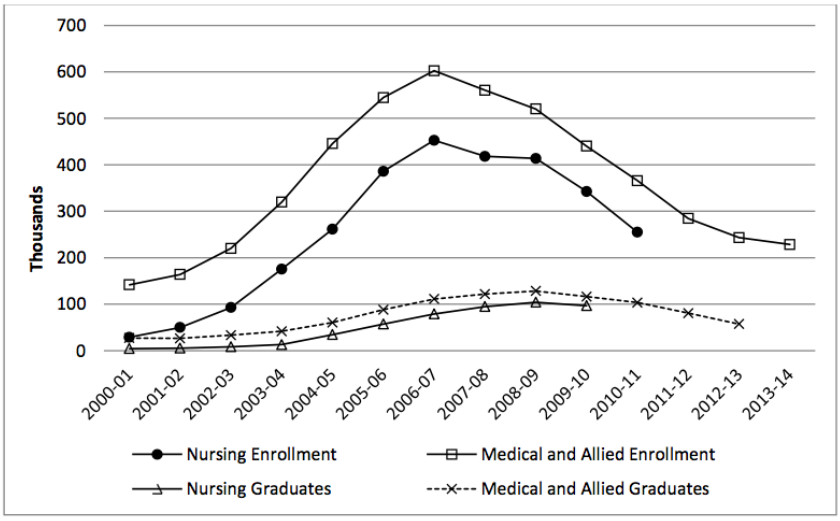
Source: POEA

Figure 1.2: Demand-supply framework in analyzing the labour market for nurses



Source: Authors

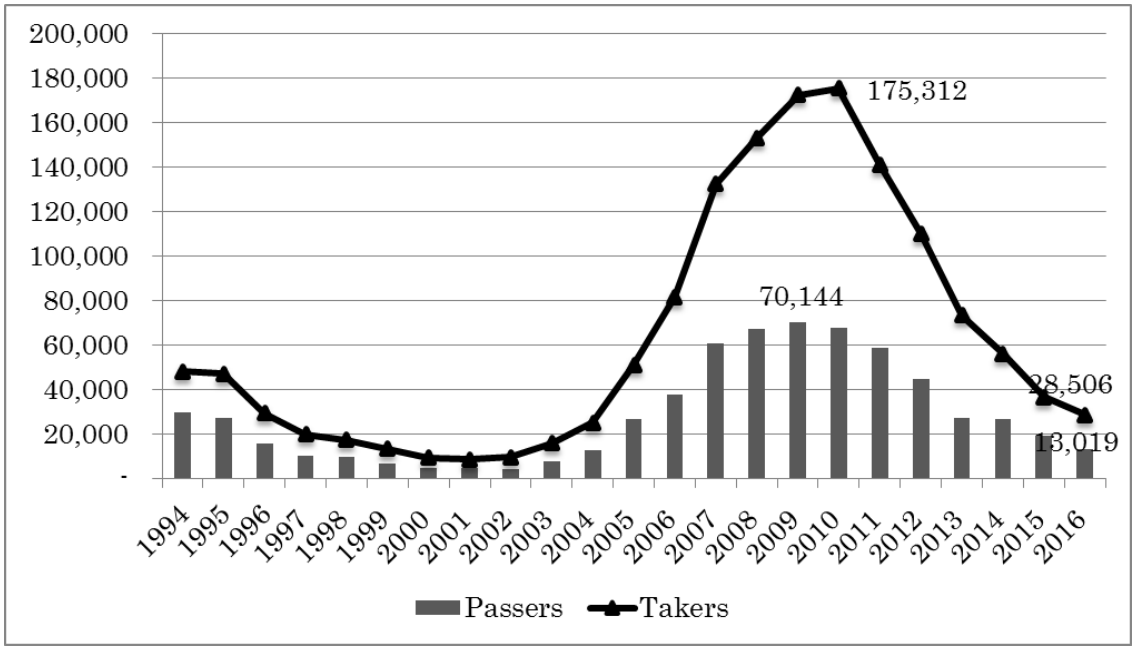
Figure 1.3: Number of enrollees and graduates in nursing and medical and allied sciences



Sources: Lorenzo et al. 2012, Commission on Higher Education (CHED) 2014, Commission on Higher Education (CHED) 2012.

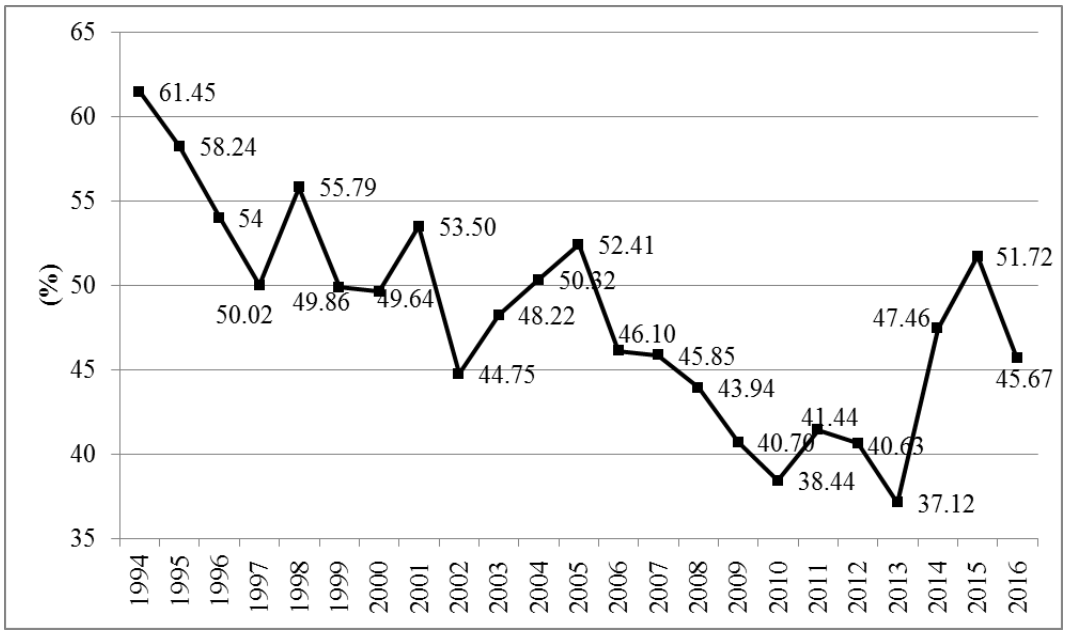
Source: Arends-Kuenning, Calara and Go (2015), p. 33.

Figure 1.4: Number of takers and passers in the NLE (1994-2016)



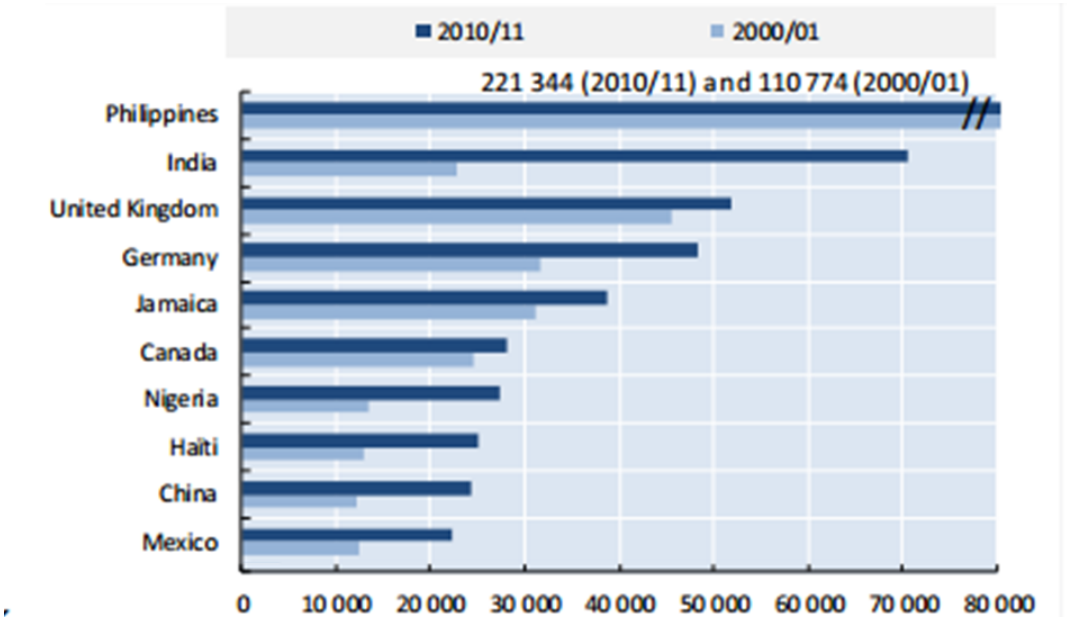
Source: Authors' compilation from CHED "Higher Education Statistical Bulletin" (various editions) and newspaper articles.

Figure 1.5: National passing rate in the NLE (1994-2016)



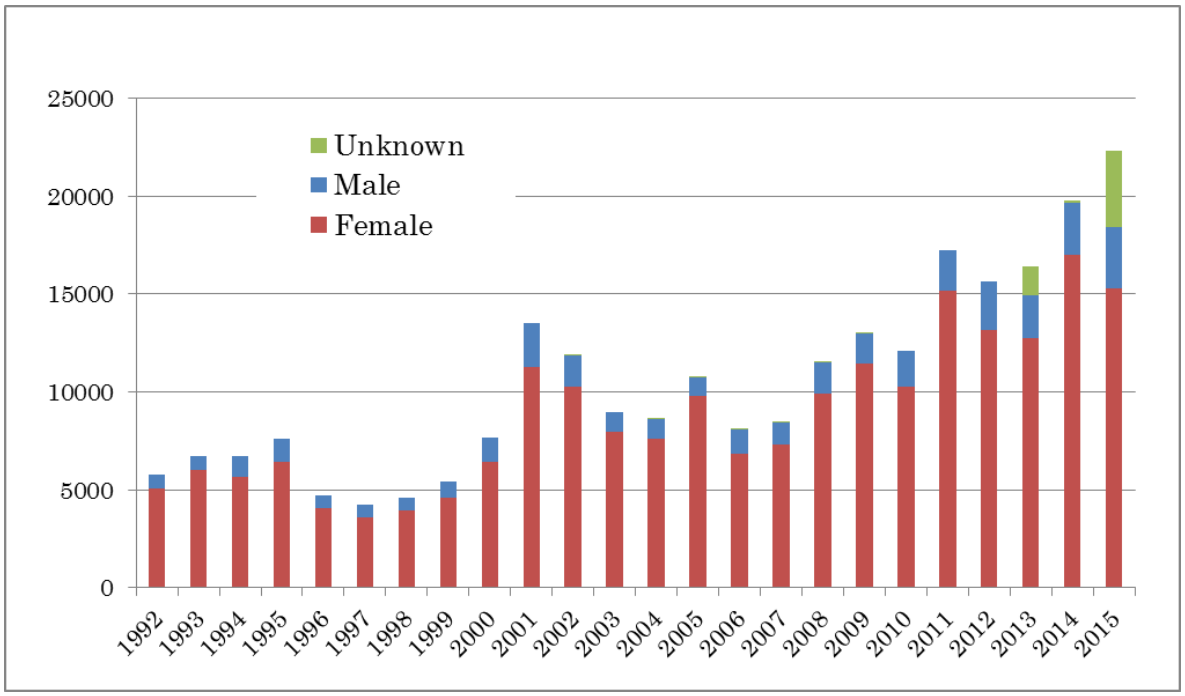
Source: Authors' compilation from CHED "Higher Education Statistical Bulletin" Various years and newspaper articles.

Figure 1.6: The Philippines shown as the top exporting country for nurses



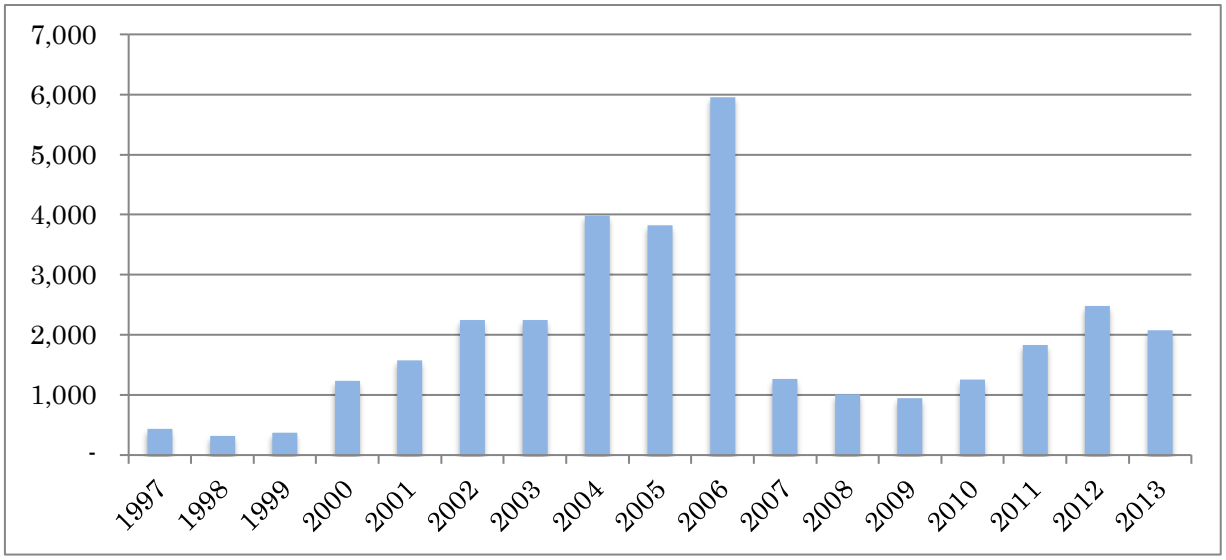
Source: OECD, 2015, International Migration Outlook

Figure 1.7: Number of professional nurses deployed overseas (New Hires, 1992-2015)



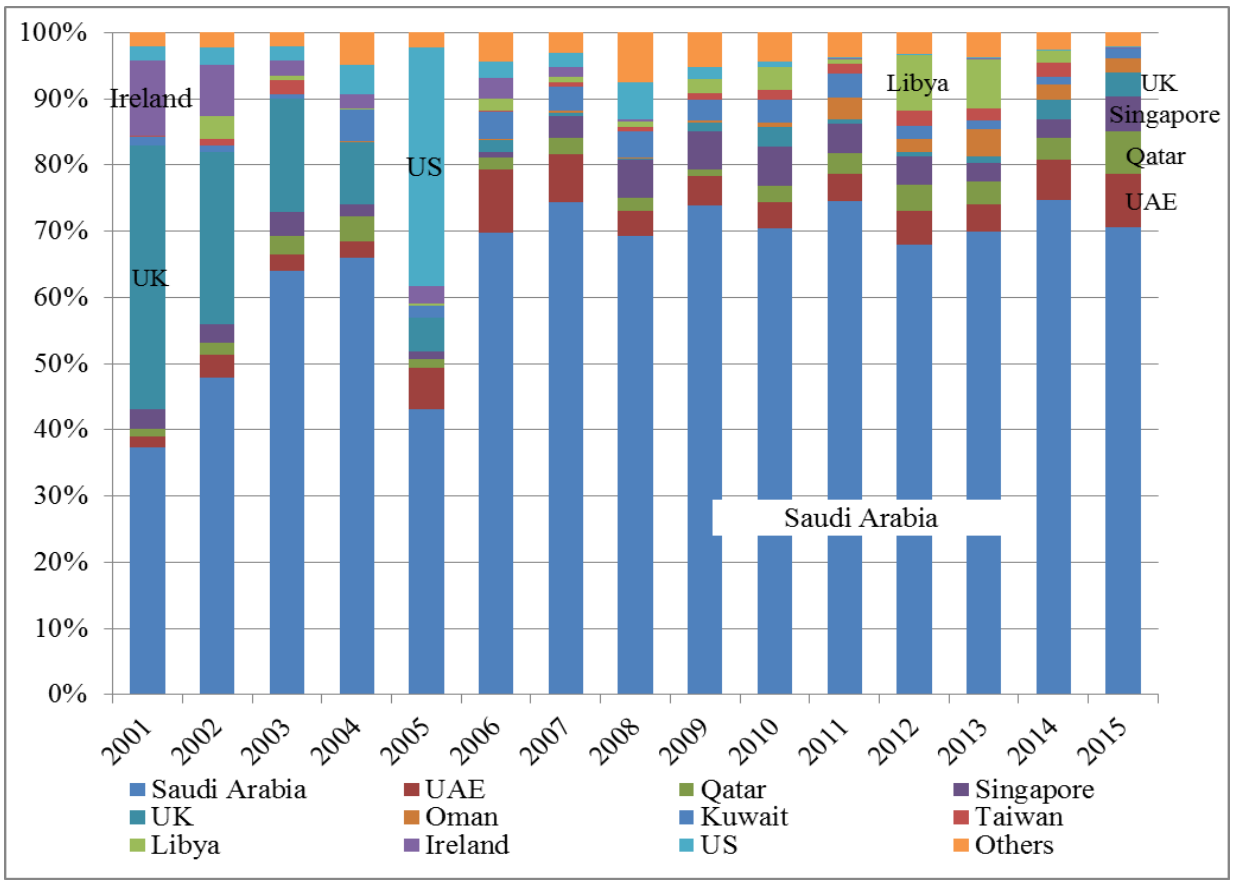
Source: POEA

Figure 1.8: Number of nurses who left the Philippines as permanent migrants (1997-2013)



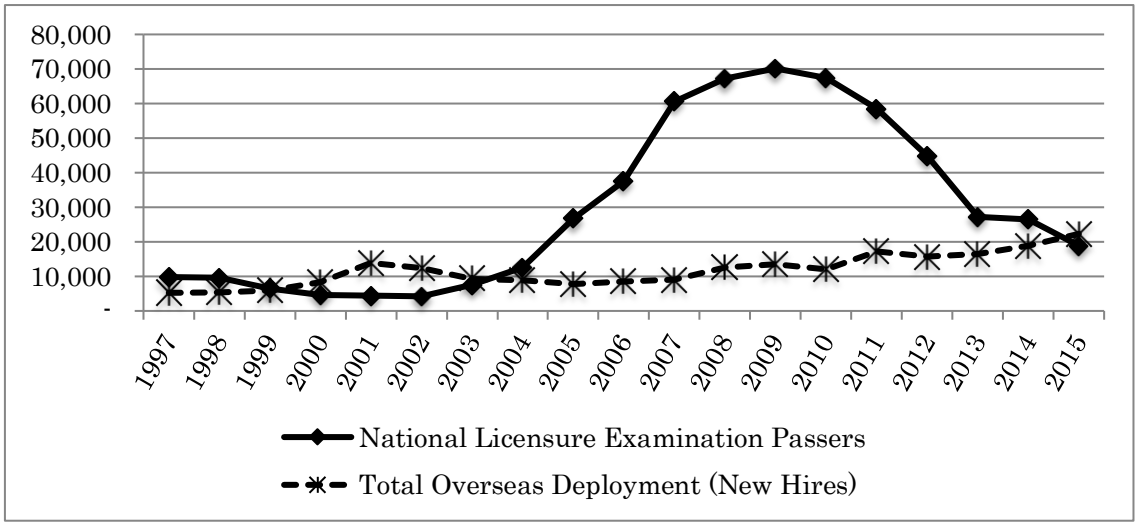
Source: For 1997-2008: Romualdez et.al. (2011) p. 80.

Figure 1.9: Composition of deployed nurses by country of destination (new hires) (2001-2015)



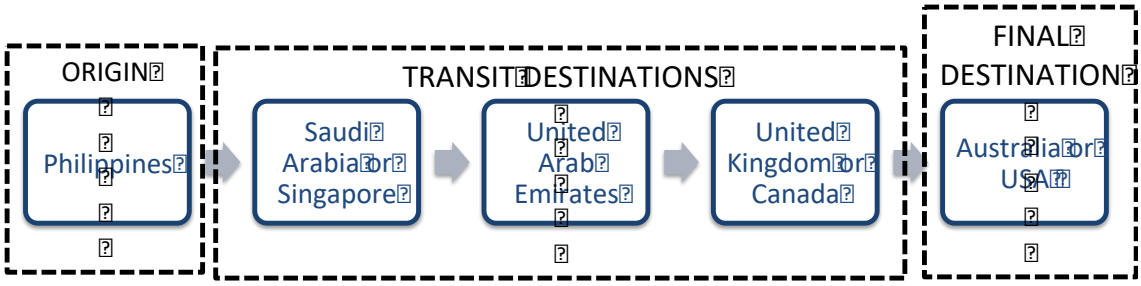
Source: POEA

Figure 1.10: Annual flows of National Licensure Examination (NLE) passers (new registered nurses) and deployed nurses (new hires)



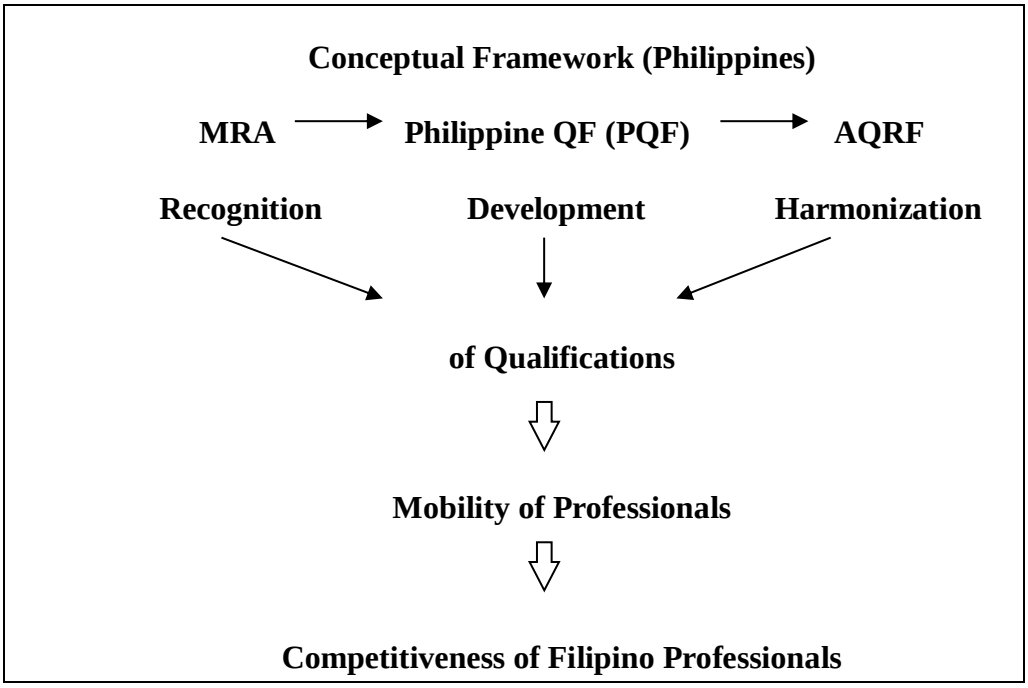
Sources: POEA and PRC

Figure 1.11: An example of stepwise international migration behavior of Filipino nurses



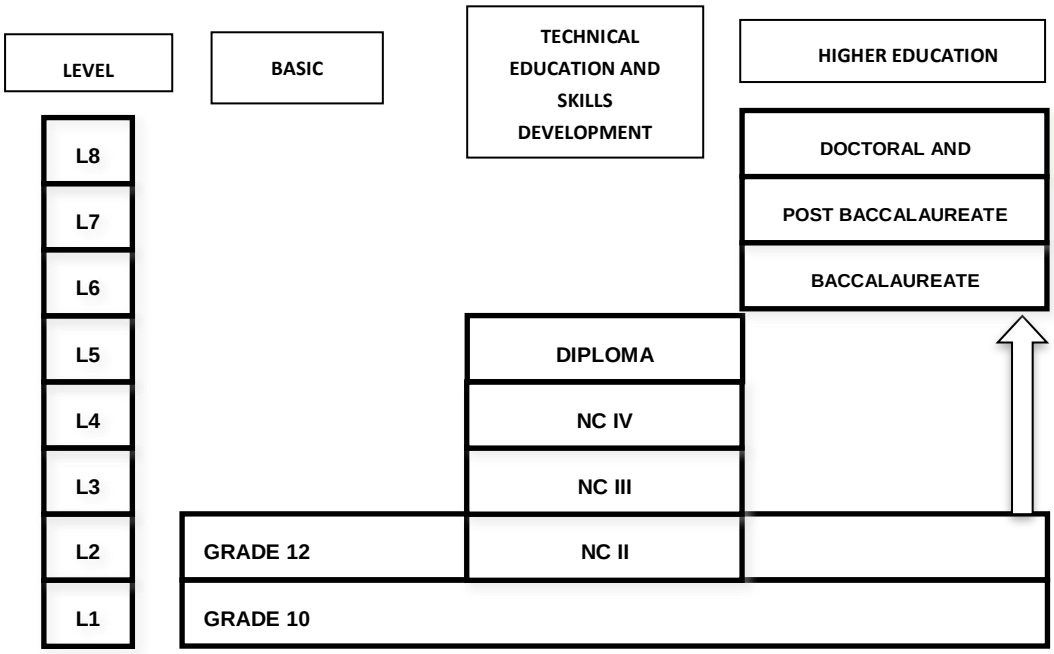
Source: Authors.

Figure 1.12: The conceptual framework in the mobility of professionals



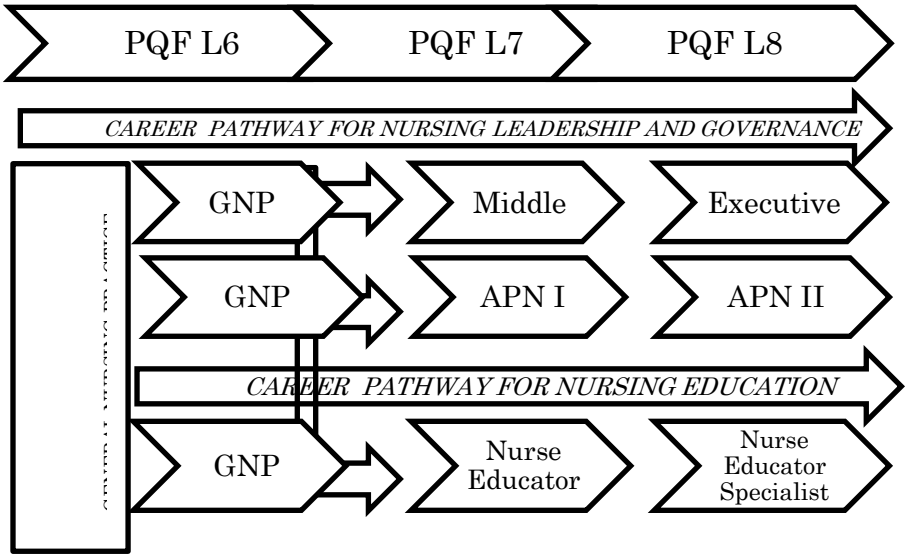
Source: Manzala (2013). "Optometry on Higher Dimension (AEC 2015)" A paper presented at the Integrated Philippine Association of Optometrists (IPAO) Midyear Convention, October 25, 2013.

Figure 1.13: The Philippine Qualifications Framework



Source: NEDA SDC-Cabinet, 2012. NC means National Competency

Figure 1.14: Career pathway for nursing levels 6 to 8

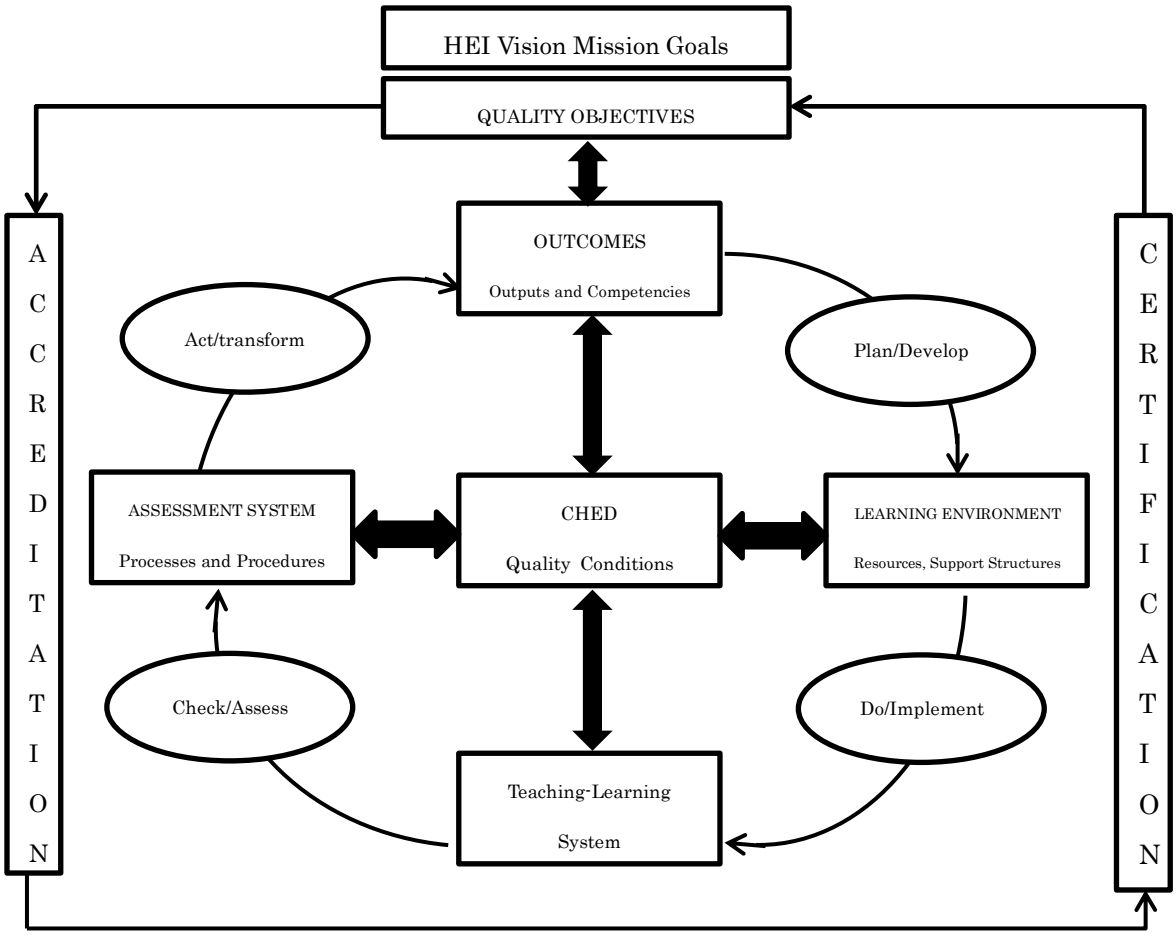


C-NARS COUNCIL FOR NURSING ADVANCEMENT RECOGNITION AND SPECIALIZATION. "At every level there should be an appropriate program prescribed, qualified trainers and training facilities for the rigorous job of "progressive nurse-human resource development."

PQF=Philippine Qualifications Framework; GNP-General Nursing Practice; APN=Advanced Practice Nurse

Source: Abaquin, 2015.

Figure 1.15: Outcomes-based Framework for Higher Education



Source: CHED Handbook on Typology, OBE, and ISA.

Table 1.1: Number of Nursing Schools in the Philippines

YEAR (PERIOD)	NUMBER	YEAR (2000-2008)	NUMBER
1920	9	2000-2001	182
1930	17	2001-2002	201
1940	14	2002-2003	230
1950	17	2003-2004	301
1960	30	2004-2005	328
1970	63	2005-2006	437
1980	130	2006-2007	439
1990	125	2007-2008	466

Sources: Author's compilation from Lorenzo 2007, Acacio 2011.

Table 1.2: Survey Results "To what extent do the following reasons for choosing to study nursing agrees with your own?" (Nursing Students)

RANK	MOTIVATIONS	MEAN VALUE
1	To help support the family financially	3.67
2	To provide service to the sick and needy	3.60
3	Nursing is a highly respected profession	3.50
4	To work abroad	3.49
5	Good salary and benefits	3.42
6	My family strongly influenced/encouraged me to become a nurse	3.25
7	Employability	3.07
8	To acquire better social status	2.97
9	Because of a role model (Parents or relatives are nurses)	2.91
10	I like the uniform	2.39
11	The scholarship grant I got is for Nursing	1.50

Responses: 4: Extremely; 3: Fairly well; 2: Not particularly; 1: Not at all
Number of respondents (n) = 315
Source: Authors' Calculations

Table 1.3: Survey Results "To what extent do the following reasons for choosing to study nursing agrees with your own?" (Nursing Graduates)

RANK	MOTIVATIONS	MEAN VALUE
1	To provide service to the sick and needy	3.42
2	To help support the family financially	3.36
3	Nursing is a highly respected profession	3.27
4	To work abroad	3.21
5	Good salary and benefits	3.05
6	Employability (Easiness to find job) in the Philippines and abroad	3.03
7	My family strongly influenced/ encouraged me to become a nurse	2.85
8	To acquire better social status	2.71
9	Because of a role model (Parents or relatives are nurses)	2.36
10	I like the uniform	2.32
11	The scholarship grant I got is for BSN	1.49
12	I want to marry a doctor	1.34

Responses: 4: Extremely; 3: Fairly well; 2: Not particularly; 1: Not at all
Number of respondents (n) = 110
Source: Authors' Calculations

Table 1.4: Estimated Number of New Registered Nurses in the Philippines

PERIOD	NUMBER OF NEW REGISTERED NURSES
1919-1950[(A)]	7,229
1951-1990[(B)]	159,950
1991-2000[(C)]	158,935
2001-2009[(D)]	289,725
2010-2016[(D)]	256,147

Sources of data: (A) Lorenzo, et.al (2011); (B) Lorenzo et.al. (2011) and BLES (2003); (C) BLES (2003); (D) compiled from newspaper announcements of NLE results for respective years.

Table 1.5: Number of Nurses Deployed under the RNHEALS and NDP Programs

YEAR	NUMBER
2011	20,801
2012	10,000
2013	21,929
2014	11,293
2015	13,371
2016	15,727
2017	9,349

Notes: Numbers indicate those deployed through RNHEALS Program in 2011-2013 and DNP Program in 2014-2017. The data for 2017 is the quota approved by DOH.
Source: Department of Health (DOH)

Table 1.6 Top Ten Destinations for Filipino Nurses (New Hires, 2001-2015)

Year	Saudi Arabia	UAE	Qatar	Singa-pore	UK	Oman	Kuwait	Taiwan	Libya	Ireland	USA	Others	Total
2001	5,045	243	143	413	5,383	3	182	9	9	1,529	304	273	13,536
2002	5,688	405	213	334	3,089	1	108	129	411	915	316	258	11,867
2003	5,740	226	242	326	1,544	-	51	200	52	207	196	183	8,967
2004	5,640	218	318	166	800	7	408	5	10	190	373	421	8,556
2005	4,627	670	133	129	546	4	191	2	23	297	3,853	243	10,718
2006	5,640	768	140	73	145	10	340	2	158	248	202	350	8,076
2007	6,266	614	214	276	38	24	304	62	66	127	186	252	8,429
2008	7,955	435	245	652	28	15	456	61	104	35	649	860	11,495
2009	9,623	572	133	745	165	41	423	123	276	3	242	668	13,014
2010	8,513	473	294	722	350	92	409	186	417	5	83	538	12,082
2011	12,839	728	519	765	138	562	606	271	121	22	18	647	17,236
2012	10,623	811	618	662	99	331	287	381	1,302	2	16	515	15,647
2013	11,453	681	571	458	152	673	226	301	1,221	6	26	623	16,391
2014	14,798	1,199	670	533	613	430	242	411	376	5	10	520	19,807
2015	15,736	1,792	1,433	1,188	804	474	354	-	-	31	16	474	22,302
Total	130,186	9,835	5,886	7,442	13,894	2,667	4,587	2,143	4,546	3,622	6,490	6,825	198,123
(per cent)	65.71	4.96	2.97	3.76	7.01	1.35	2.32	1.08	1.08	2.29	3.28	3.44	100.00

Source: POEA

Table 1.7: Annual Flow of Nurses Trained in the Philippines who Migrated to the United States, Ireland and United Kingdom (2000-2013)

Year	USA	Ireland	United Kingdom
2000	1,259		1,052
2001	1,957	1,775	3,396
2002	3,623	1,155	7,235
2003	5,052	314	5,593
2004	5,110	269	4,338
2005	4,617	366	2,521
2006	8,376	439	1,541
2007	10,217	195	673
2008	9,101	94	249
2009	6,254	17	57
2010	3,498	11	434
2011	1,587		399
2012	1,183		341
2013	999		275
Total	62,833	4,635	16,421

Sources: OECD (2016) "Health Workforce Policies in OECD Countries" Figure 4.2. United States: National Council of State Boards of Nursing (NCSBN), NCLEX Examination Statistics (US); Nursing and Midwifery Council (UK) and Irish Nursing Board (Ireland).
Notes: For USA, the data refer to the number of trained nurses in the Philippines who passed the examination to be a registered nurse. In the UK and Ireland, data are for new registrations on professional registers, and data were entered at year-end (for example, data for 2002/03 was entered as 2003 data).

Table 1.8: Number of Nurses Deployed from the Philippines to ASEAN Countries

Countries	2010	2011	2012	2013	2014	2015
Brunei	63	20	8	22	9	18
Cambodia		2				
Indonesia		1				
Laos				1		
Malaysia	9	2	1	2		
Singapore	722	765	662	458	533	1,188
Thailand					4	
Vietnam		5	3	5	2	1
TOTAL (ASEAN)	794	795	674	488	548	1,207
TOTAL (Worldwide)	12,082	17,236	15,647	16,391	19,807	22,302
Ratio of ASEAN to World (%)	6.57	4.61	4.31	2.98	2.77	5.41

Notes: There are no nurses deployed to Myanmar. In 2015, due to the changes in skill definition, Midwifery Professionals are included.
Source: POEA

Table 1.9: Salary of Nurses in Highly Preferred Destinations

Country	Amount (in local currency)	Amount (in US$)
UK	GBP31,383 - 41,373	39,134 - 51,592
USA	US$67,490	67,490
Canada	C$59,783	44,689
Australia	AU$61,000	46,506

Note: Values for UK is entry level salary (Band 7); for the other countries, average annual salary. Dollar conversion is based on exchange rates on March 4, 2017.
Sources of Data: For UK, NHS Agenda for Change Pay Rates 2016; for USA, US Bureau of Labour Statistics (May 2015); for Canada, Payscale Human Capital Research (January, 2017) and for Australia, Health Times Australia (2017).

NURSE MIGRATION SURVEY, 2016

Philippines

FOR NURSING STUDENTS

College of Nursing, Baliuag University

Center for Research and Publication, Baliuag University

And

Institute of Developing Economies –Japan External Trade Organization (IDE-JETRO). Thailand

November 2016

RESPONDENT NO. ☐

Dear Respondent:

A warm greeting! We are conducting this survey interview as part of our research on the education and career development of nurses and nursing students in the Philippines. This research is a collaboration among the following institutions:

1. *Institute of Developing Economies (IDE-JETRO), Chiba, Japan*
2. *Japan External Trade Organization (JETRO), Bangkok, Thailand and*
3. *Baliuag University, Philippines, Bulacan, Philippines*

Thank you very much for your support, and we hope that you will not leave any item unanswered. We assure you that all information you will share will be taken with utmost care and confidentiality.

Sincerely yours,

Philippine Research Team
Dean Elizabeth Roxas, President, Association of Deans of Philippine Colleges of Nursing
Dr. Reinaruth Carlos, Professor, Ryukoku University, Japan
Ms. Yurika Suzuki, Senior Research Staff, IDE-JETRO, Japan

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1. Profile

1.1. Name (Optional) :_____ 1.2. Age:_____

1.3. Gender: (Encircle the appropriate answer) 1. Male 2. Female

1.4 Religion: 1. Christian (e.g. Born Again) 2. Roman Catholic 3. Iglesia Ni Cristo
4. Muslim 5. Others (Pls. specify): _____

1.5. Name of School:_____ 1.6. Current year level:_____

1.7. Do you have any nurse in your family/among relatives? 1 – Yes 2 – No

1.8. If your answer is Yes (in 1.7), Please, specify who (Mother, Father, Grandmother, Uncle, Cousin, etc.): _____

1.9. Was nursing your top choice in college? (Encircle your choice) Yes No

1.10. What other courses did you consider before or aside from taking up BS Nursing?

(Please write them in order of preference with 1 being your top choice, 2 second choice, and 3 your third choice. Write your answers below)

1.	2.	3.

2.1. To what extent do the following reasons for choosing to study nursing agrees with your own?

Please encircle one response for each factor.

(4 – Extremely, 3 – Fairly well, 2 – Not particularly, 1 – Not at all)

	Reasons for studying nursing:	Extent			
1	To work abroad	4	3	2	1
2	Employability (Easiness to find job) in the Philippines and abroad	4	3	2	1
3	Good salary and benefits	4	3	2	1
4	To help support the family financially	4	3	2	1
5	My family strongly influenced/encouraged me to become a nurse	4	3	2	1
6	To acquire better social status	4	3	2	1
7	To provide service to the sick and needy	4	3	2	1
8	Because of a role model (Parents or relatives are nurses)	4	3	2	1
9	The scholarship grant I got is for BSN	4	3	2	1
10	Nursing is a highly respected profession	4	3	2	1
11	I like the uniform	4	3	2	1
12	I want to marry a doctor	4	3	2	1
13	Others (Please specify):	4	3	2	1

2.2. Based on your choices in 2.1., rank your answers according to the degree of importance.

Write the number of your choices only.

Top choice:	Second choice:	Third choice:

2.3. Who made the decision for you to take up nursing? (Choose only 3 main reasons from below).

Encircle the numbers of your choices

1 – Myself
2 – Father
3 – Mother
4 – Siblings (brothers/sisters)
5 – Relatives
6 – Teachers
7 – Others (Pls. specify): _____

2.4. What is/are the main sources of fund for your education? (Choose only 3 main reasons from below).

Encircle the numbers of your choices

1. Parents' income/savings in the Phil.
2. Parents' remittances from overseas
3. Sold/Mortgaged Land/Property
4. Parents' Loans (i.e. bank loans)
5. My income as a working student
6. Education Plan/Scholarship
7. Relatives' remittances from overseas (Who? Please specify_____
8. Others (Pls. Specify): _____

2.5. Where do you want to work after graduation? (Choose all appropriate choices from below).
Encircle the numbers of your choices

1. Specialty hospitals
2. Community health centers
3. Hospital abroad
4. Pharmaceutical companies
5. Call centers
6. I want to pursue graduate studies
7. Nursing school
8. Occupational health institutions
9. Others (Pls. Specify): _____

2.6. Based on your choices in 2.5., rank your answers according to the degree of importance.
Write the number of your choices only.

Top choice:	Second choice:

2.7. Reason for choosing Top Choice in 2.6.

2.8. Do you want to work as a nurse overseas? (Encircle your answer)

1. Yes (Go to 2.9.)
2. No (Go to 2.13.)

2.9. Which countries (abroad) do you want to work in as a nurse? (Write down your TOP 3 choices in the order of your preference)

TOP choice
Second choice:
Third choice

2.10. What are the reasons why you want to work as a nurse in your TOP choice of destination above? (Choose only 3 main reasons from below). Encircle the numbers of your choices

1. Family and friends live there
2. High levelof nursing skills and technology
3. People arekind
4. High salary and benefits
5. Near the Philippines geographically
6. Interested in thecountry's culture
7. Can obtain citizenship
8. Can bring/petition family
9. That country and the Philippines have good foreign relationship
10. I can speak its language
11. Possibility to obtain that country's nursing license
12. Respect for one's religious beliefs/practices
13. Low recruitment and processing fee
14. Less chances of discrimination
15. Ease in processing and getting employment
16. To marry a foreigner
17. Others (Pls. specify)_____

2.11..Based on your choices in 2.10., rank your answers according to the degree of importance. Write the number of your choices only.		
Top/Most important Reason:	Second most important reason:	Third most important reason:

2.12. Do you want to work in Japan as a nurse? (Encircle your answer)

1. Yes 2. No

2.13. Why do you want to stay and work as a nurse in the Philippines? (Choose only 3 main reasons from below). Encircle the numbers of your choices

1. Difficulty in dealing with patients from another culture
2. Ease in dealing with Filipino patients
3. Relationship with foreign superiors and foreign co-workers
4. Slow career development (promotions) abroad
5. Poor working conditions (heavy tasks, long hours of work, nightshift, etc.) abroad
6. Lack of opportunities to improve nursing skills and knowledge (competencies in nursing) abroad
7. Close family ties
8. I want to serve my country and its people
9. Difference in the way of life/ culture
10. Language barrier
11. Racial discrimination

11. Others (Pls. Specify): _____

2.14. Based on your choices in 2.13., rank your answers according to the degree of importance. Write the number of your choices only.

1.	2.	3.

2.15. If you decide to work overseas, do you plan to stay and live there permanently? (Encircle your answer)

1. Yes, I would want to live there permanently. (Go to 2.17.)
2. No, I will return to the Philippines (Go to 2.16.)

2.16. Why would you want to return to the Philippines? (Encircle only <u>one</u>)

1. Establish business
2. Retire in the Philippines
3. Work as a nurse
4. Study/get training to improve skills
5. Take care of family including parents
6. Work in other country.
7. End of contract
8. Others (Pls. specify)_____

2.17. In line with the ASEAN INTEGRATION, are you familiar with the following:

2.17.1. Philippine Qualifications Framework 1. YES (Go to 2.17.1.1) 2. NO

2.17.1.1. I am familiar with Philippine Qualifications Framework through:

2.17.1.1.1. Seminars/Conferences: 1. YES 2. NO

2.17.1.1.2. News articles

(including Internet readings): 1. YES 2. NO

2.17.1.1.3. Classroom discussions: 1. YES 2. NO

2.17.1.1.4. Others (pls. Specify) _____

2.17.2. Career Pathways for Nurses 1. YES (Go to 2.17.2.1.) 2. NO

2.17.2.1. I am familiar with Career Pathways for Nurses through:

2.17.2.1. 1. Seminars/Conferences: 1. YES 2. NO

2.17.2.1. 2. News articles

(including Internet readings): 1. YES 2. NO

2.17.2.1. 3. Classroom discussions: 1. YES 2. NO

2.17.2.1. 4. Others (pls. Specify) _____

2.17.3.Credentialing and Credit Transfer 1. YES (Go to 2.17.3.1.) 2. NO

2.17.3.1. I am familiar with Credentialing and Credit Transfer through:

2.17.3.1.1. Seminars/Conferences: 1. YES 2. NO

2.17.3.1. 2. News articles

(including Internet readings): 1. YES 2. NO

2.17.3.1. 3. Classroom discussions: 1. YES 2. NO

2.17.3.1. 4. Others (pls. Specify) _____

2.17.4. Mutual Recognition Arrangement 1. YES (Go to 2.17.4.1.) 2. NO

2.17.4.1. I am familiar with Mutual Recognition Arrangement through:

2.17.4.1. 1. Seminars/Conferences: 1. YES 2. NO

2.17.4.1. 2. News articles

(including Internet readings): 1. YES 2. NO

2.17.4.1. 3. Classroom discussions: 1. YES 2. NO

2.17.4.1. 4. Others (pls. Specify) _____

2.18. Which do you think is the most pressing problem of nurses who stay and work in the Philippines? (Encircle only one)

1. Occupational hazards
2. High ratio of patients to nurses
3. Palakasan system in getting employed and in promotion
4. Inadequate facilities in hospitals
5. Slow career development (promotions)
6. Poor working conditions (heavy tasks, long hours of work, nightshift, etc.)
7. Lack of opportunities to improve nursing skills and knowledge (competencies in nursing)
8. Limited opportunities for career advancement
9. Low salary/Few benefits
10. Others (Pls. specify): _____

Thank you very much for your kind cooperation!

NURSE MIGRATION SURVEY, 2016

Philippines

FOR NURSING GRADUATES

College of Nursing, Baliuag University
Center for Research and Publication, Baliuag University
And
Institute of Developing Economies –Japan External Trade Organization (IDE-JETRO). Thailand

November 2016

Dear Respondent:

A warm greeting! We are conducting this survey interview as part of our research on the education and career development of nurses and nursing students in the Philippines. This research is a collaboration among the following institutions:

4. *Institute of Developing Economies (IDE-JETRO), Chiba, Japan*
5. *Japan External Trade Organization (JETRO), Bangkok, Thailand and*
6. *Baliuag University, Bulacan, Philippines*

Thank you very much for your support, and we hope that you will not leave any item unanswered. We assure you that all information you will share will be taken with utmost care and confidentiality.

Sincerely yours,

Philippine Research Team

Dean Elizabeth Roxas, President, Association of Deans of Philippine Colleges of Nursing
Dr. Reinaruth Carlos, Professor, Ryukoku University, Japan
Ms. Yurika Suzuki, Senior Research Staff, IDE-JETRO, Japan

Directions: Kindly supply the necessary information. For those items which have choices, please encircle the number/s corresponding to your answer/s.

Section 1: Profile of Nurse

1.1. Name (optional):
1.2. Age:
1.3. Gender: 1 – Male 2 – Female
1.4. Religion: 1 – Christian (i.e. Born Again) 2 –Iglesia Ni Cristo 3 – Roman Catholic 4 – Muslim 5 – Others (pls. specify):
1.5. Birth Place (Province):
1.6. Current Marital Status: 1 – Single 2 – Married 3 – Widowed 4 – Others (Pls. specify):
1.7. Do you have any nurse in your family/among relatives? 1 – Yes 2 – No
1.8. If your answer is Yes (in 1.7), specify who (Mother, Father, Grandmother, Uncle, etc.):
1.9. Current occupation: 1 – Registered Nurse (General) 2 - Registered Nurse (Specialist) 3 – Educator/Teacher 4 – Caregiver 5 – Medical Representative 6 – Call Center Agent 7 – Hospital Administrator/Supervisor 8 – Others(Pls. specify):

Section 2. Educational Profile of Nurse

2.1. When did you graduate from Bachelor of Science in Nursing (BSN): (Year)

2.2. What highest academic degree did you obtain after completion of BSN? Please encircle the number of your choice

0 – None
1 – Master's units (Specify number of units: _____ units)
2 – Master's degree (Graduated)
3 – Doctoral units (Specify number of units: _____ units)
4 – Doctoral degrees (Graduated)

2.3. Did you pursue any other course/program after acquiring your BSN degree:
1 – Yes 2 – No

2.4. If your answer is Yes (in 2.3), state and list the courses/programs:

2.5. If your answer is Yes (in 2.3), state the reason why you pursued another course/programs:

2.6. How did you come to know about Baliuag University's BSN program from where you graduated from?
1 – Family/Relatives
2 – Friends/neighbors/Acquaintances
3 – Advertisements (i.e. Tarpaulins, banners, etc.)
4 – Website/Social media
5 – Teachers from high school
6 – Others (Pls. specify):

2.7. Did you receive any scholarship or financial assistance when you were taking BSN in Baliuag University? 1 – Yes (Go to 2.8) 2 – No (Go to 2.9)

2.8. If your answer is Yes (in 2.7), state and list these scholarship/financial assistance you received:

2.9. If your answer is No (in 2.7), how did you finance your BSN education?
9. - Parents' income/savings in the Phil.
10. - Parents' remittances from overseas
11. - Sold/Mortgaged Land/Property
12. - Parents' Loans (i.e. bank loans)
13. - My income as a working student
14. - Education Plan/Scholarship
15. - Relatives' remittances from overseas (Who? Please specify_____
16. - Others (Pls. Specify): _____

2.10. Who decided for you to study and take BSN as your degree?

1 – Myself
2 – Father
3 – Mother
4 – Siblings (brothers/sisters)
5 – Relatives
6 – Teachers
7 – Others (Pls. specify): _____

Section 3. Career Advancement

3.1. To what extent do the following reasons for choosing to study nursing agrees with your own? Please encircle one response for each factor.
(4 – Extremely, 3 – Fairly well, 2 – Not particularly, 1 – Not at all)

	Reasons for studying nursing:	Extent			
1	To work abroad	4	3	2	1
2	Employability (Easiness to find job) in the Philippines and abroad	4	3	2	1
3	Good salary and benefits	4	3	2	1
4	To help support the family financially	4	3	2	1
5	My family strongly influenced/encouraged me to become a nurse	4	3	2	1
6	To acquire better social status	4	3	2	1
7	To provide service to the sick and needy	4	3	2	1
8	Because of a role model (Parents or relatives are nurses)	4	3	2	1
9	The scholarship grant I got is for BSN	4	3	2	1
10	Nursing is a highly respected profession	4	3	2	1
11	I like the uniform	4	3	2	1
12	I want to marry a doctor	4	3	2	1
13	Others (Please specify):	4	3	2	1

3.2. How do you feel being a nurse and/or choosing nursing as your profession?
1 - Very happy 2 – Happy 4 – Unhappy 5 - Very unhappy

3.3. What aspects of your profession contribute to your satisfaction (happiness) or dissatisfaction (unhappiness)? Please encircle one response for each aspect.
(4 – Very Satisfied, 3 – Satisfied, 2- Dissatisfied,1 – Very dissatisfied)

	Aspects of profession:	Extent			
1	Serving the sick and needy	4	3	2	1
2	Social status of nurses	4	3	2	1
3	Working in other countries	4	3	2	1
4	Ease of employment	4	3	2	1
5	Degree of self worth	4	3	2	1
6	Salaries and benefits	4	3	2	1
7	Relationship with superiors and fellow nurses	4	3	2	1
8	Career development (including promotions, trainings, etc.)	4	3	2	1
9	Working conditions (such as hours of work, night shifts, schedules, etc.	4	3	2	1
10	Others (Please specify):	4	3	2	1

Section 4. Migration (For those who have worked abroad or have plans to work abroad)

4.1. To what extent do the following reasons for working or planning to work abroad match your own? Please encircle the number for each reason.

(4 – Extremely, 3 – Fairly well, 2 – Not particularly, 1 – Not at all)

	Reasons for Working or Planning to Work Abroad:	Extent			
1	Family and relatives live there	4	3	2	1
2	High level of nursing skills and technology	4	3	2	1
3	People are kind	4	3	2	1
4	High salary	4	3	2	1
5	Near the Philippines geographically	4	3	2	1
6	Interested in the country's culture	4	3	2	1
7	Can obtain citizenship	4	3	2	1
8	Can bring/petition family	4	3	2	1
9	That country and the Phil. have good relationship	4	3	2	1
10	Can speak the language of the country intending to go to	4	3	2	1
11	Possibility to obtain that country's nursing license	4	3	2	1
12	Respect for one's religious beliefs/practices	4	3	2	1
13	Low recruitment and processing fee	4	3	2	1
14	Less chances of discrimination	4	3	2	1
15	Ease in processing and getting employment	4	3	2	1
16	To marry a foreigner	4	3	2	1
17	Others (Pls. specify):	4	3	2	1

4.2. To what extent do you experience the following difficulties in being a nurse in the Philippines. Please encircle the number for each difficulty.

(4 – Extremely, 3 – Fairly well, 2 – Not particularly, 1 – Not at all)

	Difficulties:	Extent			
1	Dealing with Filipino patients	4	3	2	1
2	Occupational hazards	4	3	2	1
3	Limited opportunities for career advancement	4	3	2	1
4	High ratio of patients to nurses	4	3	2	1
5	Low salary/Few benefits	4	3	2	1
6	Palakasan system in getting employed and in promotion	4	3	2	1
7	Inadequate facilities in hospitals	4	3	2	1
8	Poor working conditions(heavy tasks, long hours of work, night shift, etc.)	4	3	2	1
9	Relationship with superiors and fellow workers	4	3	2	1
10	Lack of nursing skills and knowledge (competencies in nursing)	4	3	2	1
11	Gender discrimination	4	3	2	1
12	Others (Pls. specify):	4	3	2	1

(Only for those who have worked abroad as a nurse)

4.3. Which countries have you had the opportunity to work in? (State the first three countries you worked for as a nurse)

1. _____ 2. _____ 3. _____

4.4 How much did you spend on your first migration? The expenditures include passport and visa, agent fees, insurance, emigration clearance, airplane ticket, etc? (Write your answer in the blank below)

Php _____ (in Philippine peso)

4.4.1. When was the year of your first migration: _____

4.5. How did you finance your first migration?

1 –Supported by parents/Family savings
2 – Borrowed from relatives
3 – Sold/Mortgaged Land/Property
5 – Bank loan
6 – Own savings
7 – Others (Pls. specify):

4.6. Have you ever remitted (send remittance) any money from your earnings from working as a nurse abroad?

1 – Yes 2 - No

4.7. For whom did you send your remittance to? (Choose as many as appropriate)

1 – Parents
2 – Spouse
3 – Relatives
4 – Children
5. Charitable foundations
6. Church
7. Community Donations
8. Others (Pls. specify):

4.8. How was your remittance normally sent? (Choose the most common method you used)

1 – Banks/bank transfers
2 - Money remittance centers (e.g. Western Union, ML Lhuiller, Globe G-Cash, Smart Load wallet)
3 – Sent via friend who is coming home to the Philippines
4 – Couriers (e.g. LBC Padala)
5 – Others (Pls. specify):

4.9. If your answer (in 4.6) is Yes, how has the remittance been utilized? (Choose as many as appropriate)

1 –For the day to day needs of family
2 – For the education of your siblings (brothers/sisters)
3 – To purchase a house
4 – To purchase a car/motor vehicle
5 – To pay for a family member's medical treatment
6 – To pay existing loans
7 – For investment (Jewelries, stocks, etc.)
8 –For personal savings
6 – Others (Pls. specify):

Section 5. ASEAN INTEGRATION for Nursing and Nurses (to be answered by all respondents regardless of work experience abroad or in the Philippines only)

5.1.In line with the ASEAN INTEGRATION, are you familiar with the following:

5.1.1. Philippine Qualifications Framework 1. YES (Go to 5.1.1.1) 2. NO

5.1.1.1. I am familiar with Philippine Qualifications Framework through:

5.1.1.1.1. Seminars/Conferences: 1. YES 2. NO

5.1.1.1.2. News articles (including Internet readings: 1. YES 2. NO

5.1.1.1.3. Others (pls. Specify) _____

5.1.2. Career Pathways for Nurses 1. YES (Go to 5.1.2.1) 2. NO

5.1.2.1. I am familiar with Career Pathways for Nurses through:

5.1.2.1.1. Seminars/Conferences: 1. YES 2. NO

5.1.2.1.2. News articles (including Internet readings: 1. YES 2. NO

5.1.2.1.3. Others (pls. Specify) _____

5.1.3. Credentialing and Credit Transfer 1. YES (Go to 5.1.3.1) 2. NO

5.1.3.1. I am familiar with Credentialing and Credit Transfer through:

5.1.3.1.1. Seminars/Conferences: 1. YES 2. NO

5.1.3.1.2. News articles (including Internet readings: 1. YES 2. NO

5.1.3.1.3. Others (pls. Specify) _____

5.1.4. Mutual Recognition Arrangement 1. YES (Go to 5.1.4.1) 2. NO

5.1.4.1. I am familiar with Mutual Recognition Arrangement through:

5.1.4.1.1. Seminars/Conferences: 1. YES 2. NO

5.1.4.1.2. News articles (including Internet readings: 1. YES 2. NO

5.1.4.1.3. Others (pls. Specify) _____

Thank you very much for your kind cooperation!

NURSE MIGRATION SURVEY, 2016

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Sincerely yours,

Philippine Research Team
***Dean Elizabeth Roxas*,** President, Association of Deans of Philippine Colleges of Nursing
Dr. Reinaruth Carlos, Professor, Ryukoku University, Japan
Ms. Yurika Suzuki, Senior Research Staff, IDE-JETRO, Japan

Date of interview:	
Time of interview	
Name of interviewers:	
Name of interviewees:	
Designation:	
Contact details (email address and tel. no.)	

1	Name of College/School:		

2	Type of college/school:	1 – Government 2 – Private sectarian 3 – Private non-sectarian
3	Address of college/school:	
4	Name of affiliated hospitals and community health centers:	
	4.1. Name of base hospital/s:	
	4.1.1. Is base hospital owned by the School?	_____ Yes _____ No
	4.1.2. What is the bed capacity of base hospital?	
	4.1.3. What is the classification of the base hospital?	____Level 1 ____Level 2 ____Level 3
5	Year of establishment of College/University	
6	Year of establishment of College/School	
7	Year when first batch of students graduated from this nursing college/school:	
8	Current health and health allied courses offered in the undergraduate level (other than BS Nursing and including short term courses if any)	1. 2. 3. 4. 5. 6. 7.
9	Names of nursing-related programs (bachelor's degree) offered by the college/university (i.e. BS Medical Technology, BS Pharmacy, etc.)	1. 2. 3. 4. 5.
10	Names of nursing-related programs (graduate degree) offered by the college/university (i.e. MS Nursing, MA Nursing, etc.)	1. 2. 3. 4. 5.
11.	Total number of faculty in the College of Nursing , 1st Sem. SY2015-2016:	
12.	No. of fulltime faculty in the College of Nursing , 1st Sem. SY2015-2016:	
13.	No. of part-time faculty in the College of Nursing , 1st Sem. SY2015-2016:	
14.	No. of support staff (e.g., lab technician, custodian, etc.) in the College of Nursing , 1st Sem. SY2015-2016:	

15.	Does your college/university have a housing (dormitory) for your nursing students?	_____ Yes _____ No
16.	Does your college/university assist your students in looking for a job after graduation?	_____ Yes _____ No If yes, what kinds of assistance? 1 – Placement 2 – Career counseling 3 – Referrals 4 – Job fairs 5 – Pre-employment services 6 – Industry board 7 – Others (Pls. specify): _____

17. No. of student enrollees in Nursing programs by year level in the Academic Year, 2015-2016

Course and Year	Total no. of students		No. of male students		No. of female students		No. of students from overseas, including Fil-Ams		Current tuition fee per unit (in pesos)	Average number of units taken per year	
	1st Sem	2nd Sem	1st Sem	2nd Sem	1st sem	2nd Sem	1st sem	2nd Sem		1st sem	2nd Sem
BSN 1st year											
BSN 2nd year											
BSN 3rd year											
BSN 4th year											
Others (MA, PhD, etc. Please specify)											

18. What miscellaneous payments (other than tuition fees) as approved by the Commission on Higher education (CHED) does your school charge to nursing students per year?

Item	Total amount (in pesos)	Type of payment (per year? per term?)	Details (for example, only for 1st year students, only for those who will take the practicum or subject, optional, etc)
1			
2			
3			
4			
5			
6			

19. What subjects/courses or programs do you offer your students that are designed for those who will work overseas? (example: Transcultural Nursing)

Course/Program	Year and Term offered	Brief description of course
1- Trans-cultural Nursing		
2- Professional Adjustment		
3-Leadership and Governance		
4-Language Proficiency Courses		
5-Decent Works across Borders		
6-Others (Pls. specify):		

20. What is the total number of hours for your BSN Practicum/ Related Learning Experience?

Name of hospital	Average number of hours of practicum per student per term
1	
2	
3	
4	

21. How many students have graduated and/or passed the licensure examination for nurses in your nursing school/college in the past 4 years?

School year	No. of graduates	No. of those who passed the Licensure Exam			National Licensure Exam passing rate (%, estimated average for June and Nov. exam for all takers)					
					June			November		
		First Takers	Repeaters	Total	First takers	Repeaters	National Passing Percentage	First takers	Repeaters	National Passing Percentage
1 2015										
2 2014										
3 2013										
4 2012										

22. Estimate total no. of BSN graduates of this nursing college/school since its establishment	
23. Estimate total no. of licensed nurses (Board passers) who graduated from BSN of this college/school since its establishment	
24. Estimate % of licensed nurses graduated from BSN of this nursing school/college who work(ed) as nurses OVERSEAS(last 20 years)	_____%
25. Estimate % of licensed nurses who graduated from BSN of this this school/college who work(ed) as nurses WITHIN THE PHILIPPINES (last 20 years)	_____%
26. Estimate % of licensed nurses graduated from this university who do not work as nurses(past 20 years)	_____%

27.	Are there any discussions about the ASEAN Mutual Recognition Arrangement (MRA) in Nursing within your nursing school/university through for a, conferences, meetings, circulars?	Please encircle the answer 1. None at all 2. Yes, but not so much 3. Yes, there is extensive discussion

28.	In line with the ASEAN INTEGRATION, the faculty of the College of Nursing are made aware/oriented on the following:		
	28.1. Philippine Qualifications Framework, through:		
	28.1.1. Conferences:	1. YES	2. NO
	28.1.2. Formal Meetings:	1. YES	2. NO
	28.1.3. Circulars/Memos:	1. YES	2. NO
	28.2. Career Pathways for Nurses, through:		
	28.2.1. Conferences:	1. YES	2. NO
	28.2.2. Formal Meetings:	1. YES	2. NO
	28.2.3. Circulars/Memos:	1. YES	2. NO
	28.3. Credentialing and Credit Transfer, through:		
	28.3.1. Conferences:	1. YES	2. NO
	28.3.2. Formal Meetings:	1. YES	2. NO
	28.3.3. Circulars/Memos:	1. YES	2. NO
	28.4. Mutual Recognition Agreement, through:		
	28.4.1. Conferences:	1. YES	2. NO
	28.4.2. Formal Meetings:	1. YES	2. NO
	28.4.3. Circulars/Memos:	1. YES	2. NO

29. Please let us know your opinions and comments about the following:

29.1. How do prepare your nursing students and graduates to be qualified and aligned for the PQF and the ASEAN Reference Framework particularly in relation to the Mutual Recognition Agreement?
29.2. What are the challenges and issues that your nursing college/school face in terms of nursing education, curriculum, enrollment, training, career development, finances, etc.

Thank you very much for your kind cooperation!

Chapter 2

Education and Migration of Nurses:

The Case of India

Irudaya Rajan S.[☆]

Hisaya Oda[❖]

Yuko Tsujita[✿]

2.1. Overview of Nurses' Migration

2.1.1. Introduction

The nursing service is an essential part of the global health care system. The shortage of such health care workers impacts the effectiveness of the health care system in any country. India is a supplier of health care workers throughout the world. The majority of such nurses are female. The growth in migration trends among nurses from India has proliferated in recent years. This growth has been attributed to the increased global demand for nurses, which has subsequently created a surge in international recruitment efforts. Nurses are migrating in increasing numbers to practice nursing abroad, while a significant shortage of nurses exists in India (Walton-Roberts, 2012). The increased migration of nurses from certain geographical areas in India, such as Kerala, has resulted in regional variations in the nurse migration pattern. In Kerala, a major source of producing nurses in India, nursing has become the emigration strategy objective supported by the families of young women, who are now very prized in the matrimonial market (Percot, M. 2006). It is traditionally the Christian community of Kerala that provides the state with 90% of its nurses, and the majority of nurses throughout India (Mohan, 1990).

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2.1.2. Overview of Migration and Nurses' Migration

Migration from India is the highest in the world. Among the southern Indian states, Kerala and Tamil Nadu are the highest exporters of skilled workers. According to the Kerala Migration Survey (KMS), which has periodically provided estimates every five years since 1998, the number of emigrants has shown a continuous increase over the period. The number of Kerala's emigrants estimated by KMS 2014 was 2.40 million. The corresponding number was 2.18 million in 2011, 2.19 million in 2008, 1.84 million in 2003, and 1.36 million in 1998. Some of the occupations in the destination countries have more demand than the supply from Kerala can handle. In India, migration of nurses is the highest from Kerala. Corresponding to 100 nurses/ nursing assistants in Kerala in 2014, there are 85 Kerala nurses/ nursing assistants working outside India (Zachariah and Rajan, 2015). The nursing occupation has the largest demand at 42,443 persons than the actual supply from Kerala. The occupations for which the demand was larger than the supply include retail sales, engineering, clerks/ accountants, drivers etc.

The destination country by the emigrants from Kerala changes according to gender. More than 90% of male emigrants go to the Gulf countries, whereas, females only 71%. About 13% of the females work in the USA as professionals, 4.3% in the United Kingdom, and 4% in Canada, according to the latest Kerala Migration Survey. The percentage share of females among emigrants from Tamil Nadu (2015) was 14.7, and in Kerala (2014) 13.9 respectively. Among female emigrants from Kerala, 35% have a degree or higher educational qualification, whereas from Tamil Nadu, 59% of the female emigrants have the same level of educational qualification.

2.1.3. Governmental policies regarding emigration and the procedure

Traditionally Government of India, play a facilitating role in emigration. Emigration policy in India is regulated by the Emigration Act, 1983, which provides the regulatory framework for the emigration of Indian workers for overseas contract employment, and seeks to safeguard their interests and ensure their welfare. Prior to enactment of this legislation, the Emigration Act of 1922 governed the migration of Indians across the nation's borders. The main purpose of this Act is to regulate and control the recruitment and emigration of unskilled agricultural workers. The migration boom to the Middle East during the mid-1970s exposed the limitations of the Emigration Act 1922 in safeguarding the interests of workers emigrating for employment. The profile of the emigrants has changed over time, and such migration is managed under a 20th century law inspired by a 19th century mind set (Krishna Kumar and Irudaya Rajan, 2014). There is no specific emigration policy for Tamil Nadu and Kerala. However, the Non-Resident Keralite's Affairs Department (NORKA) protects the welfare of Kerala's emigrants.

2.1.4. Emigration figures from the Emigrant Clearance Required Passport Holders, Tamil Nadu and Kerala and the Destination Country

In the annual report by the Ministry of Overseas Indian Affairs (MOIA) the number of workers granted emigration clearance from Tamil Nadu was 70,313 persons in 1993 compared to the neighbouring state of Kerala with 155,208 persons, achieving the number one position in India. In 2006, Tamil Nadu took over the top spot from Kerala with 155,631 persons cleared for emigration work compared to 120,083 from Kerala, and it retained this position in 2007. Figure 2.1. indicates the volume of workers granted emigration clearance from Kerala and Tamil Nadu over the years. As per the Figure, Kerala had the highest flow of migrants until 2013. In 2014, Tamil Nadu took over that position. Tamil Nadu achieved its emigration peak in 2006, whereas Kerala achieved the same in 2008, with 180,703 workers. After that, there has been a decline in the number of workers from Tamil Nadu and Kerala.

This data is an indication of the growth of emigration applications submitted to the Emigration Clearance Required countries by the Emigration Clearance Required passport holders whose educational attainment is below certain level (currently less than ten years of schooling). As for nurses' migration, according to the estimates, 97,092 female nurses in absolute numbers emigrated from Kerala, this was 19% of the total number of female nurse migrants from India (Table 2.1).

Figure 2.1. Workers granted emigration clearance from Kerala and Tamil Nadu, 2001-2014

Table 2.1. No. of migrant nurses (estimated) and the number of nurses in India

2.1.5. Recent changes

2.1.5.1. Mutual Recognition Agreements

The Singapore Government has approved four Indian nursing institutes, the All India Institute of Medical Sciences, the Christian Medical College Vellore, the College of Nursing Thiruvananthapuram, and the Manipal Nursing College. Nurses trained at these four recognised institutions may go to Singapore and start practising in that country without requiring additional local qualifications (Seth, 2015), although our interviews with state government officials found this status is not yet common practice in 2016.

2.1.5.2. Government Orders

The government facilitates the emigration process but regards such as an individual's choice. In a bid to check widespread malpractice by recruiting agents for nurses to work in various foreign countries, such as financial disagreements between private recruiters and the nurses, and violation of human rights, the government of India has restricted such recruitment to authorised government agencies. With effect from 30 April, 2015, the emigration of nurses for overseas employment in 18 ECR countries, including countries in the Middle East, Africa and Asia, requires emigration clearance from the POE Office[13]. The recruitment of nurses for overseas employment was initially restricted through the state-run recruiting agencies viz., NORKA Roots and ODEPEC, in Kerala, and OMC in Tamil Nadu. Therefore, a foreign employer seeking to recruit Indian nurses shall register with the eMigrate system for vetting by the Indian Mission in the relevant country. Therefore, migration patterns, processes, and consequences may undergo drastic changes in the near future.

Table 2.2. Nurse recruitment agencies

2.2. Nurses in Education

2.2.1. Introduction

The global mobility of nurses recently has significantly increased. A large number of developed countries face a progressively aging population, a shortage of homegrown nurses, and a lack of ability and availability to take care of their dependents under the current demographic and economic transformation. However, they do not always meet the growing demand for nurses domestically, and the recruitment of "foreign nurses," particularly from developing countries, has become a solution to the shortage of nurses in a large number of high-income countries, although the scale of foreign nurse recruitment fluctuates from time to time based on the economic situation, immigration policy and practices, healthcare policy, and other factors in recipient countries. An average of 5.9% of the total nursing workforces in 23 Organisation for Economic Cooperation and Development (OECD) member countries was made up of foreign-trained nurses in 2013 (OECD, 2015).

[13] These countries are so called Emigration Check Required (ECR) countries specified by the Ministry of Overseas Indian Affairs, and currently the UAE, Saudi Arabia, Qatar, Oman, Kuwait, Bahrain, Malaysia, Libya, Jordan, Yemen, Sudan, Afghanistan, Indonesia, Syria, Lebanon, Thailand, and Iraq. Needless to say, nurses are not necessarily employed through recruitment agencies to work overseas.

A traditional push–pull factor analysis of migration explained that nurses migrate overseas mainly due to low salaries, poor working resources and conditions,[14] low social status, a low level of investment in health services, verbal and physical abuse in the workplace, and limited chances for promotion and exposure to new knowledge, skills, and advanced technology (Kline 2003; Kingma, 2006; Thomas, 2006; Nair, 2012; Johnson et al., 2014; Prescott and Nichter, 2014; Deshpande, 2015; Garner et al., 2015). As decision-making on migration is a complex process, these push–pull factors need to be understood in a specific research context that takes the various local, national, and global backgrounds of international migration into account. This section takes South India as an example and investigates as a factor the willingness of nursing students in India to migrate. In 2013, India was the second-largest nurse-sending country among OECD countries (70,471 India-born nurses in OCED countries), after the Philippines (OCED, 2015). The estimated number of Indian nurses abroad was reported to be 640,078 in 2011 (Irudaya Rajan and Nair, 2013). English proficiency is a competitive advantage for Indian nurses in English-speaking developed countries and Gulf countries.

The existing literature suggests that the low level of salary plays an important role in out-migration from developing countries (Prescot and Nichter, 2014; Garner et al. 2015). Even more importantly, in India, nurses' workplaces often are considered hierarchical, from central government at the top to state and other government, and private organizations at the bottom. Government jobs are preferred by the overwhelming majority of nurses in India due to the better terms and conditions of employment. Government jobs generally offer more security, pensions, more legal rights to take time off, relaxed working atmospheres, and much better pay. In contrast, the working conditions and salary level in the private sector tend to be poorer. Worse still, our interviews with nurses found that the statutory minimum wage for nurses in private facilities is not always paid. This discourages qualified nurses from working in their field in India. At the same time, if nurses work in private hospitals where relatively lower pay and poor working conditions are offered, it is insufficient to repay the loan which nurses, particularly those from lower-middle-class families, borrowed to finance their nursing education in private institutions. They would rather go abroad to earn more and repay the loan as soon as possible.

Nurses in India traditionally are regarded as lower on the occupational pyramid, even though they require higher education due to caste and religious norms (i.e., purity, pollution, and seclusion). Nurses come in contact with many unknown patients, deal with all types of bodily fluids, and from some patients' points of view, seem to be engaged in a type of work that resembles simple household chores. The stigma and moral suspicion attached to nursing prevent

[14] Hospitals in India suffer from a shortage of nurses. For example, the nurse patient ratio is 1:60 in public hospitals in Mumbai city during evening and night shifts (Suryanarayan, 2010), and the average ratio across the state is 1:40 (Yasmeen, 2014).

many Hindus and Muslims from entering into the nursing profession. Therefore, nursing previously was regarded as a job mainly for Christian women.

However, traditional and cultural constraints on occupational choice gradually have been transformed by increasing overseas employment opportunities and remittances. The emigration of nurses from India on a small scale dates back to as early as 1950. In the 1970s, many nurses migrated to the Gulf countries, and a much larger outflow of nurses to various countries (Healey, 2013) began in the 1990s as it became easier to apply for passports and visas. Becoming a nurse increasingly is regarded as a pathway to overseas employment. Raising a child to become a nurse is an elaborate family strategy in India (Redfoot and Houser, 2005; Percot and Irudaya Rajan, 2007).

The economic benefit of becoming a nurse also has some effect on a nurse's social status (Johnson et al., 2014; Prescot and Nichter, 2014; Garner et al., 2015). Some argue that individual nurses have higher values in the arranged marriage market due to their higher earnings, larger dowries, and opportunities for the husband and his family to settle abroad (Percot and Irudaya Rajan, 2007).

This section aims to fill the gap in knowledge about nursing students' willingness to migrate for work after graduation using information gathered from our primary survey in Kerala and Tamil Nadu in India. The potential mobility of nursing students who will be responsible for the next generation's healthcare in India and foreign countries is important in terms of contemplating a wide range of issues on international migration from developing countries to developed countries. The remainder of this section is organized as follows. The section 2.2.2 describes data collection, socioeconomic context, and nursing education. The middle section 2.2.3 illustrates an analysis of nursing students in terms of their socioeconomic backgrounds, motivations, and future career prospects, and the section 2.2.4 presents a summary of the major findings.

2.2.2. Data collection and context

2.2.2.1. Data collection

Data were collected mainly through face-to-face interviews with students at three nursing institutions in the Thiruvananthapuram district, Kerala, and two nursing colleges in Chennai, Tamil Nadu, using a pre-tested structured questionnaire. We selected a government institution in each state capital and the rest were private institutions. Table 2.3 shows basic information about the sample nursing colleges. Government institutions are older than private institutions. They started as medical colleges and later added diplomas in the nursing course before commencing a bachelor of science (BSc) nursing course. Therefore, as teaching institutions, they have a longer history than just teaching BSc nursing. They are more competitive in terms

of admissions because they have established reputations in nursing education and offer lower tuition fees than private institutions.

The sample population was restricted to all final year students in each college because they were presumed to be more self-aware of future career prospects than younger students. The survey was carried out on campus as per the institutions' requirements from January to February 2016 in Kerala and August to October 2016 in Tamil Nadu.

This was followed by the authors' interviews with other nursing institution principals, faculty, state government officials, nursing council officials, nurse recruitment agencies, researchers working in this area, and focus group discussions with a group of five to 10 final-year BSc nursing students from 11 institutions in the state of Kerala and Tamil Nadu. These follow-up interviews were administered between March 2016 and January 2017. The data collection and analytical methodology employed in this study constituted a mixed-methods approach that utilized both quantitative and qualitative techniques. A quantitative analysis was used to generalize the students' socioeconomic backgrounds, motivations, and career prospects, and a qualitative analysis was employed to triangulate the quantitative findings and describe the reasons and root causes behind the students' answers.

Table 2.3. Sample nursing colleges

2.2.2.2. Brief Socioeconomic Context

The state of Kerala, located on the southwest end of the Indian subcontinent, has a high Christian population (18.4%), as opposed to 2.3% in India as a whole (2011 Census).[15] By educational standards, Kerala has the highest literacy rates of the major Indian states, particularly among females (92.1% in Kerala vs. 64.6% in India; 2011 Census). [16] The unique combination of a large Christian population and a high level of education among females have made Kerala a major source of nurses in India. Tamil Nadu, located on the southeast end of the Indian subcontinent, has a 6.1% Christian population, and the female literacy rate is 73.9%, higher than the average of the nation (65.5%). The state had the first council of nursing in all of Southeast Asia under the Madras Presidency during the British colonial period and the first college of nursing in India.

The overview of out-migration from both states is summarized as follows based on the recent large sample surveys on migration (Zachariah and Irudaya Rajan, 2015; Irudaya Rajan et al.,

[15] http://censusindia.gov.in/ (retrieved on 1 February 2017).
[16] Same as footnote 1.

2017). The total number of emigrants, who usually are a member of a household but lived outside India at the time of the survey, are estimated to be 1.25 million from Kerala and 2.23 million from Tamil Nadu. In Kerala, one out of five households has emigrant(s), while the corresponding figure in Tamil Nadu is one out of 10. The major destinations for Kerala emigrants are Gulf countries, the share of which is 86% of the total emigrants' destinations, while those of Tamil Nadu are more diverse: Singapore, the United Arab Emirates, Saudi Arabia, the United States, and Malaysia. The proportion of Gulf countries in the Tamil Nadu emigrants' destinations is approximately half. The size of remittance is 36.3% of the Net State Domestic Product in Kerala and 14.0% in Tamil Nadu, and they are 1.5 times the annual state government expenditure in Kerala and 1.8 times that in Tamil Nadu.

Nursing Education

Growing global demand, coupled with other factors, has led to the establishment of a large number of nursing institutions that attract younger students (Blythe and Baumann, 2009; Spentz et al., 2014). This growth has further been accelerated by the state. The National Health Policy (2002) states that "the ratio of nursing personnel in the country vis-à-vis doctors/beds is very low according to professionally accepted norms. There is also an acute shortage of nurses trained in super-speciality *(sic.)* disciplines for deployment in tertiary care facilities." [17]Accordingly, the number of private institutions that offer BSc degrees in nursing has increased since 2002 in Kerala (Figure 2.1) and since the mid-2000s in Tamil Nadu (Figure 2.2). The total number of recognized institutions for BSc nursing courses for the 2016–17 academic year in Kerala and Tamil Nadu are 124 and 166, respectively, and the annual intakes of students are 6,760 in Kerala and 9,470 in Tamil Nadu (Indian Council of Nursing, 2016). In the list, there are only seven government institutions (475 students) in Kerala and five (250 students) in Tamil Nadu. [18]

The application process for BSc nursing programs in Kerala is currently a single online submission, whether students prefer government or private institutions. Students are admitted based on their grades in physics, chemistry, biology, and English. Half of the students in private institutions are admitted based on the government list of student's grades. In Tamil Nadu, a series of nursing and paramedical counseling are conducted for a large number of government and private colleges. Students who are interested in studying nursing are invited for the counseling and admitted to the BSc course based on their merit rank. [19]

[17] https://childlineindia.org.in/CP-CR-Downloads/National_Health_policy_2002.pdf (retrieved on 1 February 2017)
[18] http://www.indiannursingcouncil.org/Recognized-Nursing-Institution.asp?show=bsc (retrieved on 5 January 2017).
[19] https://mbbscounselling.co.in/paramedical-counselling-2016-2017-seat-allotment-and-counselling-process/ (retrieved on 15 March 2017)

Interestingly, our sample shows that 40.9% of the students in government colleges relied on their family and relatives as the most important source of information on where to study, while 75.0% of their counterparts in Tamil Nadu learned about their college through counseling. In the case of private colleges, most students in Kerala learned about their college through relatives and family (38.0%), followed by websites (25.0%). However, 73.9% of their counterparts in Tamil Nadu learned about their college through family and relatives, but the college website was an important source of information only for 13.0% of the sample students.

In each state, nursing colleges basically follow the same syllabus specified by the nursing council and university to which they belong. The only major difference in education between government and private institutions in Kerala is that a one-year paid internship in a government hospital is compulsory for students in government institutions immediately after completing the course (four years). In Tamil Nadu, BSc nursing is a four-year program, however, including a six-month exclusive internship period for the last six months.

Figure 2.1. Established year of educational institutions offering BSc programs in Kerala

Figure 2.2. Established period of educational institutions offering BSc and their number of intake students permitted in Tamil Nadu

2.2.3. Data analysis and discussion

2.2.3.1. Socioeconomic background

The sample size in this analysis is 218. Table 2.4 presents the social backgrounds of the students and clearly shows that the proportion of Christian students (43.1%) exceeds the proportion of the Christian population in the state (18.4% in Kerala and 6.1% in Tamil Nadu in the 2011 Census). However, the proportion of Hindu students is more than half. Previously, it has previously been stated that the Christian community provides Kerala with 90% of its nurses and the majority of nurses throughout India (Mohan, 1990). However, this sample proves that nursing is not exclusively dominated by Christians anymore. At the same time, Christians are more dominant in Tamil Nadu (59.3% in Tamil Nadu, in contrast with 37.1% in Kerala). As for caste composition, more other backward classes (OBCs), scheduled castes (SCs), and scheduled tribes (STs) are found in the sample,[20] as government institutions have reserved seats based on

[20] Scheduled castes (SCs) and scheduled tribes (STs) are stipulated by the president or each respective state government in accordance with the Constitution of India. SCs traditionally have been known as "untouchables" within Hindu society, while STs largely comprise aboriginal groups. OBCs are broadly defined as socially and economically backward groups other than SCs and STs.

caste, religion, and community. Disaggregated by states, Tamil Nadu has only one general caste of students (1.7% of the sample), while 36.8% of the sample students are general castes in Kerala. It appears nursing is more accepted to all religions and castes as an occupation in Kerala.

Moreover, fathers of nursing students tend to have low education levels. The proportion of students with fathers who have completed tertiary education is 6.0%. The proportion of students with fathers who have a professional occupation, such as a government clerk, computer engineer, accountant, advocate, and teacher, is only 7.8% of the total sample. On the contrary, the mother's education is found to be higher than the father's, even after considering the state average. Of nursing students' mothers, 12.4% have a university degree. The overwhelming majority of nursing students' mothers are categorized as homemakers.

Table 2.4. Social background of sample students

The economic background of students is shown in their possession of consumer durables and other items (Table 2.5). In the sample, 19.3% of the students' parents own a car, while the corresponding figure for motorcycles is 59.2%. As for their parents' house, 49.5% of the sample students live in two bedrooms with an attached bathroom, concrete roof, and mosaic floor (categorized as a very good house), and 41.3% of the sample students' parents stay in one bedroom with brick and cement walls with a concrete or tile roof (categorized as a good house). Although the diversification of religious and caste backgrounds is evident, it seems that the economic background of nurses remains mainly lower-middle class and some upper-middle class with relatively highly educated mothers from rural areas.

Table 2.5. Economic background of sample students

The motivation to become a nurse often is influenced by family circumstances, particularly in Kerala (Johnson et al., 2014). In our sample, 49.5% of students have at least one nurse in their extended family, including cousins and aunts. This is particularly true for Kerala students: 60.4% of the sample students in contrast to 20.3% of students in Tamil Nadu. As for religious groups, Christians (56.3%) are more likely to have any relative nurse than non-Christians (44.4%). Similarly, Christians (27.7%) are significantly more likely to have nurses in their immediate families, such as a mother, sister, or brother, than non-Christians (16.1%). Therefore,

it seems that the choice to pursue a nursing career is inherited through family and relatives, particularly among Keralites and Christians.

The proportion of students who think being a nurse is disadvantageous to finding a spouse is 26.6%, while 55.1% think it is advantageous to finding a spouse in the future. The rest (18.4%) think that it is neither advantageous nor disadvantageous. There is no clear difference among states, religion, caste, and type of college. This implies that the social stigma attached to the nursing occupation has lessened from before.

2.2.3.2. Motivation

We assumed that overseas employment opportunities are major motivations to study nursing. However, the highest number of students in the sample said they study nursing due to the easiness of finding a job (Table 2.6). Better salary is also one of the main reasons (87.6%) for studying nursing, followed by providing services to the sick (87.2%) and getting a job overseas (76.6%). Interestingly, there is a clear difference across states: 84.3% of students in Kerala aim to get a job overseas, while it is only 55.9% in Tamil Nadu.

Regarding the most important reason for choosing nursing study, the easiness of finding a job is the most important reason in the total sample (36.7% in total, 34.6% in Kerala, and 42.4% in Tamil Nadu). Getting a job overseas is the second-most important reason for the total sample (22.0%) and students in Kerala (25.2%). However, it is the third-most important reason in Tamil Nadu (13.6%), and the proportion of the students in the sample is much lower. Students in Kerala considered studying nursing for the overseas employment opportunities, while their counterparts in Tamil Nadu believe nursing jobs would be easy to find.

Of the students, 67.9% decided to study nursing on their own. However, this proportion differs across states. In Kerala, 76.7% made up their mind on their own or jointly with family member(s), while only 44.1% of the students in Tamil Nadu did so. In Tamil Nadu, mothers and relatives played important roles in the decision to study nursing. In fact, sample students in Tamil Nadu studied nursing due to financial difficulties (71.2%) and family compulsion (12.8%). There is no statistical difference on personal decision-making between Christians and non-Christians; however, regarding caste category, general castes (82.5%) were more likely to choose nursing on their own than OBCs (65.5%) and SC/STs (52.6%). The lower-castes group was relatively influenced by parental decision-making.

The structured questionnaire contains a question asking, “Were you happy to choose nursing as a profession at the time of admission, and are you happy with this profession presently?” The answer was rated on a five-point scale (1 = very unhappy to 5 = very happy). The mean scores of students were 3.85 at the time of admission and 4.16 at present. Similarly, students assessed

the parents' satisfaction with their children's choice: 4.12 at the time of admission and 4.22 at present. According to students, parents tend to be happier than they are about their child's choice.

Spearman's rank-order correlation between students' and parents' happiness tend to be lower: 0.42 at the time of admission and 0.46 at present. Students are not necessarily as happy as their parents. During our follow-up visit to nursing colleges, a principal elaborated on this point, stating that some students are not interested in studying nursing at all since they were forced to do so by their parents. Our focus group discussions with final-year students in nonsample private institutions further revealed that there are always a few dropout students during the first year, either because they face financial difficulties or they have no interest in nursing. Dissatisfaction during the final year usually was related to answers such as "not interested in nursing" or "study is difficult," even if students chose nursing as their profession.

Spearman's rank-order correlation between admission time and the present is higher both among students (0.75) and their parents (0.82). Both students and parents who were happier at the time of admission tend to be satisfied with their career choices at present. Students who chose to study nursing on their own (mean scores of 4.27 at the time of admission and 4.29 at present) are significantly happier than those who are not at present or who were at the time of admission (mean scores of 3.59 at admission and 3.86 at present).

Table 2.6 Reasons why students chose to study nursing

2.2.3.3. Future Prospects

Students in the sample are interested in government jobs. Of the sample students, 90.4% plan to take a government examination. State government services is more popular (71.1%) than central government services (64.2%) and army/navy/air forces (26.2%). There is no statistical difference in terms of willingness to take the exams of state services across states (Kerala and Tamil Nadu) and type of school they attend (government or private). However, regarding central government services, Kerala students (67.9%) are more interested in taking the exam than their counterparts in Tamil Nadu (54.2%). Students in government institutions (78.4%) are more willing to take the exam than students in private institutions (49.5%). Christian students are less likely to take government examinations than their non-Christian counterparts. Regarding the relationship between students' planning to take a government examination and caste groups, OBCs (91.4%) and SC/STs (89.5%) are more likely to take the government examinations than general castes (87.7%), as OBCs and SC/STs have reserved seats in the public sector.

Sample nursing students are interested in government jobs, and at the same time, 79.4% of the sample students are interested in working abroad after graduating from a BSc course, and in particular, 72.5% of the sample students are interested in both taking a government examination and going abroad. Among the destinations they have in mind, Gulf countries, such as Saudi Arabia, Kuwait, and the United Arab Emirates, are the most popular destinations, followed by English-speaking developed countries, including Australia, the United States, Canada, the United Kingdom, and Singapore (Table 2.7).

Table 2.7. Students interested in working overseas and the countries they wish to work in (multiple answers)

Estimation

We examined students' socioeconomic characteristics for the determinants of international migration. A probit analysis was performed to investigate the determinants of students' willingness to migrate overseas. Three dependent variables were examined. The first variable was a student's willingness to migrate overseas. The second dependent variable was a student's willingness to migrate to the Gulf countries. The third dependent variable was a student's willingness to migrate to developed countries. Employment opportunities in Gulf countries are relatively easier to find than in developed countries and are often regarded as a stepping stone to working in Western countries (Percot and Irdaya Rajan, 2007). In contrast, nursing qualification is not automatically recognized in some developed countries and "foreign" nurses generally need to pass or achieve the minimum required score of English-proficiency tests. Employment opportunities in developed countries are not easily accessible, as they do not always necessarily open their door to foreign nurses, depending upon the degrees of nursing shortages, immigration policies, health policies, among other things.

The explanatory variables are described in Table 2.8. Religion and caste might matter in terms of working abroad. Christians are pioneers of going abroad, and they are more likely to go abroad than non-Christians (Hindu and Muslim). Lower castes might be more willing to go abroad to improve their economic status and, ultimately, their social status, but at the same time, they are reserved for a certain percentage of jobs in the public sector. This affirmative action might discourage them from going abroad. If there is a nurse who is relative or immediate family member, students are more likely to know nurses working abroad and have extensive information about overseas employment opportunities, or at least have some ideas about what working outside India might be like. Being a female nurse might be advantageous and at the same time can be disadvantageous, as females have a wide range of opportunities abroad,

including in hospitals, retirement homes, and schools, while male nurses are in demand, particularly in some specialties, such as operating and emergency rooms in some countries. The parental house was a proxy for the economic conditions for the students. Students in Kerala were likely to be more willing to go abroad than their counterparts in Tamil Nadu, as their previous generations went abroad. Some students' motivation factors to study nursing at the time of admission are included in the explanatory variables, specifically to get a job overseas, for a better salary, and due to family compulsion/necessities. Those who aim to study nursing as a means of getting a job overseas are likely to be willing to go abroad. The type of parental house is a continuous variable (1 = *Kucha* house to 5 = luxurious house; for details see the Table 2.5 footnote), and the remaining variables are binary variables.

Table 2.8 Summary statistics

Estimation Results

Being Christian is not clearly related to the students' willingness to work abroad in general. However, when it comes to specific destinations, Christians have a clear preference. They are less willing to go to Gulf countries than non-Christians, and at the same time they are more willing to go to developed countries than non-Christians. As pioneers of overseas employment, Christians have an extended network and relatives abroad, particularly in developed countries. They do not have to go to Gulf countries as a stepping stone to their final destinations (i.e., developed countries). This is particularly true for students at government institutions. Being a Christian decreases their willingness to go to the Gulf countries by 11.8 percentage point and those who study at government institutions by 13.0 percentage point. Being a Christian increases their willingness to go to developed countries by 13.7 percentage point and by 26.3 percentage point for Christians at government institutions (for brevity, results for students at government institutions are not shown). Students at government institutions tend to be academically better performers when they are admitted to colleges. They have more options to work, such as clinical staff in government hospitals, teaching in colleges, and more, after graduation.

OBC, SC, and ST students are more willing to go abroad than general caste students. It is assumed to be easier to improve their economic conditions, and ultimately social status, by working abroad. It is noted that their parents' economic conditions tend to be worse than those of general caste students. For example, the mean score of the family house is significantly different between general castes (3.9) and other groups (3.5 for OBCs and 3.4 for SC/STs).

General castes are more likely to possess consumer items. For example, 82.5% of general caste students have a fridge as opposed to 75.0% of OBC students and 50.0% of SC/ST students.

Students in Kerala would more like to go abroad than their counterparts in Tamil Nadu. This is particularly so when it comes to working in the Gulf countries because of geographical proximity and because there is a large flow of Keralite communities accruing in the Gulf countries. A principal of nursing college on the borders of Tamil Nadu and Kerala explained to us that Tamil Nadu parents normally are opposed to children, particularly female children, going abroad to work as nurses. However, interestingly, when the sample is disaggregated to government and private students, students in private institutions in Kerala are more interested in going abroad. Indeed, a large number of students at the government college in Kerala are interested in joining the government services, particularly central government services (67.9%).

As expected, those who chose to study nursing to bet an overseas job are more interested in going abroad than those who are not. This is particularly higher in the case of overseas employment in general and developed countries. Students who study nursing due to expected higher income show a higher propensity to work abroad. Interestingly, those who are compelled to study nursing do not want to go to developed countries. This is particularly so among those who study nursing in private nursing institutions, but not among those who study them in government institutions (disaggregated results not shown for brevity).

Table 2.9. Results of the probit analysis (marginal effects)

2.2.4. Section Summary

The global mobility of nurses has increased in recent years due to the increasing demand for nurses. International demand has led to the establishment of a large number of nursing institutions in India, which is one of the major "exporting" countries. This chapter examined nursing students' willingness to migrate abroad to work after graduation. By doing so, we showed nursing students in terms of socioeconomic background, motivation, and future career prospects.

In the past, nursing was dominated by Christians. The stigma attached to nursing slowly has disappeared. The social background of nursing students is more diverse than ever. Their economic backgrounds seem to be mainly from the lower-middle class and some from the upper-middle class. Sending a child to nursing school is a family strategy that has extended to non-Christians who wish to escape their current economic conditions, particularly in Kerala. Some students are even forced to study nursing by their families. Among the sample students,

67.9% chose to study nursing on their own; however, the rest of the students were sent to nursing schools by their parents and relatives. Lower caste people tend to be influenced to become nurses by their family. The level of satisfaction in studying nursing is higher among those who study nursing by their own choice than those who are forced to do so.

The motivation to study nursing is not only for overseas employment opportunities but also the easiness of finding a job and the higher level of salary. Students in Kerala are more willing to go abroad to become nurses. As of their final year, students are interested in both joining public services and overseas employment. Our estimation results found that Christians are less willing to go to Gulf countries than non-Christians while they are more willing to go to developed countries than non-Christians. OBCs and SC/STs are more interested in going abroad, and students in Kerala are more keen to work abroad, particularly in Gulf countries. Interestingly, those who are forced to study nursing are less willing to be engaged in working overseas, particularly in developed countries than those who choose to study nursing on their own.

The socioeconomic background of nursing students has broadened. This is partly attributable to the decreasing social stigma attached to nursing and the availability of loans.[21] Moreover, opportunities to study nursing have increased due to the bonding of medical institutions in which some private health facilities have financed students' tuition fees in exchange for working over a certain period after they graduate from nursing institutions (Garner et al., 2015). This gives underprivileged students an opportunity to study nursing. However, some hospitals force nurses to hand over their original nursing licenses, so they can only leave after they have paid a large sum of money (Rajagopal, 2016). The Supreme Court of India recently directed the government to create guidelines that would regulate the working conditions of nurses and to consider revising minimum wages in the private sector. One of the major push factors of international migration from India is the low level of salary and working conditions, particularly in the private sector. Low wages lead to some nurses leaving nursing for higher paying jobs (Shahina 2012 cited in Prescott and Nicher, 2014). Meeting minimum wages and decent working conditions are an urgent policy agenda.

Due to increasing reports of financial disagreements between private recruiters and nurses and of exploitation and human rights violations abroad in recent years, India's central government has changed its policy on emigrating nurses. It now requires that recruitment be carried out through public sector recruitment agencies and emigration clearance be obtained from the offices of the Protector of Emigrants when nurses are recruited to work in certain Middle

[21] There are other fees than tuition fees in private institutions, such as clinical training at hospital, refundable fees, hostel fees, etc. Some students pay donations to secure their seats. The highest donation paid by a student in the sample, as far as he or she knows, was INR 125,000 at the time of admission. Our interviews with 10 private institutions found that, on average, INR 100,000 per annum (excluding hostel fees) was required to finance private education in Kerala.

Eastern, African, and Asian countries. This became effective at the end of April 2015. Current nursing students might be affected in their future international migration and career development. This will remain our future research agenda.

2.3. Migration of Indian Nurses

2.3.1. Introduction

The international migration of nurses is not a new phenomenon; however, it is increasing significantly due to the rapidly growing global demand for nurses (OECD 2007; Grignon et al. 2012; Buchan and Calman 2013). Ageing populations and low fertility rates are the causes of severe shortages of nurses in developed countries. In addition, demand for nurses in developing countries has accelerated in recent years due to the increasing demands for quality health care that is accompanying their economic progress. On the supply side, this robust demand is attracting nurses from developing countries. Larger salaries, better working environments and higher living standards are luring nurses. The growing demand has also led to the establishment of a large number of nursing institutions in several developing countries, which are attracting more young people to the study of nursing.

India is considered the second largest exporter of nurses after the Philippines.[22] A large number of Indian nurses have migrated to work in Organization for Economic Cooperation and Development (OECD) countries, the Gulf countries and some Association of Southeast Asian Nations (ASEAN) countries. The estimated number of Indian nurses abroad was reported to be 640,078 in 2011 (Irudaya Rajan and Nair 2013). English proficiency is a competitive advantage to Indian nurses in English-speaking countries. The geographical proximity to the Gulf countries and ASEAN countries is also to their advantage.

The migration of nurses from India dates back to the 1940s and 1950s when newly established oil companies in the Gulf recruited small groups of nurses (Healy 2013). In the 1970s, many nurses, mainly Malayali nurses from Kerala, migrated to the Gulf countries to fill positions in the growing numbers of hospitals triggered by the oil boom in the Middle East. The large-scale migration of Indian nurses to the global market began in the 1990s due to the serious shortage of nurses in developed countries. OECD countries actively recruited nurses from developing countries, including India. There were roughly 570,000 foreign-trained nurses in 23 OECD countries in 2013[23]. The United States has the largest number of foreign-trained nurses with 246,291 foreign nurses (2012), which is around 6% of total nurses in the U.S. This number far

[22] It is at least the second source country of nurses to OECD countries (OECD 2015).
[23] Figures were extracted from the Health Workforce Migration section of OECD. Stat. http://stats.oecd.org/ (Data extracted on March 10, 2016).

exceeds those in the United Kingdom (86,000 nurses in 2014), which has the second largest number of foreign-trained nurses among OECD countries. Germany also accepts a rather large number of foreign-trained nurses (70,000 in 2010).

The start of this large-scale international migration coincides with a rapid increase in nursing educational institutions in India, most of which are private. This was particularly conspicuous in the southern states such Karnataka, Andhra Pradesh, Kerala and Tamil Nadu.[24] This expansion in the number of nursing institutions indicates that it was not driven by a need to fill nursing shortages in India, but mainly to cater to the global scarcity of nurses.

One way to understand migration is that it occurs by the force of 'push' and 'pull' factors.[25] From the perspective of nurses, international migration is generally motivated by push factors, such as lower wages, poor working environments and so on (Kline 2003; Kingma 2006). They are also compelled by pull factors, such as higher wages, better facilities, higher living standards and so on (Kingma 2006). Push and pull factors are paired; they are two sides of the same coin. Knowing the push factors and analysing their impacts on migration decisions is an important step toward understanding migration issues and policymaking.

A couple of studies have analysed the determinants of nurse migration in the Indian context. The determinants are roughly categorized as follows: economic factors, institutional factors and social factor. Economic factors are considered the most significant (e.g., Percot 2006; Thomas 2006). Salaries paid in developed countries are significantly higher than those paid in India. Nurses working in private hospitals are particularly underpaid compared to nurses in public hospitals, which motivates them to migrate overseas (Thomas 2006). The institutional factors have several dimensions, including poor working conditions, such as shockingly low nurse-to-patient ratios, and inadequate healthcare facilities (Thomas 2006; Nair 2012). The lack of career advancement is also considered. Thomas (2006) interestingly points to the possibility that nurses belonging to Scheduled Castes and Scheduled Tribes (SC/ST), which are the lowest on the social ladder in India, are promoted faster than nurses from higher castes because spots are reserved for them by the reservation policy. This motivates nurses from higher castes to migrate. The social factors refer to the perceived low status of the nursing profession because of religious norms and the concept of impurity (Thomas 2006; Nair 2012). This perception drives nurses to migrate to countries where they are respected. However, a couple of studies have pointed out that higher salaries also improve the social status of nurses (Johnson et al. 2014; Prescot and Nichter 2014; Garner et al. 2015), which interestingly gives them higher value in the marriage market (Percot and Irudaya Rajan 2007).

[24] See Tsujita et al. (2017) for the case of Kerala.
[25] See Prescot and Nichter (2013) for their criticism on push-pull analyses of migration.

While economic factors still greatly influence decisions to migrate, the patterns of migration and the characteristics of migrating nurses are changing as India has been experiencing rapid economic and social transformations. This section examines characteristics of nurses and factors correlated with the international migration of nurses based on a survey conducted in Tamil Nadu, the southernmost state of India. Nursing education is active in the southern part of India, and Tamil Nadu is one of them. Between diploma courses (general nursing) and BSc nursing programs, there were 372 schools in Tamil Nadu, offering 15,430 seats in 2012 (INC 2012). This number is the third largest after Karnataka and Andhra Pradesh. Labour migration, including nurses, is active in this region as well; therefore, Tamil Nadu is a reasonable site for this study. We argue that new trends are emerging that depart from the traditional nurse migration trends. In addition, this section briefly touches upon the issue of the shortage of nurses in India, which is related to the overseas migration of nurses to some extent.

This paper consists of four sections. The first section explains the data that we collected during our field survey and reports incidents of migration among the sample. The second section presents findings regarding the characteristics of migrate nurses and factors that may be correlated with the migration decisions of nurses. The last section provides conclusions.

2.3.2. Data and Incidence of Migration

2.3.2.1. Data collection

The survey on nurse migration in Tamil Nadu was conducted from June 2016 to December 2016 in partnership with the Institute of Developing Economies, Japan, and LISSTAR, Loyola College, Tamil Nadu, India. Alumni from two nursing schools, Madras Medical College School of Nursing, which is a government-run school (MMC hereafter), and St. Isabella School of Nursing, a private school established by a Christian group (St. Isabella hereafter), were interviewed. Both schools are located in Chennai, Tamil Nadu, which is the southernmost state in India. MMC opened in 1963 and St. Isabella opened in 1983. Both are well-reputed, premier institutions in nursing education in Tamil Nadu. Chennai is an important place for nursing education in India as it is home to the first nursing school on the Indian subcontinent (1871). It is difficult to obtain random samples for this type of study unless we have a complete list of nurses who graduated from two schools with contact information. Therefore, we relied on a snowballing sampling method. However, every effort was made to represent all four decades (1980s, 1990s, 2000s and 2010s) in our sample, which enabled us to analyse the changing characteristics of nurses and their profiles.

We originally interviewed 345 nurses including 23 male nurses, but we eventually excluded the male nurse sample because of its small size, and also excluded those who graduated from

nursing colleges after 2013. Most receiving countries require nurses to have a minimum of two to three years of practical experience. Therefore, nurses who graduated after 2013 would be ineligible for international migration at the time of the survey. The final number of nurses in the sample was 265 (167 from MMC and 98 from St. Isabella). We did face-to-face interviews with most of the nurses in India. For nurses living outside of India, we approached them by telephone, email, text message and Skype. The questionnaire comprised five sections: respondent's (nurse) profile, details of nursing education, career details, details of migration experience if any and family profile. The questionnaire was originally made for our parallel study on nurse migration in Kerala and was revised in a manner that was appropriate for Tamil Nadu. It was pre-tested at both MMC and St. Isabella in early 2016 and revised before the formal investigations began.

The year of graduation ranged from 1981–2011 for the MMC alumni and from 1986–2012 for the St. Isabella alumni. All of the nurses were from the state of Tamil Nadu except five nurses (two from Kerala, two from Andhra Pradesh and one from Gujrat). Among the 265 nurses, 119 were Hindu, 135 were Christian and 11 were Muslim. By caste, 20 nurses belonged to Hindu general castes (Forward Caste), 126 belonged to the Other Backward Caste (OBC), 65 belonged to the Most Backward Caste (MBC), and 54 were from the Scheduled Caste (SC). Hindu general's social status is considered highest and SC's status is lowest. OBC and MBC, which are the two most voluminous groups, are in the middle of the social ladder.

2.3.2.2. Incidence of International Migration

Most of the nurses in our sample started their professional careers at hospitals in Tamil Nadu. Two hundred twenty-four nurses were recruited by hospitals around the Chennai Metropolitan area and 27 were recruited by hospitals in other districts in Tamil Nadu. The remaining 14 nurses were employed by hospitals in Bangalore, Karnataka and Hyderabad, Andhra Pradesh. Since Karnataka and Andhra Pradesh are Tamil Nadu's neighbouring states, their mobility at the time of their initial employment was very limited.

On average, migrant nurses worked in India for 7.5 years before joining a hospital abroad. Many of them left India in their 20s. Two nurses in our sample migrated after just one year of practical experience; however, these are likely exceptional cases. The maximum number of years before international migration was 19. The number of current and returned migrant nurses is 66 out of 265 or about 25% of our sample. Among them, 39 nurses were currently working outside of India and the rest had returned. This study considered both of them as migrant nurses.

As for the destination, the Asia and Pacific region attracted more than 50% of nurses who migrated. Malaysia and Singapore were the two of the top destinations, as 16 nurses migrated to

Malaysia and 12 to Singapore (see Table 2.10). While the Gulf countries, such as Saudi Arabia and UAE, were also popular destinations, they received just 16 nurses jointly. Malaysia and Singapore are preferred due to their geographical and cultural proximities, as well as their historical influence.[26] According to Irudaya Rajan et al. (2015), Singapore is ranked the number one destination for Tamil Nadu migrant workers. Its popularity was also clearly observed in our sample. Among developed countries, Australia and Ireland are also popular destinations in our samples.

Table 2.10. Overseas Destination of Sampled Migrant Nurses

2.3.3. Findings

2.3.3.1. School type and migration

The composition of migrant nurses by school was as follows: 30 nurses from MMC, a government school, and 36 from St. Isabella, a private school, which is 18.0% and 36.7%, respectively (See Table 2.11). The difference in ratios is statistically significant at 1%. Nurses who graduated from St. Isabella tended to migrate overseas more than those who graduated from MMC. This seems to show that international migration among nurses from the private school is more prevalent than their counterparts from the government school.

Migrant nurses from MMC worked an average of 8.93 years at hospitals in India before migrating and those who graduated from St. Isabella worked an average of 6.38 years. The difference between the two schools is significant at the 1%. Nurses who graduated from private schools seemed to migrate at younger ages than those from government schools. The results show a stark difference in migration incidence between nurses who graduated from the government school and those who graduated from the private school. International migration was very active among those who graduated from the private school, but it was less active among nurses who graduated from the government school.

One of the reasons for this difference is that salaries between private hospitals and public hospitals differ significantly. Under the Madras Medical Code, positions at state government medical facilities, such as government hospitals and public health centres, were not open to nurses who had graduated from private schools until 2012 in Tamil Nadu. On the other hand, those who completed their education at government schools got a government job all over

[26] During the British colonial era, a substantial number of Tamil workers were sent to Malaysia to work in plantations by the British authority (Irudaya Rajan et al. 2017). Most Malaysian Indians and Singaporean Indians are of Tamil decent, and Tamil language is one of Singapore official languages.

Tamil Nadu. Because of this uniquely discriminative policy, the type of school automatically determined where a nurse would work after graduation. In principle, studying at private schools resulted in working at private hospitals and vice versa for those studying at government schools.

It is a fact that nurses are underpaid at private hospitals compared to nurses working at public hospitals. In Tamil Nadu, state government hospitals pay junior nurses around Rs. 32,000 to 35,000 per month while private hospitals pay around Rs. 8,000 to 9,000 per month.[27] Some nurses even work without pay in order to gain the experience needed for international migration. In the Gulf countries, nurses usually receive the equivalent of Rs. 70,000 to 80,000 per month with free accommodations. Therefore, the salary gap between working at a private hospital in India and working abroad is huge. This gap serves as a great incentive for nurses who are working at private hospitals to migrate. But it is not so attractive to nurses in the public sector if costs of migration including opportunity costs are taken into account. Jobs are secured as a government employee, and fringe benefits are provided. Working environment at public hospitals is also considered better. There are excellent private hospitals with the latest facilities and equipment and that pay well, but they are exceptional and limited in number.[28]

Because of the disadvantages in terms of salary, job security and working environment, nurses at private hospitals who were educated at private schools are more likely to migrate than their counterparts. On the other hand, many nurses at government hospitals are not interested in leaving India. Responses from nurses in government hospitals indicate that the main reason they do not migrate, apart from family constraints, is that they are simply not interested in international migration. This result is in line with findings by Thomas (2006) who showed (through surveys with nurses in Delhi) that nurses at private hospitals are more prone to international migration than nurses at public hospitals. Our study supports Thomas' finding.

However, from the year 2012 onwards, private nursing students have been allowed to take jobs at state government hospitals if they pass an examination. In fact, we found a couple of nurses who graduated from St. Isabella after 2012 working at one of the government hospitals. At the same time, we also found that some nurses from MMC joined private hospitals. This shift in government policy could change the composition of migrant nurses from Tamil Nadu in the future.

Table 2.11. School type and incidence of international migration among nurses

[27] This information was obtained during interviews with nurses in Chennai. See also Chhapial (2016), which reports some figures on nursing salaries in Maharashtra.

[28] Some private hospitals pay well, but the pay is not on par with the salary paid to nurses at government facilities, except for some nurses who provide specialized operations and treatments. This was uncovered during interviews with nurses at private hospitals.

2.3.3.2. Religion, social status and migration

Religion is categorized as Hindu, Christian or Muslim. The social class to which a nurse belonged was classified as Hindu general, OBC and SC. These religious and social class variables are considered here because of the importance of religion and social class on an individual's or household's choices in India, including migration decisions (Keshri and Bhagat 2012; Tsujita and Oda 2015). The incidences of international migration based on religions and social classes are presented in Table 2.12.

Among the religious variables, 24 out of 119 Hindu nurses (20.1%), 38 out of 135 Christian nurses (28.1%) and 4 out of 11 Muslim nurses (36.4%) (see Table 2.12). Muslim nurses tended to migrate more than others. Though the small sample size of Muslim nurses merits some caution when interpreting the estimated coefficient, this result likely reflects their specific migration patterns to the Gulf countries and to Malaysia. Statistically significant differences in terms of the propensity to migrate between Hindu nurses and Christian nurses were not observed[29]. It is well documented in the existing literature that Christians have traditionally dominated the international migration of nurses from India (Percot 2006; Nair & Percot 2007). However, our study shows a statistical non-difference between Hindu and Christian nurses, on average. As the popularity of the nursing profession has risen with the economic and social status of nurses, the perception of the nursing profession has changed from a job of impurity to a ticket to international migration and success. Because of this changing perception, it is quite understandable that choosing a nursing job is not only confined among Christians but for anyone who simply likes to pursue nursing duties whatever the reason is.

As for the social class classification, the level of migration incidence of Schedule Castes (SCs), the lowest strata, is lower than Hindu generals, and Other Backward Castes (OBCs) though it is not statistically different from others (Table 2.13). Since SCs are tended to be socially and economically behind, their higher propensity to migrate is expected. However, our sample shows otherwise on average. One reason for this is probably due to the government's reservation policy. SCs are given priority in school admission, recruitment, and promotion in the government sector, inducing them to stay in India (Thomas 2006). Probably the result indicates that the impact of pushing SC nurses to migrate are diluted by the force of retaining them. Interestingly the propensity to migrate of MBCs is statistically lower than other classes. Only seven nurses out of 65 (10.8%) had overseas migration experiences.

[29] In fact, the difference in the ratio is not statistically significant at 10 % by a two-tailed test but it is significant at 10% by a one-tailed test.

Table 2.12. Religion, social class and incidence of international migration among nurses

2.3.3.3. Motivations and Migration

Personal motivations to become a nurse were also taken into account to see how they are related to overseas migration. We used the reason for choosing the nursing profession at the time of school admission to measure nurses' motivations. The respondents were asked why they chose to study nursing. There were six questions with 'yes' or 'no' answers: 'Did you choose to be a nurse (1) because of overseas employment opportunities, (2) because of easiness to find a job, (3) because of higher salary, (4) owing to family encouragement, (5) to achieve better social status, or (5) to provide service to the sick?'

More than 80% of nurse students answered 'yes' to the question (2): easiness to find a job, followed by the question (3): higher salary (76%). Around 50% of nurse students chose to study nursing for overseas employment opportunities.

As for the relationship between motivations to become a nurse and migration, those who answered 'yes' to the question (1) tend to migrate more than those with 'no' answers. Forty-nine nurses have overseas employment experiences out of 135 nurses who said 'yes' (36.3%) while 17 nurses have migration experiences out of 130 nurses who answered 'no' (13.1%). The difference is statistically significant. This implies that the majority of migrant nurses had a strong intention of going abroad as a nurse when they chose a nursing career.

Nursing students who chose to study nursing for gaining higher social status tend to remain in India. They were less likely to migrate than those who said 'no' to these questions. Just nine nurses have overseas employment experiences out of 72 nurses who said 'yes' (12.5%) while 57 nurses have migration experiences out of 193 nurses who answered 'no' (29.5%). The difference is statistically significant. Likewise, nursing students choosing a nurse career for providing services to patients are also less likely to go abroad. Thirty-six nurses have overseas experiences out of 181 who said 'yes' (19.9%) while 30 nurses have migration experiences out of 84 nurses who answered 'no' (35.7%). The difference in ratio is also statistically significant.

The evidence here suggests that individual reasons to become a nurse at the time of admission had strong effects on the decision to migrate overseas and bifurcated the career paths of nurses.

Table 2.13. Motivations and incidence of international migration among nurses

2.3.3.4. Financial obligation and migration

Whether or not a nurse (a nurse's family) took loan at the time of admission to the college of nursing may influence the decision to migrate overseas because their financial obligations make them to choose to work abroad to pay back. In our sample, 81 nurses took loan for financing their nursing education and 21 nurses out of them migrated overseas later. This ratio is not statistically different from that of non-loan takers. We heard on several occasions during our research that a student's family had taken out a loan to finance her studies and she had to migrate overseas to repay it. However, the evidence does not support such anecdotes. As several studies note, nurses come mainly from middle class families, taking loan to finance education may not be a serious financial burden.

2.3.3.5. Changes in economic and social statuses

It is interesting to see how nurses' perception about their economic and social statuses changed. For this, we obtained responses from nurses in terms of changes in economic and social statuses over the last 10 years. Our samples verify positive developments in this regard. We asked nurses who had more than ten years of professional experience to evaluate their economic and social statuses compared to ten years ago. Among the 209 nurses who satisfied this condition, 199 (95.2%) said their status in society has improved (138 nurses felt that their status much improved), while only 10 nurses said there was no change. No one reported that the situation got worse (see Table 2.14). The main reasons for this improvement were: (1) increased salary, (2) job security, and (3) improved social status and respect. These improvements in all aspects have attracted Hindus and Muslims who were previously reluctant to participate in the nursing profession because of religious norms and social stigma. As a result, Hindu and Muslim communities have founded many nursing schools to cater to the rising demand for this type of education.

From a closer examination of data, it is observed that MMC graduates felt stronger positive changes than St. Isabella graduates. Out of 138 nurses who felt much improvement, the number of MMC nurses is 121 while the number of St. Isabella nurses is 17. The ratio of nurses who graduated from MMC is disproportionally higher. Furthermore, it is interesting to note that eight out of 10 nurses who said that there was no change were graduates of St. Isabella. These might reflect lower salaries paid to nurses and poor working environment at private hospitals in which many of St. Isabella graduates work.

Table 2.14. Changes in the status of nurses over the last 10 years.

2.3.3.6. Changes in life before and after migration

The responses from migrant nurses in the previous sub-section confirmed an increase in economic and social status of nurses over the last ten years. We also asked migrant nurses if they had noticed any changes in their lives before and after migration. Many of them pointed to positive changes (Table 2.15). Fifty-one out of 66 migrant nurses replied to this question (multiple answers). Forty-eight nurses said that their life positively changed before and after migration. Twenty-eight nurses noted that their economic status and income had increased after migration, while 13 noted that their social status had increased. Moreover, 11 nurses said their professional skills, including the ability to handle new equipment, had improved. Only three nurses reported indifference or negative changes. Therefore, positive changes were generally evident in our samples. This tendency attracts more nurses, particularly those working at private hospitals, to go abroad.

Table 2.15. Changes before and after international migration

2.3.4. Section Summary

Based on our Tamil Nadu survey, this section has analysed the characteristics of Indian migrant nurses and the factors that are related to their migration. Our data indicate that nurses who graduate from private schools are more prone to international migration than nurses from government schools. In Tamil Nadu, occupational choice among nurses was limited until 2012 due to government policy. Under the Madras Medical Code, nurses for government medical facilities such as government hospitals and healthcare centres were for several decades recruited only from a pool of those who graduated from government-run schools. In principle, studying at a private school meant having to work in a private hospital after graduation, which was not the case for students studying at a government school. Lower salaries and poor working conditions at private hospitals are known. In addition, jobs at the government hospitals are more secured. Our samples imply that part of the international migration of nurses can be explained by the gap between the private sector and the public sector in terms of salary, job security and working environment.

Our study also examined that whether or not motivations to be a nurse are related to overseas migration. The response from sampled nurses reveals that the majority of migrant nurses had a strong intention of going abroad when they chose a nursing career.

As for the relationship between religion and the tendency to migrate, our study shows a statistical non-difference between Hindu and Christian nurses, on average. Because of this changing perception of a nurse from a job of impurity to a ticket to international migration and success, the popularity of becoming a nurse has risen not only among Christians but also among Hindus. As part of evidence for this, our samples show that the improvement of economic and social statuses of nurses over the last ten years. This positive change has attracted Hindus and even Muslims who were previously reluctant to participate in the nursing profession because of religious norms and social stigma.

We also asked migrant nurses if they had noticed any changes in their lives before and after migration. Many of them pointed to positive changes such as increases of their economic and social statuses as well as the improvement of their professional skills as a nurse. A very small number of nurses commented that nothing changed or some negative change occurred before and after migration. In general, positive changes were evident in our samples.

While overseas migration among nurses is active, it contributes to an acute scarcity of nurses in India (Gill 2011, 2016; Walton-Roberts 2012). India has been facing a shortage of nurses since its independence in 1947 when there were 1402 nursing schools and 7,047 seats for students[30]. This number increased to 49,197 institutions and 266,592 seats by 2013 and the number of nurses reached 2,124,667 (WHO 2016). Despite such huge increases in the labour force, the problem remains. The ratio of nurses and midwives in India was 1.7 per 1,000 residents in 2011, which is lower than the world average of 3.28 and way below that of high-income countries (8.5). The Indian Nursing Council stipulates that the country should have a nurse-patient ratio of 1:4. However, this is not honoured and the reality is far from ideal. For example, the ratio was 1:40 in state government-run hospitals in 2013 in Karnataka, according to a newspaper report (Yasmeen 2014). We also heard of nurse-patient ratios that were 1:10 and even worse during our visits to several hospitals in Tamil Nadu and Kerala. Overall, it is reported that an additional 2.4 million nurses are needed to fill India's nursing gap (WHO 2010).

For countries like India where the number of medical doctors per capita is not sufficient and public health requires significant improvement, nurses play key roles in preventive, curative and antenatal healthcare. Nurses are needed not only in urban centres but also in rural areas where the majority of the population lives and access to medical facilities is limited. Comparatively speaking, nurses are scarcer in rural areas than urban areas although their presence is much

[30] Figures were from Nurse and Midwifery in India, Ministry of Health and Family Welfare. http://nursingandmidwifery.gov.in/state_nursing_councils.html#.WMa9x2-LT3h (Data extracted on Mar. 5, 2017).

more important (Gill, 2011, 2016; Rao et al. 2013). Therefore, it is critical to retain nurses in rural areas amid the nursing shortage.

Migration occurs by the force of 'push' and 'pull' factors. As our results hint that international migration of Indian nurses is generally motivated by push factors, such as lower wages, poor working environments, and lack of job security at private hospitals in India and are pulled by factors such as higher wages, better facilities, higher living standards and so on in recipient countries. Though the shortage of nurses in India cannot be explained by migration alone, the government efforts that improve working conditions for nurses to ease the situation are called for.

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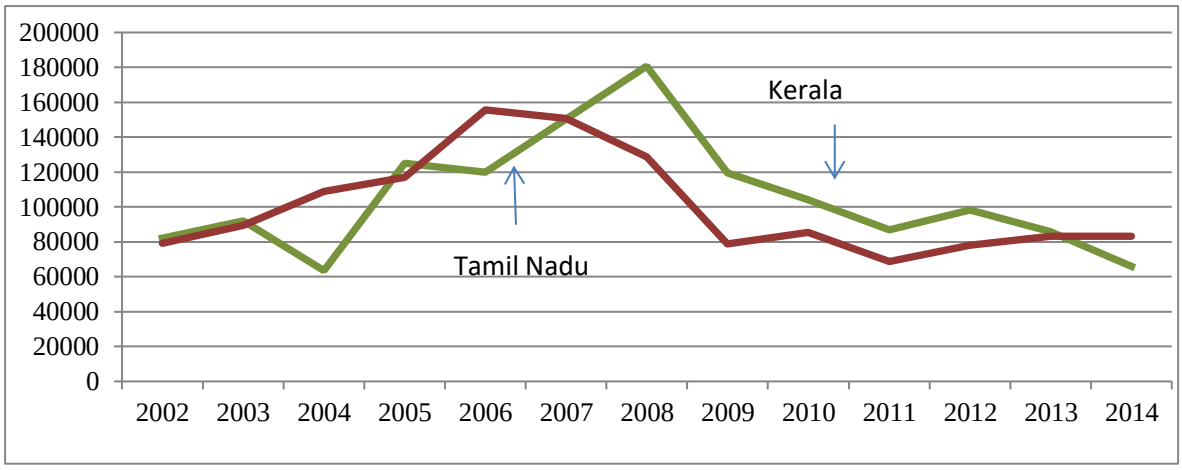
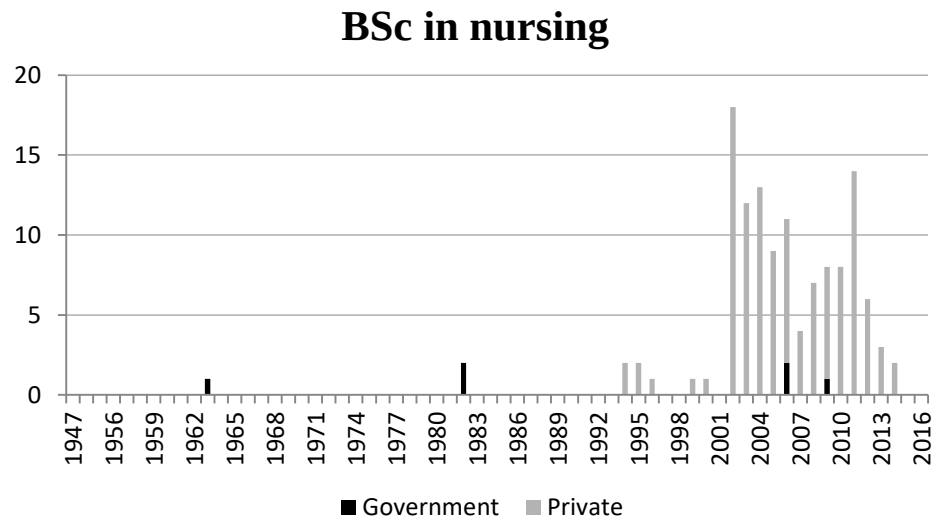
Figure 2.1 Workers granted emigration clearance from Kerala and Tamil Nadu, 2001-2014



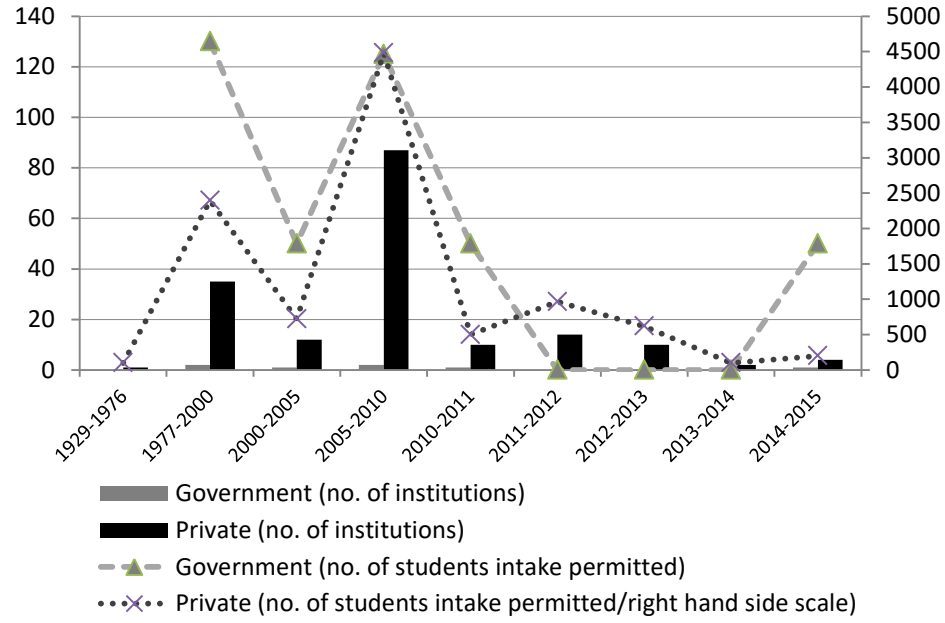
Source: Ministry of Overseas Indian Affairs, Annual Reports

Figure 2.2. Established year of educational institutions offering BSc programmes in Kerala.



Source: Kerala Nurses and Midwives Council.

Figure 2.3. Established period of educational institutions offering BSc programmes in Tamil Nadu.



Source: Tamil Nadu Nurses & Midwives Council (http://www.tamilnadunursingcouncil.com/syw04.php).

Table 2.1 No. of migrant nurses (estimated) and the number of nurses in India

		Kerala			India		
		Male	Female	Total	Male	Female	Total
2011	Total Emigrants	1944069	336474	2280543	10229506	1770494	12000000
	Nurses	24552	97092	121644	129190	510888	640078

Source: Estimated by Irudaya Rajan and Sreelekha Nair based on the methodology developed for the KMS 2011, and financed by the Department of Non-Resident Keralite's Affairs, Government of Kerala and the Ministry of Overseas Indian Affairs, Government of India (Zachariah and Irudaya Rajan 2012).

Table 2.2. Nurse recruitment agencies

Public agency	State	Established year	No. of registered nurses	Registration fees for nurses (INR)	No. of placement in 2016
Non-resident Keralites Affairs Department (Norka-Roots)	Kerala	established in 2002 under Norka and recruited from 2006	17,000	free	-
Overseas Development and Employment Promotion Consultants (ODEPEC)	Kerala	1977	35,000	250	-
Overseas Manpower Corporation (OMC)	Tamil Nadu	1978	60,000	1000	240

Source: Authors' visit to the agencies in August 2016, and websites.

Table 2.3. Sample nursing colleges

	State	Type of college	Location	Year of starting BSc nursing	No. of BSc seats (first year) per year	Current annual tuition fees (INR)
A	Tamil Nadu	State government	Urban	1983	25	on stipend
B	Tamil Nadu	Private	Urban	2012	35	40,000
C	Kerala	State government	Urban	1972	75	18,000
D	Kerala	Private	Rural	2007	50	55,000
E	Kerala	Private	Rural	2009	60	55,000

Source: Authors' survey in 2016.

Table 2.4. Social background of sample students

	Total	
	N	%
No. of observations	218	100.00
State		
Kerala	159	72.94
Tamil Nadu	59	27.06
Type of college		
Government	107	49.08
Private	111	50.92
Gender		
Male	9	4.13
Female	209	95.87
Religion		
Hindu	113	51.83
Christian	94	43.12
Muslim	11	5.05
Caste		
General	57	26.15
OBC	116	53.21
SC/ST	38	17.43
Unclassified	7	3.21
Place of origin		
Rural	95	43.58

Urban	123	56.42
Parental education		
Father		
Below primary	6	2.75
Primary school	15	6.88
High school	123	56.42
Higher secondary school	47	21.56
Tertiary	13	5.96
Others	10	4.59
Unknown	4	1.83
Mother's education		
Below primary	10	4.59
Primary school	17	7.80
High school	101	46.33
Higher secondary school	55	25.23
Tertiary	27	12.39
Others	8	3.67
Father's occupation		
Unskilled labor	56	25.69
Skilled labour	22	10.09
Transport and freight	26	11.93
Sales and trade	35	16.06
Professional	17	7.80
Agriculture	18	8.26
Military and police	8	3.67
Working overseas (unspecified-occupation)	17	7.80
Retired, unemployed or dead	19	8.72

Notes: Unskilled labour: coolie, security guard, helper, construction worker and daily wage labour. Skilled labour: plumber, painter, carpenter, lineman, tailor, mechanic, electrician, postman, pasting, machine operator and weaver. Transport and freight: driver, three wheeler driver and bus conductor. Sales and trade: shopkeeper, shop proprietor, business, agent and vender. Professional: advocate, company manager/supervisor/employee, government clerk, accountant, teacher and computer engineer. Agriculture: farmer, fisherman and tapping.

Table 2.5. Economic background of sample students.

	Total BSc	
	N	%
Possession of consumer durables and other items		
Car	42	19.27
Motor cycle	129	59.17
Mobile phones	215	98.62
TVs	213	97.71
Refrigerator	157	72.02
Computer/Laptops	92	42.20
Net connection	46	21.10
House type		
Luxurious	11	5.05
Very good	108	49.54
Good	90	41.28
Poor	7	3.21
Kutcha	2	0.92

Notes: Luxurious is three or more bedrooms with attached bathrooms, concrete roof, and mosaic floor. Very good is two bedrooms with attached bathrooms, concrete roof, and mosaic floor. Good is one bedroom, brick and cement walls, and concrete or tile roof. Poor is brick walls, cement floor, and tin or asbestos roof. *Kutcha* is mud walls, mud floor, and thatched roof. N=218.

Table 2.6. Reasons why students chose to study nursing

	Total	
	N	%
No. of students who answered 'Yes'		
Ease of finding a job	194	88.99
Higher income	191	87.61
To provide services to the sick	190	87.16
To get a job overseas	167	76.61
Family encouragement	155	71.10
To achieve better social status	146	66.97
Financial difficulties	143	65.60
To improve self-confidence in decision making	102	46.79
To find a better spouse	47	21.56

Family compulsion	28	12.84
At least one parent is nurse	8	3.67
To escape from social pressure at home	4	1.83
Other reasons	6	2.75
Most important		
Easiness to find a job	80	36.70
To get a job in overseas	48	22.02
To provide service to the sick	40	18.35
High income	21	9.63
Owing to financial difficulties	9	4.13
Owing to family encouragement	6	2.75
To achieve better social status	5	2.29
Other reasons	5	2.29
Owing to family compulsion	3	1.38
Parents/one of the parents are/is nurse	0	0.00
To get self-confidence in decision making	1	0.46

Notes: Sample students were requested to answer ‘yes’ or ‘no’ to all the questions. N=218.

Table 2.7. Students interested in working overseas and the countries they wish to work in (multiple answers).

	Total	
	N	%
Total	218	100.00
Yes	173	79.36
Gulf countries	70	32.11
Australia	34	15.60
USA	21	9.63
Canada	21	9.63
UK	18	8.26
Singapore	11	5.05
Ireland	6	2.75
Switzerland	5	2.29
New Zealand	3	1.38
European countries	2	0.92
Germany	1	0.46
Italy	1	0.46

Malaysia	1	0.46
West Africa	1	0.46
Depends on husband	1	0.46
No idea	7	3.21
Any place	6	2.75

Table 2.8. Summary statisticsNotes: N=211. Standard deviation in parenthesis for the continuous variable.

Variable	Mean	Valuable Description
Interested in overseas employment	0.7936	1 if nursing student is interested in working abroad and 0 otherwise
Interested in employment in Gulf countries	0.3211	1 if nursing student is interested in employment in working in Gulf-countries and 0 otherwise
Interested in developed countries	0.4817	1 if nursing student is interested in employment in working in developed countries and 0 otherwise
Christian	0.4312	1 if nursing student is Christian and 0 otherwise
General castes	0.2701	1 if nursing student is general caste and 0 otherwise
OBCs	0.5498	1 if nursing student is Other Backward Classes and 0 otherwise
SC/STs	0.1801	1 if nursing student is Scheduled Casts or Tribes and 0 otherwise
Rural	0.5642	1 if nursing student is from rural area and 0 otherwise
Nurse in family/Relative	0.4954	1 if nursing student has any nurse in family or relative and 0 otherwise
Female	0.9587	1 if nursing student is female and 0 otherwise
Family house type	3.5459 (0.6857)	1 if parents of nursing student live in 'kutcha' house, 2 if they live in poor house, 3 if they live in good house, 4 if they live in very good house and 5 if they live in luxurious house
Kerala	0.7293	1 if nursing student is from Kerala and 0 otherwise
To get a job overseas	0.7661	1 if nursing student study nursing to get a job overuses and 0 otherwise
High income	0.8761	1 if nursing student studies nursing due to expected high income and 0 otherwise
Family compulsion/necessity	0.1284	1 if nursing student is compelled to study nursing and 0 otherwise

Notes: N=211. Standard deviation in parenthesis for the continuous variable.

Table 2.9. Results of the probit analysis (marginal effects).

	All		Gulf countries		Developed countries	
Religion (Base category: Non-Christian)						
Christian	0.0273		-0.1184	*	0.1365	*
	(0.0555)		(0.0688)		(0.0774)	
Castes (Base category: General)						
OBC	0.1857	**	0.0990		-0.0220	
	(0.0773)		(0.0803)		(0.0933)	
SCST	0.1318	***	0.5699		0.0630	
	(0.0512)		(0.1153)		(0.1219)	
Rural	0.0022		0.0239		0.0588	
	(0.0664)		(0.0074)		(0.0874)	
Nurse in family/relatives	0.0160		-0.0532		0.0498	
	(0.0638)		(0.0766)		(0.0853)	
Female	0.0063		-0.1749		-0.0699	
	(0.0893)		(0.1762)		(0.1591)	
Family house type	0.0205		-0.0277		0.0330	
	(0.0377)		(0.0522)		(0.0600)	
Kerala	0.2021	**	0.2321	***	0.0620	
	(0.0988)		(0.0765)		(0.1105)	
Individual motivation (Base category: No)						
To get a job overseas	0.4794	***	0.0605	*	0.3680	***
	(0.0801)		(0.0801)		(0.0750)	
High income	0.2479	**	0.1240		-0.0031	
	(0.1241)		(0.0837)		(0.1147)	
Family compulsion/necessity	-0.1157		-0.0100		-0.2579	***
	(0.0888)		(0.0913)		(0.0943)	
Pseudo-R^2	0.3097		0.0781		0.1351	
No. of observations	211		211		211	

Notes: Marginal effects are calculated based on the binary variables set to zero. Standard errors are in parentheses. ***, ** and * show results are statistically significant at 1%, 5% and 10%, respectively.

Table 2.10. Overseas Destination of Sampled Migrant Nurses

Region and Country	No. of Migrant Nurses
Asia and Pacific	34
Malaysia	16
Singapore	12
Australia	5
Bangladesh	1
Gulf Countries	16
Saudi Arabia	9
UAE	7
Europe	9
Ireland	4
United Kingdom	2
Italy	2
France	1
Africa	4
West Africa	2
Kenya	1
Sudan	1
Total	66

Table 2.11. School type and incidence of international migration among nurses

School Type	MMC	St. Isabella	Total
Migrant Nurses	30	36	66
Non-Migrant Nurses	137	62	199
Total	167	98	265
% migration	18.0	36.7	24.9

Table 2.12. Religion, Social class and incidence of international migration among nurses

Religion	Hindu	Christian	Muslim	Total
Migrant Nurses	24	38	4	66
Non-Migrant Nurses	95	97	7	199
Total	119	135	11	265
% migration	20.1	28.1	36.3	24.9

Social Class	General Hindu	Other Backward Caste	Most Backward Caste	Scheduled Caste(SC)	Total
Migrant Nurses	7	38	7	14	66
Non-Migrant Nurses	13	88	58	40	199
Total	20	126	65	54	265
% migration	35.0	30.2	10.8	25.9	24.9

Table 2.13. Motivations and incidence of international migration among nurses

	Overseas employment	Easiness to find a job	High salary	Family encouragement	Higher social status	Services to the sick
YES	135	218	202	188	72	181
% migrant among 'Yes' nurses	36.3	22.9	25.7	24.5	12.5	19.9
NO	130	47	63	77	193	84
% migrant among 'No' nurses	13.1	34.0	22.2	26.0	29.5	35.7

Difference in ratio	Yes* (positive)	Indifference	Indifference	Indifference	Yes* (negative)	Yes* (negative)

Note: "Difference in ratio" tests whether or not the ratio of migrants among 'yes' answers differs statistically from the ratio of migrants with 'no' answers. * indicates statistical significance at 1% level.

Table 2.14. Changes in the status of nurses over the last 10 years.

Description	MMC	St. Isabella	Total No.
Much better	121	17	138
Better	26	35	61
Same	2	8	10
Worse	0	0	0

Note: No. of responses is 209.

Table 2.15. Changes before and after international migration

Description	No.
Increase of economic status/income	28
Improvement of social status	13
Improvement of professional skills	11
Lifestyle changed	4
Everything changed	2
Other positive changes	3
No change before and after migration	2
Loss due to migration	1

Note: No. of responses was 51. Multiple answers were allowed.

Chapter 3
Thailand: A Potential Nurse Receiving Country, focusing on Nurses' Mobility and Human Resource Development

Patcharawalai Wongboonsin
Yupin Aungsuroch
Naomi Hatsukano

Introduction

The mobility of human resources in the ASEAN countries is a key component to deepen economic integration across the region, especially after establishment of the ASEAN Economic Community. ASEAN has negotiated mutual recognition arrangements (MRAs) for several professional services to facilitate the movement of professionals to practice in other ASEAN countries through mutual recognition of their qualifications. In this paper, we discuss the nursing profession as the example of a professional service in Thailand, the applicable human resource development, and nurses' mobility.

Thailand, a member of ASEAN, is facing an ageing population. At the same time, the country has promoted medical tourism and geared its health care industry towards providing international services. The country will potentially need more nurses in terms of their number and expertise in response to this developing situation. Indeed, some hospitals in response to the new demand, are reported to have started to hire foreign nationals to support the Thai registered nurses and/or work as coordinators to help with the foreign patients.

Section 1, analyses the policy environment and demographic situation affecting nurses' mobility in Thailand, Section 2 explores the evolution of nurses' human resource development, and Section 3 introduces examples of the inflow to Thailand of foreign nationals with nursing knowledge and skill, in order to investigate the key factors, processes, and consequences of such inflows on the mobility of nurses. This offers a basis for further discussion for the policy implications to improve the flow of skilled labour, especially of nurses, within the ASEAN region.

1. The Economic, Social, and Political Environment for Nursing Services in Thailand

1.1 Economic and Socio-Demographic Trends

1.1.1 Economic Trends

Thailand has transformed remarkably from a rural-based subsistence agrarian economy of 8.27 million people, as recorded in the 1st nationwide population census in 1911, to rank as one of the world's 25 biggest economies. Thailand's gross domestic product (GDP) per capita stood at

US$5,647 in 2011, and the World Bank reclassified Thailand as an upper middle income country. In 2016, Thailand's the market size achieved US$23.5 trillion (Thailand Board of Investment, 2014, 2016). The World Bank (2016) projected the Thai economy would grow at the rate of 3.2% in 2017, compared to 2.8% in 2015.

While the Thai economy is widely perceived to be led by agricultural exports, most of the national income is in fact achieved by manufacturing and the services sector. Thailand has served as an attractive host country for foreign direct investment and a dynamic gateway to fast-growing economic markets. With the remarkable growth of foreign direct investment, up by 21% during 2010-2016, compared with 0.7% across the globe, Thailand occupies the 4th rank in Asia's top prospective host countries for various global multinational enterprises, and has the 2nd largest economy in ASEAN. In 2016, Thailand was ranked 2nd for ease of doing business among the emerging economies in east Asia, the 5th in Asia's financial literacy index, 11th in the index of world's most promising emerging economies, and 14th in the global competitive manufacturing index. Thailand is also on its way to increase regional cooperation with a number of fast-growing economies in Asia, such as China, India, Vietnam, Malaysia, and Singapore, to become the major hub of regional connectivity, according to Thailand's Board of Investment (2016).

Since 2003, the services sector has served as a major contributor to the national economy. It also serves as an indicator of economic development (Koonnathamdee, 2013). The services sector has lately employed as much as 40% of the work force and produced up to 50% of the Thai gross domestic product, compared to 15% of the work force and 35% of the gross domestic product by the manufacturing sector. This is despite the notion that the services sector lagged behind manufacturing productivity by 30%. In 2017, the services sector is expected to remain the key driver of growth to help Thailand achieve the higher-income status and create new job opportunities (World Bank, 2016).

One may note that Thailand has been observed as a relatively restricted services market compared to other ASEAN member countries and other regions, while certain services remain relatively protected from foreign and domestic competition. This is particularly true regarding professional services and those provided by many state enterprises. Nevertheless, Thailand is perceived to possess considerable potential to strengthen its services sector and increase productivity and innovation services if it can provide a supportive regulatory environment for doing business and generating competition, combined with deeper trade integration through implementation of the ASEAN Economic Community commitments and free trade agreements (World Bank, 2016).

1.1.2 Socio-Demographic Trends

Thailand officially became an ageing society in 2010, and is expected to reach the status of an

aged society in less than another decade. According to Wongboonsin et al. (2014a), in 2010, not all provinces in Thailand were ageing. There were nine of 77 provinces below the threshold of 10% elderly people aged 60 years and above. This is expected to be the case until 2030, when all provinces will have the share of elderly persons above 10% of the total population. At that time, 69 provinces will be considered as aged with the elderly share exceeding 20%, and another eight provinces will have achieved ageing status once their elderly share is between 10 and 20%, as shown in Figure 3.1.

=== Figure3.1 ===

The above notion is attributable to the fact that Thailand has experienced a more rapid speed of demographic transition as shown in Figure 3.2. Previous studies (Wongboonsin and Wongboonsin, 2014a, 2014b) maintained that the demographic transition in Thailand has been faster than in other developing countries, including those in ASEAN.

=== Figure 3.2 ===

Based on the 2010 Population and Housing Census conducted by the National Statistical Office, the Office of the National Economic and Social Development Board (NESDB) in Thailand made a 30-year projection of the population growth and forecast that by 2040 there will be 20.5 million people aged over 60 years, the equivalent 32.12% of the total population. The number of people of working age and children is projected to decline from 42.74 million and 12.6 million in 2010 to 35.18 million and 8.2 million respectively by 2040 (NESDB, 2013a).

One of the primary drivers of rapid ageing is the very rapid decline in fertility rates, with the total fertility rate per woman (TFR) falling from around from 6.1 in 1965 to the below replacement level of 1.6 births per Thai woman in 2010. Unless appropriate policy intervention is in place in time, the NESDB expects the TFR in Thailand to decline further to 1.3 by 2040 (NESDB, 2013a).

Another primary driver of the rapidly ageing society in Thailand is the increase in longevity. According to the birth data in Thailand, life expectancy has increased from 51.6 years in 1950-1955 to 73.3 years in 2005-2010. Assuming a medium variance, it is expected to increase to 80.5 years by 2050 and 86.4 years by 2100 (United Nations, 2015).

Among other reasons, medical advances have served as the major factor contributing to this increase in longevity. As the people in Thailand have recently come to live in closer proximity to health care services, Thailand has experienced a lower risk of death due to serious illnesses and disease compared with the past. Technological innovation during the last few years has also led

to better food quality and a better quality of life. Meanwhile, the people in Thailand have recently been more aware of their well-being as can be seen from the boom in the fitness industry and the supplements food market (Keeratipongpaiboon, 2012; Wongboonsin et al., 2014a).

This demographic transition may destabilise the Thai economy and society at large, posing a hindrance to the sustainability of long-term economic growth. Given the projection that the proportion of the working-age population will fall from 63% by 2022 to 55% by 2040, the shrinking workforce will negatively affect the economy as a whole, unless there are adjustments in terms of labour productivity and a structural shift towards technology and innovation-driven production methods (NESDB, 2013b; Wongboonsin et al., 2015a).

As argued in a previous study (Wongboonsin et al., 2014b), it remains a matter of concern if in the future the people who are living longer will remain healthy. The increasing number of older persons is expected to increase the demand for health care services. The status of the ageing population determines the supply of health care services. If the period of morbidity associated with the older ages can be delayed or compressed, the demand for health care services may reduce accordingly.

The above notion corresponds to the fact that Thailand has experienced a declining role of the family in care activities. Families in Thailand have downsized from 5.2 persons on average in 1980 to 3.3 persons by 2006/ 2007 (Wongboonsin et al., 2014b). According to the 2010 Population and Housing Census (NSO, 2012), the average size of a private household will continue to decrease to 3.1 persons. Part of the explanation is the tendency for Thai people to have fewer children and they now live separate from the parents' home (Wongboonsin et al., 2014b). The one-generation household will become a prominent living arrangement for the elderly, particularly in the north, as 31.4% were found in such households in 2007. (Keeratipongpaiboon, 2012).

1.2 Policy Regimes: Looking Back and Moving Forward

1.2.1 Flagship Policy: Thailand 4.0

As mentioned earlier, during the recent decades Thailand has transitioned through three economic development models, starting by emphasising the agricultural sector to drive the economy. This was followed by the model focusing on light industry, which changed the national economy from low-income to middle-income status. Then came the model emphasising heavy industry that achieved continued economic growth. However, Thailand has become stuck in the middle-income trap and is facing a number of challenges; including an ageing society, workforce shortages, skill limitation in the Thai workforce, and lagging behind in terms of manufacturing

technology. Therefore, new business in Thailand lacks the ability to attract new sources of investment, and important export markets such as the United States, Europe, and China are experiencing a period of economic decline, combined with the relocation of manufacturing bases from Thailand to countries with lower labour costs, some disparities in society, public health, natural disasters, and environmental degradation stemming from inequitable development. This is according to a statement by the Thai Prime Minister delivered at the International Conference on Blue Ocean Strategy on 16 August, 2016 (Chan-o-cha, 2016).

Thriving in the 21st century by means of security, prosperity, and sustainability is Thailand's ambition. The Thailand 4.0 policy has been designed to transition the Thai economy away from the middle-income trap while restructuring it into a value-based higher-income economy in accordance with the 20-year national strategy plan, in order to ensure achieving competitive advantage, rather than just a comparative advantage. Thailand 4.0 is comprised of three elements: 1) A knowledge-based economy, with the emphasis on research and development, science and technology, creative thinking and innovation; 2) An inclusive society with equitable access to the fruits of prosperity and development; and 3) Sustainable growth and development. This new flagship policy is designed to be a shift away from the so-called “more for less” to a “less for more” economic focus. In other words, rather than commodities, industry, and the trade in goods, the economy will focus on innovation, technology, creativity, and the trade in services. This will produce a transformation from traditional farming to smart farming, from traditional SMEs to smart enterprise start-ups, from buying technology to developing innovative technology, from traditional services to high-value services, and from unskilled labour to knowledge based workers/ highly-skilled labour.

1.2.2 Health Care Policies and Medical Tourism

To transform the comparative advantage into a dynamic competitive advantage, the current government has targeted ten industrial sectors as the new growth engines, including health care, wellness, and bio-medicines. While bio-med will move towards new technology, one would expect to see health technology as a new sector, and health and wellness as even a new industrial sector.

The current Thai government has progressive policies in place to ensure making “Thailand, the hub of wellness and medical services” from 2016-2025, and transitioning Thailand into the medical hub in four major segments: wellness, medical services, academic medical centres, and health care products.

The medical hub policy aims at utilising the existing human and natural resources to their highest potential in order to enhance the income level of many different parties, while manifesting a

realistic improvement in the quality of life of the Thai people.

The current policies have been upgraded from general health care policies and those concerning medical tourism launched earlier, in order to increase patients' access to health care and promote Thailand as the Medical Hub of Asia. The former includes the universal health care system to cover the public and private sectors by the service providers. The public service providers include a tiered system of: a) Large regional hospitals with a comprehensive set of specialists, and smaller hospitals with a capacity ranging from 200 to 250 beds; b) Community health centres providing primary care in rural areas; and 3) Expansion of specialist clinics across the country, particularly in rural areas. In the past, the development of medical tourism in Thailand was driven primarily by the private sector using medical tourism facilitators as the main market channel (Kantawongwan et al., 2015; Thailand Board of Investment., 2017a).

Progress from the past development included high quality, affordable health care services and universal access to health care through major health care reform across the Kingdom of Thailand by means of financial aid and infrastructure development. According to Thailand's Board of Investment (2017a), there were more than 1,000 public and 300 private hospitals nationwide in 2016. Efforts are being made to develop Practical Nurses to assist the doctors and registered nurses. This qualification only requires completion of a one-year training course as opposed to the four years required to qualify as a registered nurse.

As part of the progress during the last few years, Thailand has become an important destination for medical tourism. Foreign patients visiting Thailand as tourists per year increased from 1.4m in 2008 to 2.5m in 2012 (Wongchuay & Jaroenwisan, 2015). During 2014-2015, there was an 11.7% annual growth in the income earned by the private hospitals focusing on foreign patients, compared to the 7% growth in income achieved by private hospitals focusing on domestic patients; income from foreign patients grew from 25% of total income earned by the private hospitals in 2014 to more than 30% in 2015. Moreover, Thailand has enjoyed 40% of the global market share for medical tourism, i.e. 2.5 million medical tourists out of 26.5 million tourists from around the world visited Thailand. Notably, visitors came from Japan, USA, UK, United Arab Emirates, expats in CLMV (Cambodia, Laos, Myanmar, and Vietnam) (Ministry of Public Health, 2016; Kasakorn Research Center, 2016; Thailand Board of Investment, 2017a).

According to the Ministry of Public Health (2016), foreign patients visit hospitals in Thailand 3.2 million times/year. Despite the tendency of people from ASEAN to visit Malaysia and Singapore, there was an increase of patients with higher purchasing power from Myanmar visiting private hospitals in Thailand, in addition to the 20% year-on-year increase of visitors from the UAE. Medical tourists visit Thailand around 2.6 million times/year. 80% of the medical services are

recorded as provided to foreign patients. They visit mainly for a check-up (17 %), followed by cosmetic surgery (14 %), and dental care (11 %). Among the visitors, expats visit hospitals in Thailand around 600,000 times/year.

Thailand is expected to provide services to around 4.41 million foreign patients in 2017, with around 4.5 hundred thousand visiting as medical tourists. This is expected to generate an income of around TB138.39 billion (Kantawongwan, et al. 2015; Ministry of Public Health, 2016).

Factors contributing Thailand as an important destination for medical tourism include the international standard of health care services and the comparatively low cost (Amornvivat, 2012). According to Table 3.1, the positioning of Thailand as providing high quality and friendly services for foreign medical tourism patients who visited hospitals in Thailand 2.25 million times in 2015, above the Singaporean level despite its reputation for high-end, specialty medical services, and Malaysia, which is geared towards Muslim visitors. Thailand also has 54 JCI accredited hospitals, compared to 22 in Singapore and 13 in Malaysia. Four of the JCI accredited hospitals in Thailand have also received advanced HA accreditation. They are among the first to receive this accreditation in Asia.

===Table 3.1 ===

Figure 3.3, shows that Thailand has also attained a comparative advantage in terms of the cost of medical services for such popular surgical procedures as coronary artery bypass graft, heart valve replacement with bypass, hip replacement, knee replacement, spinal fusion, and gastric bypass. This is particularly relevant when comparing costs in the United States of America and Singapore. It is also the case for knee replacement and spinal fusion compared with Malaysia, which mainly handles the Muslim visitors.

=== Figure 3.3 ===

1.3 Legislative and Regulatory Regimes Governing Immigration and the Employment of Skilled Workers

As in many countries across the glove, in order to work legally in Thailand a foreign national is required to secure the relevant valid visa and work permit issued in that person's name. Those with a tourist or transit visa are not allowed to apply for a work permit.

Foreign nationals who wish to work, conduct business, or undertake investment activities in Thailand must apply for the Non-Immigrant Visa at a Royal Thai Embassy or Royal Thai Consulate-General in the applicant’s home country. Various categories of Non-Immigrant Visa are currently available according to the qualifications of each individual person. They include

(Ministry of Foreign Affairs, 2017):

1) Non-Immigrant Visa Category B (Business): Issued to foreign nationals who wish to enter Thailand to work or to conduct business. The following corporate documents must be provided by the hiring company in Thailand: Business registration certificate and business licence; list of the shareholders; company profile; details of the business operation; list of any foreign workers stating their name, nationality, and position; map indicating the location of the company; the Balance Sheet, Statement of Income Tax and Business Tax; and the Value-added tax registration. Additional documents may be requested as and when necessary.
2) Non-Immigrant Visa Category B-A (Business Approved): Granted to qualified applicants under the jurisdiction of the Office of the Immigration Bureau in Bangkok. The applicant's associate company in which he or she will invest or conduct business may apply for this type of visa on behalf of the applicant at the Office of the Immigration Bureau. Once the application is approved, the Immigration Bureau advises the relevant Royal Thai Embassy or Royal Consulate-General via the Ministry of Foreign Affairs to issue the visa to the applicant. The holder of this category "B-A" visa is permitted to stay in the Kingdom for a period of one year from the first date of entry.
3) Non-Immigrant Visa Category IB (Investment and Business): Issued to foreign nationals employed to work on investment projects under the auspices of the Board of Investment of Thailand (BOI). Such projects must involve or bring benefit to Thailand in the following ways: Export promotion; increased employment; utilise local raw materials; projects based in the provinces; encourage technology transfer to Thai nationals; not hinder an existing domestic business.
4) Non-Immigrant Visa Category B (Teaching): Issued to foreign nationals who intend to take up employment in Thailand as school teachers at a level below university graduate.

Currently, there is a standard process and the One-stop Service for foreign nationals who wish to work in Thailand. Figure 3.4, shows the standard process, Figure 5 illustrates the One-stop Service. The One Stop Service Centre for Visas and Work Permits was established on 1 July, 1997 by authority of the Regulations of the Office of Prime Minister promulgated on 30 June, 1997. The Centre simplifies the visa extension and work permit issuance procedure in order to create a good investment environment. It facilitates the application for visa extensions and work permits (e.g., stay permission, re-entry permit, and work permit). The Centre is located in the Chamchuree Square Building, Floor 18, Phatumwan, Bangkok.

===Figure 3.4 ===

=== Figure 3.5 ===

Persons eligible to apply for the visa extension and work permit at the One-Stop Service Centre shown in Figure 3.5 are (Thailand Board of Investment, 2017b):

1) Foreign nationals who are executives or experts with privileges accorded by the following laws: Investment Promotion Act B.E. 2520 (AD 1977); Petroleum Act B.E. 2514 (AD 1971); Industrial Estates Authority of Thailand Act B.E. 2522 (AD 1979).
2) A foreign national investor. If investing not less than 2 million Baht, he or she will be granted a 1-year permit. If investing not less than 10 million Baht, he or she will be granted a 2-year permit.
3) A foreign national who is an executive or expert. His/her associate company should be registered with capital or possess assets of not less than 30 million Baht.
4) A foreign national who is a member of the foreign press must present a letter from the Ministry of Foreign Affairs and a copy of the ID Press Card issued by the Department of Public Relations.
5) A foreign national who is a researcher or developer in science and technology.
6) A foreign national employed in a branch office of an overseas bank, foreign banking office of an overseas bank, provincial foreign banking office of an overseas bank, or the representative office of a foreign bank in which the offices are certified by the Bank of Thailand.
7) A foreign national working on a necessary and urgent basis for a period not exceeding 15 days.
8) A foreign national who is an official of a representative office for foreign juristic persons concerning an International Trading Business or the Regional Office of a Transnational Corporation in accordance to the Foreign Business Act B.E. 2542 (1999).
9) A foreign national who is an expert on information technology.
10) A foreign national who works at the regional operating headquarters.

Holders of the above-mentioned types of visa wishing to work in Thailand must be granted a work permit prior to starting work. The visa fee is 2,000 Baht for a single-entry with three-month validity and 5,000 Baht for multiple entry with one-year validity (Thailand Board of Investment, 2017b).

In general, foreign nationals are only allowed to perform work that does not violate the Alien Working Act, and not in activities prohibited to foreigners. Those working for two different individual employers or business establishments, even if the same work, shall obtain two work permits respectively, one for each employer/ business establishment. However, foreign nationals may be exempt from the work permit requirement under the immigration laws to handle necessary and urgent work for a period of up to 15 days. Moreover, under the Alien Act B.E. 2551 (A.D. 2008), the following foreign nationals are not subject to the requirement to obtain a work permit:

Members of diplomatic or consular delegations and certain related persons, certain persons related to the United Nations, certain persons working in Thailand pursuant to an agreement between Thailand and a designated foreign government or international agency, certain persons stipulated by Royal Decree, and certain persons authorised by the Council of Ministers, according to the Alien Working Act B.E. 2551 (A.D. 2008) (Government Gazette, 2008).

The Royal Decree on Recruitment of Foreigners B.E. 2559 (A.D. 2016) is a new law regarding changes in the requirements for a foreign-owned business to bring foreign nationals to work in Thailand. It has been effective since August 16, 2016, with the main objective to protect the interests of foreign workers in Thailand and comply with international standards, besides preventing and suppressing the exploitation of foreign workers, forced labour, and human trafficking (Government Gazette, 2016).

The new law applies to the following: 1) Licenced business establishments that recruit foreign nationals to work with an employer in Thailand; and 2) Employers who recruit foreign nationals to work with themselves in Thailand. According to this new law, any employer who wants to recruit a foreign national to work with him must obtain permission granted by the Director General (DG) of the Department of Employment. The recruiter of foreigners must be a recruitment company licenced by the Director General. The company must be a private limited company or a public limited company having paid-up capital of at least TB1 million, and ¾ of the capital must be owned by Thai nationals. The licence-holder is not entitled to demand any payment other than the fees and expenses at the rates specified by the Director General, nor any payment from the recruited foreigner. The licence-holder must also place with the Director General a guarantee of not less than TB5 million against damages that may result from bringing foreigners to work in Thailand. Any employer who recruits a foreigner to work in his own business is required to place a guarantee with the Director General against the costs and damages which may result from hiring the foreigner. Non-compliance is subject to civil and criminal penalties, for which the maximum imprisonment term is three years (Government Gazette, 2016).

1.3.1 Regimes Governing the Practice of Nursing Services: Local and Foreign

According to Section 4 of the Professional Nursing and Midwifery Act B.E. 2528 (A.D. 1985), "nursing" means activity with people related to caring and helping when they are sick, including rehabilitation, disease prevention, and health care promotion, as well as assisting physicians to perform curative treatment. In doing so, it shall be based on scientific principles and the art of nursing. Meanwhile, "Professional Practice of Nursing" means the practice of nursing an individual, family, and the community by the following action (Government Gazette, 1985):

1) To provide education, advice, counselling, as well as resolving health care problems
2) To act and assist individuals physically and mentally, including their environment, in order

to overcome the problems of illness, alleviate symptoms, prevent dissemination of a disease, and provide rehabilitation

3) To provide treatment for primary medical care and immunisation
4) To assist physicians to apply treatments

Registration and Licencing

According to the Professional Nursing and Midwifery Act B.E.2528 (A.D. 1985), "Licence" means the licence issued by the Thailand Nursing and Midwifery Council (TNMC) to a person qualified to perform the profession of nursing, midwifery, or both (Government Gazette, 1985). According to the Thailand Nursing and Midwifery Council, to practice professional nursing services in Thailand the person needs to pass the national licencing examination and be registered and obtain the licence to practice from the Thailand Nursing and Midwifery Council. In Thailand, there are two categories of nursing licence, which can be obtained only through passing the licencing examination governed by the Thailand Nursing and Midwifery Council (Thailand Nursing and Midwifery Council, 2016):

1) First-class licence: This category of nursing licence is issued to a professional nurse who has graduated the four-year programme
2) Second-class licence: This category of nursing license is issued to a technical nurse who has graduated the two-year programme

All nursing licences shall be signed by the General Secretary and President of the Council. The Thailand Nursing and Midwifery Council requires renewal of the nursing licence every five (5) years. To renew the nursing licence, 50 unit-hours of continuous education are required (Thailand Nursing and Midwifery Council, 2016).

The Thailand Nursing and Midwifery Council regards all persons registered to practice nursing as "practitioners in nursing." All practitioners in nursing are required to perform the following roles (Thailand Nursing and Midwifery Council, 2016; Kruth, 2013):

1) To provide education, advice, and resolve health care problems
2) To act and assist individuals physically and mentally in order to resolve their health care problems, alleviate any symptoms, prevent disease proliferation, and ensure rehabilitation of patients suffering from health care problems
3) To provide treatment as required by primary medical care and immunisation
4) To assist physicians administering treatments

There are also advanced practice nurses who receive special training identified by a post-master's education. For example, the following specialties are recognised by Thailand: Community Nurse Practitioner; Medical and Surgical Nurse; Gerentological Nurse; Paediatric Nurse; Maternity and

Child Nurse; Advanced Midwifery Practice Nurse; Mental Health and Psychiatric Nurse; Anaesthetist Nurse; Infection Control Nurse; and a Community Nurse. The roles have expanded from those mentioned above to cover their specialty (Thailand Nursing and Midwifery Council, 2016; Kruth, 2013).

Requirements for Overseas-Qualified Nurses: It is possible for registered nurses from overseas to practice their professional services in Thailand if they register with the Thailand Nursing and Midwifery Council. To register, they are subject to comply with the following requirements (Thailand Nursing and Midwifery Council, 2016):

1) Pre-requisites: Qualification of education and licence in the home country
2) Educational qualifications: Minimum Diploma (3 years) from a qualified nursing school overseas
3) Recent clinical practice: Minimum of 3 years of experience as specified in the ASEAN Mutual Recognition Arrangement (MRA) for Nursing Services
4) Licensure or applicable exams: Passed the licensing exams as for local nurses
5) Competency assessment: In the process of regulation formulation
6) Verification of registration
7) Verification of the nursing education transcript
8) Others: Licence renewal every five years, as for local nurses

Competency of Registered Nurses

According to Thailand Nursing and Midwifery Council (2016), the competency of registered nurses means the knowledge, ability, and attitudes that enable nurses to practice with safety and responsibility within the scope of their profession while being effective team members, maintaining personal and professional development, and above all, striving to be decent members of society. Such a definition is based on the following assumptions:

1) Competency can be categorised into many levels according to the difficulties and complexities of the practice settings and patients' problems.
2) Registered nurses are capable of providing nursing care and services to patients of all ages, whether ill, healthy, or at risk. Nurses can work in all healthcare facilities: Primary, Secondary, and Tertiary. They possess a breadth of knowledge in the treatment of and preventive measures for patients with diseases or illnesses that are major problems in the country. They also possess skills in the care of non-complicated cases, promotion of health care, prevention of disease, and the care of patients suffering an acute state or a chronic condition. They have knowledge and basic skills in providing health care in critical or emergency situations and in midwifery.
3) The skills and knowledge of registered nurses can be developed and improved through experience, and with the programmes and studies outlined by each organisation.

The competency of registered nurses in Thailand is categorised into 8 aspects: 1) Ethics, Code of Conduct, and the Law; 2) Core Nursing and Midwifery Practice; 3) Professional Characteristics; 4) Leadership, Management, and Quality Improvement; 5) Academic and Research Competency; 6) Communication and Relationships; 7) Information Technology; and 8) Social Competency (Thailand Nursing and Midwifery Council, 2016).

For competency in *Ethics, code of conduct, and the law,* registered nurses shall demonstrate knowledge and understanding of the theories and principles of virtue, ethics, the code of professional conduct, religion, culture, human rights, consumer rights, children's rights, patients' rights, and the general principles of the relevant laws. The latter includes the National Health Act, the Mental Health Act, the Health Security Act, the Health Care Act, the Health Care Facility Act, the Nursing and Midwifery Profession Act, and other relevant acts. Registered nurses are expected to be aware of the scope of nursing practices, the regulations related to the limitations and conditions of nursing and midwifery professional practices, and other related professions. They must be sensitive to ethical and legal issues, and be capable of making moral decisions and incorporating morality into their nursing practice appropriately, as described below (Thailand Nursing and Midwifery Council, 2016):

1) Be aware of one's own values and beliefs and not judge others based on these values and beliefs. Provide nursing care by respecting the patient's values and beliefs, as well as their human dignity.
2) Realise one's own limitations and able to consult the appropriate experts. Never take risks which may adversely affect the patient.
3) Be accountable for all outcomes of personal nursing practice.
4) Assist patients/clients about their rights and how to understand them.
5) Take appropriate action to protect patients/clients who are vulnerable to a violation of their rights or immoral and unethical practices.
6) Be capable of analysing ethical issues and making ethical decisions appropriately in uncomplicated health care situations.
7) Administer nursing care with kindness and compassion, taking into consideration the optimal benefit of the patients, the professional code of ethics, and the relevant laws and regulations.

For competency in *Core nursing and midwifery practices,* registered nurses must be able to integrate the concepts, the science of nursing, as well as related science, and the art of nursing for basic nursing practice, and administer safe, efficient, and quality holistic nursing care delivery through the nursing process, evidence-based information, ethics, and the professional code of ethics by taking into consideration each patient in terms of health promotion, disease prevention, nursing therapy, and rehabilitation across the age groups and in any health care status (healthy, at risk, acute, critical, or chronic), particularly illnesses that are significantly problematic at the

national and community level. The core nursing and midwifery practices includes the following (Thailand Nursing and Midwifery Council, 2016):

1) Knowledge of, and ability in, the nursing process: Registered nurses are knowledgeable and capable of providing care for patients of all age groups and in every state of health (ill, healthy, or at risk), as well as appropriately promoting health care and preventing or resolving illnesses that are major problems for the country. They must be competent to perform the following:

1.1) Assess a patient's condition by utilising assessment techniques suitable for each individual and his or her culture and health care status.

1.2) Derive from suitable sources the information necessary to provide suitable holistic nursing care (physical, mental, intellectual, and social aspects).

1.3) Assess the health risks and health care promotion factors, including those concerning each patient, the physical environment, as well as the applicable social and cultural factors.

1.4) Analyse data and apply the nursing diagnosis based on the data and diagnostic principles through the critical thinking process.

1.5) Formulate the nursing care plan using information and empirical knowledge, and set a clear goal/outcome. Engage the patients, families/care givers in planning practical and specific plans to suit each patient, society, and the cultural context.

1.6) Perform nursing intervention congruent with the nursing diagnoses and health care plans through nursing skill and relevant knowledge, including evidence based nursing practice techniques according to the academic principles appropriate for the patient and the family, including self-care promotion, safety, and appropriate local wisdom to achieve the nursing goal.

1.7) Evaluate nursing intervention in accordance with the goal/outcome in a timely manner, and continuously monitor the patient's care until achieving the goal/outcome, or when the patient can take care of him/herself.

1.8) Record the nursing care practice accurately and completely in a timely manner according to the nursing process.

2) Knowledge and ability in health promotion and disease prevention: Registered nurses are knowledgeable in the principles, strategies, and the means of health care promotion, empowerment, and behavioural modification. They are also capable of managing health care promotion, disease and illness prevention across age groups, life-cycle conditions, and enabling patients to be self-reliant in their health care at the individual, family, group, and community level.

2.1) Assess the growth and development of each patient using appropriate means and assessing the health care risk factors.

2.2) Diagnose the health and nutrition conditions, growth and development status, and the risks concerning disease and illness throughout the life-cycle that are a major issue for the nation.

2.3) Develop an appropriate health promotion plan for each patient and the family.

2.4) Implement the principles of health care promotion, health care education, behaviour

modification, and empowerment in promoting important health-related behaviour (i.e. exercise, diet, and stress management).

2.5) Provide immunisation as specified by the Public Health Ministry.

2.6) Provide advice regarding health care, as well as its promotion, and the growth and development of normal children, detect and correct any deviation, and refer as appropriate.

2.7) Assess and diagnose families, population groups, and communities through appropriate techniques, and apply operational approaches in the community to strengthen and build community participation in order to reduce the risk factors regarding health care and develop suitable health care promotion activities.

2.8) Justify local wisdom and apply it to the prevention of illness and promotion of health care of individuals, families, and the community.

2.9) Initiate health promotion projects, as well as disease and illness prevention, for families, groups, and communities.

3) Knowledge and ability to provide continuing health care to ill patients: Registered nurses are knowledgeable about the response to the needs of the patients and their families regarding the physical, mental, and social aspects of health care. They are capable of implementing therapeutic nursing principles to provide continuity of health care to patients in acute, emergency, critical, or chronic states that are uncomplicated, until they are capable of self-care or transfer to an appropriate care unit, or death. They also understand their role in managing public disasters.

3.1) Assess the health care status, risk condition, and self-care ability.

3.2) Diagnose a patient's health care status and provide suitable care for a patient suffering an acute, emergency, critical, or chronic condition.

3.3) Implement therapeutic nursing principles and technology to alleviate symptoms, providing comfort, observe, and prevent complications or disability, and the spread of disease, as well as the promotion of suitable rehabilitation for the nature of the specific illness afflicting each individual.

3.4) Apply continuity of health care principles and home health care principles to develop the potential of patients regarding self-care.

3.5) Apply palliative care principles for a terminally-ill patient and the family in order that he or she may pass away peacefully and with dignity.

3.6) Justify local wisdom and the search for social support and provide appropriate health care for the patient.

4) Knowledge and ability in family nursing and midwifery: Registered nurses are knowledgeable of family theory, the physical and psychosocial stages of women during pregnancy, childbirth, and the post-natal period. They are capable of providing pre-natal health care services, risk-condition screening, normal delivery, care of the mother and the new-born and the family during

the post-natal period, and be an advocate for breast-feeding and family planning services.

4.1) Utilise the nursing process to provide care for the appropriate health status according to the context of the patient and the family, and appropriately apply local wisdom for the health care of women during pregnancy, delivery, and the post-natal period, the families, new-born babies in normal condition, and women at high risk or suffering complications.

4.2) Provide pre-natal care, screen for health care risk conditions or complications, and make a referral as appropriate.

4.3) Assist at a normal delivery and know how to perform episiotomy and repair.

4.4) Effectively promote breast-feeding.

4.5) Provide assistance to physicians performing an obstetric procedure.

4.6) Provide family planning services within the scope of the profession.

4.7) Teach, advise, and consult about safe sex, marriage preparation, parenthood preparation, childbirth preparation, and the health care of the mother during pregnancy and labour, and health care for babies.

4.8) Promote bonding with the father, mother, the new-born baby, and family members during the pregnancy, childbirth, and post-natal periods.

5) Procedures and skills/techniques of general nursing practice: Registered nurses shall possess the knowledge and skills/techniques about general nursing practice. They shall treat patients of all ages and health status to alleviate the symptoms and resolve health care problems.

5.1) Perform nursing procedures in accordance with the regulations of the Nursing Council concerning restrictions and conditions relevant to the Nursing and Midwifery Profession B.E. 2550, which includes the following: Wound treatment, wound dressing, suturing, stitch removal, abscess excision from a region which does not endanger the vital organs, nail removal, wart and corn removal (cauterisation), incision for removal of a foreign body from a region that does not endanger the vital organs using local anaesthesia, and eye irrigation.

5.2) Possess the skills and techniques for general nursing practice as specified by the Nursing Council.

For the *Professional characteristics* competency, registered nurses shall attain professional characteristics as follows: Be trustworthy; be a good role model for health care; exhibit appropriate conduct for the interaction with patients, family members, colleagues, and others; and have the ability to assess and respond to situations appropriately. These characteristics include continuous self-improvement, a positive professional attitude, and expression of opinions with confidence based on sound knowledge, analytical thinking, and good reasoning skills (Thailand Nursing and Midwifery Council, 2016).

1) Professional personality

1.1) Being trustworthy and perceived as a competent and professional nurse.

1.2) Being responsible, honest, and self-disciplined.

1.3) Possessing analytical and clinical judgment skills.

1.4) Possessing emotional maturity, able to control emotions, and argue with valid reasons.

1.5) Able to apply good health care practice and demonstrate an effort to reduce one's own health risk factors.

1.6) Practices nursing care willingly and enthusiastically.

1.7) Being culturally sensitive for the interaction with patients and colleagues; supportive of colleagues and praising them if appropriate.

1.8) Being aware of the rights and duties of the nursing profession, protecting one's own rights, and acting responsibly within the scope of the profession.

2) Continuous self-development

2.1) Employing self-analysis and assessment, accepting criticism, and using such criticism for self-development.

2.2) Seeking opportunities for life-long learning and using various means and methods to learn.

2.3) Acquiring nursing and relevant knowledge and applying it to the working improvement.

3) Possessing a positive attitude towards the nursing profession.

3.1) Being proud of oneself as a nurse and having faith in the profession.

3.2) Being a member of a professional organisation, as well as supporting, cooperating with, and participating in activities of the organisation.

3.3) Expressing opinions and providing suggestions that are useful for the profession and operation of the organisation.

3.4) Protecting the interest of the public, the organisation, and the profession.

For competency in *Leadership, management, and quality improvement*, registered nurses are expected to be knowledgeable about leadership theory, teamwork, basic management theory, healthcare management processes, economic principles, quality assurance, quality improvement, and application of such knowledge. They must possess problem-solving skills and function as effective members of nursing or multi-disciplinary teams to achieve the goals (Thailand Nursing and Midwifery Council, 2016).

1) Leadership skills

1.1) Demonstrate leadership characteristics; using appropriate leadership strategies in applying nursing practice.

1.2) Demonstrate the ability to persuade with sound reasoning.

1.3) Demonstrate the ability to motivate, support, and create a healthy working environment.

1.4) Demonstrate courage in decision-making for the benefit of the patients and the organisation.

1.5) Seek support and cooperation from the relevant parties.

1.6) Negotiate for common interests in uncomplicated situations.

1.7) Contribute to, and participate in, organisational improvement.

2) Nursing practice management and quality improvement

2.1) Be knowledgeable and demonstrate effective management skills.

2.2) Set goals and priorities, and formulate an action plan in order to achieve the goals as appropriate for the situation and resources' availability.

2.3) Evaluate performance and strive for improvement.

2.4) Possess a positive attitude and ability regarding quality improvement; participate in the quality assurance process for nursing practice and the organisation.

2.5) Demonstrate problem solving skills to overcome operational and organisational challenges.

3) Teamwork

3.1) Be knowledgeable of the principles of teamwork and team building.

3.2) Collaborate, consult, and provide useful information to nursing/ multi-disciplinary teams and other related agencies in order to achieve the common goals.

3.3) Be an effective nursing team leader/shift leader/project leader; competent in job analysis and assignment; function accordingly at conferences, performance monitoring, and reviews; provide suggestions in order to prevent operational problems.

3.4) Be accountable for the team's performance and results.

4) Optimal Resource Utilisation

4.1 Procure and prepare the necessary materials and equipment as sufficient and ready for use.

4.2) Utilise the necessary and appropriate materials and equipment according to the purpose, professional standards, and health care requirements.

4.3) Utilise appropriate nursing practice taking into consideration the costs and added value.

For the *Academic and research competency,* registered nurses shall be aware of the significance of research and knowledge development. They must possess basic knowledge about research methods, knowledge management, application of empirical information of practices, and disseminate such knowledge to the health care team and the public (Thailand Nursing and Midwifery Council, 2016).

5.1) Realise the gaps in one’s understanding and ask meaningful questions, leading to the development of knowledge of nursing practice.

5.2) Use appropriate means to research knowledge; summarise the main ideas from textbooks, professional articles, or simple research and apply them to nursing practice.

5.3) Apply the knowledge from personal experience and disseminate this knowledge to others.

5.4) Share knowledge and information with colleagues and concerned staff in order to improve the work and resolve work-related problems.

5.5) Cooperate with research which is beneficial to the patients, the organisation, and society by respecting the rights of the research subjects and the code of ethics of the researchers.

5.6) Utilise research methods for the pursuit of knowledge to improve the work standard.

For competency in *Communications and relationships*, registered nurses must possess skills in communication, presentation, effective exchange of information, interpersonal relationships, media literacy, and professional relationships (Thailand Nursing and Midwifery Council, 2016).

1) Communication

1.1) Be capable of empathetic listening in order to form a clear and accurate conclusion of the main idea.

1.2) Be capable of reading and summarising the main idea from data and technical articles in Thai and English.

1.3) Be capable of writing an accurate technical paper in Thai in accordance with professional and international reference standards.

1.4) Be capable of providing nursing and health care information to patients using appropriate language and media.

1.5) Possess professional communication skills and able to advise and instil a sense of confidence.

2) Relationship building

2.1) Acknowledging ideological differences and use appropriate gestures, language, and expressions.

2.2) Interact with others with respect to individuality and equality.

2.3) Give and receive assistance from others according to their ability and as appropriate.

2.4) Interact with the health care teams and related personnel according to social norms.

2.5) Engage in appropriate professional relationships.

For competency in *Information technology*, registered nurses shall be computer literate, and possess basic programme processing, calculation, and the collection and presentation of data skills. They must also be able to use the Internet to research information regarding health care and nursing knowledge. They must be knowledgeable about information technology, health care and nursing information, the nursing care classification system, and the application of technology in nursing, practice, management, education, and research (Thailand Nursing and Midwifery Council, 2016).

1) Possess knowledge of the basic work-related programmes, the components of information technology, the health care and nursing information systems, and the nursing classification system.

2) Be able to use the basic computer programmes necessary for nursing practice, the basic analytical programmes, and the presentation programmes to compile, collect, and present information.

3) Use the electronic information networks to research of information about health care, nursing, and other related fields; be able to communicate and exchange views with, and learn from, personnel in the health care teams and the general public.

4) Participate in data collecting in order to set up and develop the nursing and health care information database.
5) Participate with the information system's development for organisational purposes.

For *Social competency*, registered nurses shall be aware of the relevant social, economic, political, and cultural changes. They must be capable of analysing information for the benefit of their professional and social development. They shall participate in the development of the health care systems and society, while adapting to the social environment and pursuing a healthy lifestyle (Thailand Nursing and Midwifery Council, 2016).
1) Follow the social, economic, and political changes regularly from diverse sources to ensure information accuracy.
2) Analyse and evaluate information and the changes in society, the economy, and politics.
3) Participate in the development of the health care policies of the organisation, local communities, the country, and professional organisations.
4) Adapt to the social and cultural context and respect the Sufficiency Economy Principle.[31]
5) Maintain and promote the national values and culture, as well as local wisdom and the way of life of the community by using good judgement and understanding diverse cultures.

1.4 Implication of Human Resources in the Nursing Services

1.4.1 Demand and Supply of Nurses

Besides Thailand's rapidly ageing society and its prospect as the Asian medical hub, Thailand has also lately turned into a destination for retirement migration from the developed countries. Figure 3.6, shows the rising trend of Thailand's retirement visa applications from 10,709 applicants in 2005 to 60,046 applicants in 2014. A study by Tangchitnusorn and Wongboonsin (2014) found that westerners are the majority of applicants (Tangchitnusorn & Wongboonsin, 2014). Among them, people from the UK ranked (19.6%), followed by the USA (15.4%), Germany (12.9%), Switzerland (7.7%), France (6.9%), Australia (6.6%), Norway (6.3%), the Netherlands (5.1%), Sweden (4.9%), and other developed western countries (14.6%), according to the Immigration

[31] Sufficiency Economy is a philosophy conceived and developed by the late His Majesty King Bhumibol Adulyadej of Thailand over 60 years of tireless development work to improve the lives of the Thai people and bring them genuine and lasting happiness. The philosophy is based on the fundamental principle of Thai culture. It is a method of development based on moderation, prudence, and social immunity, one that uses knowledge and virtue as the guidelines for living. The **goal** of implementing the Sufficiency Economy Philosophy is to create a balanced and stable development, at all levels, from the individual, family, and community to society at large, by developing the ability to cope appropriately with any critical challenges arising from extensive and rapid changes)i.e. globalisation(in the material, social, environmental, and cultural conditions of the world. The **principle** of the Sufficiency Economy stresses the importance of following/adopting the middle path for appropriate conduct by the population at all levels of society)individual, family, community, and the nation(in terms of development and administration in order to modernise in line with the forces of globalisation. In other words, we should try to avoid extreme thoughts, behaviour, and actions. Sufficiency has three components: moderation, reasonableness, and self-immunity, with two accompanying conditions: appropriate knowledge and ethics & virtues.)See details in http://www.thaiembassy.org/chennai/th/news/4112/53868-ปรัชญาเศรษฐกิจพอเพียง-(Philosophy-of-Sufficiency-E.html(

Bureau (2014).

=== Figure 3.6 ===

Given the above notion together with the increased prevalence of chronic illness as opposed to communicable diseases, one could expect a rising demand for health care services, from both local and foreign patients. However, as in many other countries across the globe, Thailand has long suffered chronic shortages in the nursing workforce as well as academic human resources in nursing science (National Health Commission Office of Thailand, 2011; Khunthar, 2014; Sawaengdee et al., 2016). According to Figure 3.7, the incremental supply is expected to reach 154,489 local RNs across Thailand, with a decline from 45,125 RNs during 2007-2011 to 35,100 RNs during 2012-2015.

=== Figure 3.7 ===

From the density perspective, Thailand had 20.8 skilled health workers per 10,000 people for basic health care availability. This is slightly below the WHO's threshold minimum standard of 22.8 (WHO and GHWA, 2014).

According to Figure 3.8, there was a projection of demand by the Ministry of Public Health, University Department, by the private sector for an increase from 96,979 RNs in 2000 to142,366 RNs during 2010-2015. The current ratio of nurses to population is 1:251 in Bangkok, while the figure for the northeastern region is 1:611, and elsewhere 1:450 (Bangkok Post, 2014). At the RN level in particular, the current ratio of professional nurses to the population is 1: 374 in the Bangkok Metropolitan Area (BMA), which is seven times higher than the density ratio of 1: 2,621 in the northeastern region overall. The data of professional nurses or RNs is provided as background information about the density for the Third National Plan for the Development of Nurses and Midwifery, B.E. 2555-2559 (A.D. 2012-2016) (Thailand Nursing and Midwifery Council, 2012).

=== Figure 3.8 ===

Recently, the National Health Commission Office of Thailand (2011) voiced a shortage of over 43,000 nurses. The shortage is evident more in the public than in the private sector. The nursing workforce at the professional, or Registered Nurse (RN) level, has suffered a decline of 41.3% since 2010. 6,840 public health centres across Thailand reportedly lacked sufficient RNs. There is a shortage of 18,230 RNs at community hospitals, general hospitals, and the specialist hospitals. Meanwhile, private hospitals and health care centres have demanded 18,000 more RNs. Shortage

of these caregivers is also severe for the chronically ill and terminal patients, disabled persons, and the elderly (Khunthar, 2014; Sawaengdee et al., 2016).

This is the case despite those in the professional nursing services being recorded as the majority of workers (83 %), followed by support/non-professional tasks (10 %). The latter includes the following tasks: (a) Coordinating with hospital quality improvement programmes, (b) Involved in risk management, (c) Helping to negotiate when problems arise, (d) Fostering human resources development, and so on. There were only 3% of local registered nurses serving as faculty/ academic human resources, while there were 4% of local registered nurses moving out of professional nursing, as shown in Figure 3.9.

===Figure 3.9 ===

As part of the explanation, there is a high proportion of ageing registered nurses in Thailand. The average age of registered nurses in Thailand is 37.8 years old, with the working life expectancy of registered nurses at 22.55 years. Thailand has experienced a 4.4% annual loss rate, or annual exit rate. This annual loss rate/ exit rate is expected to increase to over 15% by 2020. About 20,000 RNs are forecast to leave the profession soon. Those actively working as nurses are mainly the relatively younger group aged between 20-24 years old. Those considered actively working as nurses were found to have decreased with age, and less than 50% of registered nurses are aged 35-39 years old. They tend to transfer to administrative and support jobs. Those leaving the nursing profession are mainly between 30-44 years old (National Health Commission Office of Thailand, 2011).

Thailand has experienced a decline in new nursing graduates over the past decade (Gaesawahong, 2014). Newly graduated RNs have reportedly left the profession for careers that are less demanding and offer higher financial rewards. The majority of new graduate registered nurses work for some years as nurses but later switch to other positions unrelated to nursing, work as academics, or take support jobs as administrators. New graduate registered nurses are free to choose their workplace and prefer to move to private hospitals for the better working conditions and salary. Most new graduate registered nurses start work in nursing after an average waiting time for employment of 2.24 months. Some start working in other occupations or continue studying for a master's degree (National Health Commission Office of Thailand, 2011).

The shortage in the nursing workforce and the decline in new nursing graduates are partly attributable to the notion that nursing is not an attractive employment sector. Besides, the demanding working conditions and the regulatory regime governing this profession has negatively affected the mismatch between supply and demand for nursing services. Among others,

healthcare facilities in the public sector under the responsibility of the Ministry of Public Health could employ new graduate nurses only as temporary employees, rather than civil servants.

The current regulatory regime does not allow recruitment of nurses into the civil service. They can only be recruited as government employees, a category of employment which is less secure and with a relatively lower income and poor fringe and welfare benefits compared to civil service staff (Khunthar, 2014; Sawaengdee et al., 2016). Figure 3.10, shows that the salary of registered nurses in Thailand is mainly between TB20,000-40,000, according to a survey conducted in 2012.

=== Figure 3.10 ===

Foreign Workforce in the Health Care Service

Based on archival research, which also included a review of previous literature (Wongboonsin et al. 2014a, 2015b), the current study maintains that a transnational migration of professional workers in the categories of foreign medical doctors and foreign nurses into Thailand has existed, albeit at a relatively small extent, when compared with other professions. This study also argues that Thailand has so far been relatively open to foreign medical practitioners compared with the degree of openness for the transnational mobility of foreign nurses to practice their nursing profession in private hospitals and/or medical centres in the Bangkok Metropolitan Area and major tourist locations across the nation. Despite an increasing number of foreigners with a nursing background moving to Thailand, they have mainly only been able to access non-professional tasks rather than professional nursing services.

There were 229 Thai licenced foreign practitioners during the period as early as 1949-1986, and six (6) more during 1987-2003, after passing the Thai medical practice licence examination in the Thai language. There were also a number of foreign medical doctors who did not pass the Thai medical practice licence examination working in Thailand. The foreign medical doctors without a Thai medical practice licence were hired as consultants and executives, positions which do not require the medical practice licence. Lately, at the private Bangkok Hospital, there are five (5) foreign medical doctors from Japan, Bangladesh, and China who have passed the Thai medical practice licence examination and obtained the Thai medical licence from the Medical Council of Thailand (Bangkok Post, 2014).

Table 3.2, shows that as of November 2016, there was a total of 949 foreign workers from ASEAN member countries with a work permit in the sector of Health care Services and Social Welfare under Section 9 of the 2008 Foreign Workers Employment Act. There were 28 foreign workers from ASEAN countries with a work permit in the sector of Health Care Services and Social Welfare under Thailand Board of Investment (BOI) - promoted businesses during the same period,

according to Table 3.3. The data covers a wide range of job categories available in the sector of health care services and social welfare. We cannot tell how many are registered nurses practicing their professional nursing services.

=== Table 3.2 ===
=== Table 3.3 ===

In 2000, there were 15 foreign workers with training and working experience as registered nurses (Chalamwong and Tansaewee, 2005; Chuapetcharasopon, 2013). So far, this study could identify only two (2) foreign registered nurses who have passed the Thai nursing licence examination, and thereby were granted the national nursing licence. One is German, and the other is from an ASEAN country. This is in spite of the national nursing practice licence examination being in the Thai language. Given the relatively poor competency in foreign language proficiency among existing local professional nurses, this study expects private hospitals that focus on foreign patients to be looking for foreign workers with a nursing background. The notion corresponds with the news report (Bangkok Post, 2014) that a major hospital in the Bangkok Metropolitan Area was in the process of employing dozens of employees with a nursing background from the Philippines to cater for its foreign patients. Currently, foreign patients comprise five (5) to 10% of that hospital's total number of patients. Initially, that hospital planned to hire them as nursing assistants, and then encourage them to obtain a Thai nursing licence.

Foreign workers with a nursing background have so far mainly been hired in positions that do not require the nursing licence. They are, for example, liaison staff, medical coordinators, international case managers, or international nurse educators. For positions entitled as international nurse educators, the position includes the following functions: to educate local staff in English and improve their understanding of the standards of international hospitals. At another major private hospital in the Bangkok Metropolitan Area, around 80% of the hospital's total foreign staff work as medical coordinators and translators, with less than half having a background in nursing. Meanwhile, at another major private hospital in the Bangkok Metropolitan Area, the medical coordination teams consist of 100 foreigners, fewer than a dozen with a nursing background. This is to serve its 1.1 million patients each year, of whom 550,000 are foreigners (Bangkok Post, 2014).

The starting salary for foreign staff in private hospitals in Thailand is 22,000 Thai Baht on average, which is more than double the starting salary in Manila, the Philippines (15,000 pesos). In the near future, the salary for incoming workers from the Philippines is expected to reach 40,000 Thai Baht, excluding housing, compared to the salary for a newly hired Thai nurse at more than 30,000 Thai Baht, including overtime, at private international hospitals (Bangkok Post, 2014).

1.4.2 Commitment to the Intra-ASEAN Mobility of Nurses

1.4.2.1 ASEAN Agreement on the Movement of Natural Persons

Together with other ASEAN countries, Mr. Boonson Teriyapirom, Thailand's Minister of Commerce, signed on behalf of the Thai government on November 19, 2012, the ASEAN Agreement on the Movement of Natural Persons in Phnom Penh, Cambodia. This covers the rights and obligations additional to those set out in the ASEAN Framework Agreement on Services and its Implementing Protocols in relation to the movement of natural persons between Member States. The agreement also purports to facilitate the movement of natural persons engaged in the conduct of the trade in goods, services, and investment between Member States, and establish streamlined and transparent procedures for application for immigration formalities for temporary entry or temporary stay by natural persons to whom this Agreement applies, and to protect the integrity of Member States' borders and protect the domestic labour force and permanent employees in the territory of the Member States. Under the ASEAN Agreement on the Movement of Natural Persons, or the ASEAN MNP for short, Thailand has so far tabled the following horizontal commitments (ASEAN, 2012):[32]

1) Market Access (MA): Temporary movement of natural persons is unbound except in the following categories:

a) Business Visitor: Thailand has defined a business visitor as a natural person who stays in Thailand for the purpose of participating in business meetings or customer contact, entering into contracts to sell or purchase services, visiting business establishments or other similar activities, and entering with the purpose to establish a commercial presence in Thailand. Such temporary entry will be permitted for an initial period of not more than 90 days and may be extended for a cumulative period of not more than one year.

b) Intra-corporate Transferee: This includes a corporate transferee at a managerial or executive level, or a specialist, provided that such person has been employed by the company concerned outside Thailand for a period of not less than one year immediately preceding.

2) National Treatment: Unbound, except as provided in the horizontal commitment on Market Access.

3) Additional Commitment: Foreigners are also allowed to own condominium units according to the laws and regulations governing the ownership of condominium units.

In other words, under the ASEAN Agreement on the Movement of Natural Persons, Thailand only allows business visitors and intra-corporate transferees from other ASEAN countries to enter and stay in Thailand on a temporary basis for business purposes to engage in the conduct of the trade in goods, services, and investment in Thailand. At the initial stage, Thailand will allow

[32] ASEAN Agreement on the Movement of Natural Persons - Annex 1—Schedule of Commitments -- Thailand. Thailand's Schedule of Movement of Natural Persons Commitments, p. 34.

business visitors to stay in Thailand for not more than 90 days, and the period may be extended to not more than one year. Meanwhile, intra-corporate transferees, which includes executives, managers, specialists, and employees of an organisation within an ASEAN Member State, who are transferred temporarily to supply a service through commercial presence, are allowed them to stay for not more than one year. The period may be extended three times and each time for not more than one year (ASEAN, 2012).

These natural persons permitted to stay temporarily in Thailand under the ASEAN Agreement on the Movement of Natural Persons may engage in a range of 25 professional services, which includes nursing services (ASEAN, 2012).

Under the ASEAN Agreement on the Movement of Natural Persons, when it comes specifically to nursing services, Thailand has limited its scope to these two sub-classes of nursing services: 1) Services provided by nurses (CPC 93191); and 2) Nursing of physiotherapeutic and paramedical services provided by a hospital (CPC 1.1: 93191). The CPC Code 93191 is described as "Delivery and related services, nursing services, physiotherapeutic and paramedical services." The CPC Code 93191 includes the following services: a) Services such as supervision during pregnancy and childbirth; b) Supervision of the mother after the birth; c) Services in the field of nursing care (without admission), advice and preventive care for patients at home, the provision of maternity care, children's hygiene, and so on; d) Services provided by physiotherapists and other paramedical persons (including, home-opathology and similar services); and e) Physiotherapy and paramedical services in the field of physiotherapy, ergotherapy, occupational therapy, speech therapy, homeopathy, acupuncture, nutrition, and so on. These services shall be provided by qualified persons, other than medical doctors (ASEAN, 2012).

In the latest Schedule of Commitment tabled by Thailand under the ASEAN Agreement on the Movement of Natural Person, and the Schedule for the Movement of Natural Persons Commitment, in CPC 93191, Thailand has specified that there is a limitation on market access as indicated in the horizontal section. Thailand has further added in the Schedule of Commitment in CPC 93191 that s person working in a nursing department is required to have the licence to work for not more than one nursing department, and has obtained the licence to practice in Thailand. While the limitation on "National Treatment" indicated in the horizontal section also applies to CPC 93191 for nursing services, Thailand further adds that a person who applies for the licence to work must have a domicile in Thailand. Meanwhile, for the nursing department of physiotherapeutic and paramedical services provided in a hospital (CPC 1.1: 93191), Thailand has remained unbound for both the market access and national treatment (ASEAN, 2012).

In other words, only registered nurses who are employed by an organisation within an ASEAN

Member State at the specialist level in delivery and related services, nursing services, physiotherapeutic and paramedical services, are allowed to transfer and provide their services in Thailand for not more than one year. The period may be extended three times and each time for not more than one year. Thailand unbounds itself under the ASEAN Agreement on the Movement of Natural Persons for registered nurses transferring from a commercial organisation in an ASEAN member state to provide services in CPC 1.1:93191 in Thailand.

Based on the above notion, one can interpret that no new graduate nurses from ASEAN member countries are allowed to access on an individual basis the nursing services market in Thailand. Likewise, no registered nurses below the specialist level are allowed to transfer from a company in any other ASEAN member country in order to provide their services in Thailand.

1.4.2.2 ASEAN MRA on Nursing Services

Article V of the ASEAN Framework Agreement on Services (AFAS) provides that ASEAN Member Countries may recognise the education or experience obtained, requirements met, and licence or certification granted by another ASEAN Member Country for the purpose of licencing or certification of services supply. Accordingly, the ASEAN Mutual Recognition Arrangement on Nursing Services was signed on December 9, 2006. This particular ASEAN Mutual Recognition Arrangement on Nursing Service was designed to facilitate the mobility of nursing professionals within ASEAN, enhance the exchange of information and expertise on standards and qualifications, promote adoption of best practice for professional nursing services, and provide opportunities for capacity building and the training of nurses. The ASEAN Mutual Recognition Arrangement on Nursing Services is in accordance with the efforts of the ASEAN Member States to recognise the ASEAN Vision 2020 for the Partnership in Dynamic Development geared towards the creation of a stable, prosperous, and highly competitive ASEAN Economic Region (ASEAN, 1997, 1995, 2008).

The ASEAN Mutual Recognition Arrangement on Nursing Services was also in accordance with the new blueprint of the ASEAN Economic Community, the AEC Blueprint 2025, which consists of five characteristics (ASEAN, 2015b): (a) A highly integrated and cohesive economy, (b) A competitive, innovative, and dynamic ASEAN, (c) Enhanced connectivity and sectoral cooperation, (d) A resilient, inclusive, people-oriented, and people-centred ASEAN, and (e) A global ASEAN. The latest version of ASEAN's vision, ASEAN Vision 2025, envisions a peaceful, stable, and resilient community with an enhanced capacity to respond effectively to all challenges, with ASEAN as an outward-looking region within a global community of nations, while maintaining ASEAN's centrality. It also envisions vibrant, sustainable, and highly integrated economies, enhanced ASEAN connectivity, as well as strengthened efforts to reduce developmental gaps, including the Initiative for ASEAN Integration. We further envision ASEAN

empowered with the capability to seize opportunities and address challenges in the coming decades (ASEAN, 2006, 2015a).

The above notions reflect the three (3) objectives of the ASEAN Mutual Recognition Arrangement on Nursing Services, as noted below (ASEAN, 2006).

MRA Objective I: Exchange information and expertise in order to promote adoption of the best practice for standards and qualifications;

1) Compile the required information: The following measures have been implemented in Thailand;
    a) Recognising basic qualifications (local and foreign): At the bachelor degree level; All nursing curricula approved by the Thailand Nursing and Midwifery Council and recognised by the Office of the Higher Education Commission, Ministry of Education.
    b) List of recognised institutions (local and foreign): 80 Accredited Nursing Institutes, as at October, 2012.
    c) Domestic laws and regulations pertaining to registration: The 1985 Nursing and Midwifery Act, Amended in 1997; Nursing Regulations on the Nursing and Midwifery Code of Ethics and Professional Conduct.
    d) Requirements for post basic practices: (i) Post-basic training of nursing specialities; (ii) Post-master's training, including the Master of Nursing Science (MNS), Ph.D., Doctor of Nursing Science (DNS), post-master's training, the College of Advanced Practice Nurses, Certified Board of Nursing (Advanced Practice Nurses).
    e) Requirements for specialisation credentials in Thailand: (i) Advanced Practice Nurses' Certification; (ii) Nurse Practitioner Certification (Post-basic).
    f) Code of Ethics and Professional Conduct and Nursing Practice Safety Guidelines: (i) Code of Ethics and Professional Conduct Standards for Nursing Services; (ii) Clinical Nursing Practice Guidelines.
    g) Continuing professional development requirements in Thailand: (i) Regulations on nursing and midwifery registration, licensing and renewal; (ii) Renewal of the licence every 5 years, and compliance with the requirement of the 50-hour Continuous Nursing Education programme.
    h) Registration policy and procedures in Thailand: (i) Regulation on nursing and midwifery registration, licensing and renewal; (ii) Guidelines on the regulations of licensing for nurses and midwives; (iii) Nurses graduating from accredited nursing institutes must register as a member of the Thailand Nursing and Midwifery Council.
    i) Process for the licence to practice: (i) Regulations on nursing and midwifery registration, licence, and renewal; (i) Nurses who have registered must take and pass

the Licence Examination.

j) Number of foreign registered nurses in Thailand: Entered as "None".

k) Contact details of the professional regulatory authority: Provided by the Office of the Secretary General, Thailand Nursing and Midwifery Council.

l) Information about the certificate of good standing, period of registration, and verification of registration documents, only at the request of the Professional Regulatory Authority for nursing services in ASEAN member states.

2) Publication of the information compiled through national and ASEAN websites

a) Website address of the Professional Regulatory Authority: Objective met. (http://.tnc.or.th webpage: ASEAN Thailand Nursing and Midwifery Council)

b) Linking national websites to the ASEAN Health Care Services website: Objective met.

c) Regular periodic updates of national websites' content for the ASEAN Joint Coordinating Committee on Nursing (AJCCN) by the AJCCN representatives: In process: December every year by the Office of the Secretary General.

MRA Objective II: Facilitate the Mobility of Registered Nurses within ASEAN (ASEAN, 2006).

1) Recognise the registration mechanism in ASEAN member states: Objective met.

2) Adhere to the National Treatment for Foreign Registered Nurses to ensure equal treatment for Local and Foreign Registered Nurses including health care and welfare insurance: Medical care and vacation provided by the employers.

3) Mechanism to monitor that Foreign Registered Nurses comply with the Professional and Ethical Code and Standards in Thailand: Objective met.

4) Regarding Foreign Registered Nurses who fail to practice in accordance with the Professional and Ethical Code of Conduct and Standards of Practice in Thailand, the Professional Regulatory Authority of Nursing of Thailand shall provide information at the request from the professional regulatory authority for nursing of ASEAN member states: Objective met. The information is provided upon request by the Office of Registration and Licensure, Thailand Nursing and Midwifery Council.

MRA Objective III: Provide opportunities for capacity building and training of Registered Nurses (ASEAN, 2006).

1) Conferences/Forums (List of relevant websites in Thailand; Website announcing regular conferences/ forums for registered nurses): Objective met. The websites include the following, (i) http://www.eng.moph.go.th, (ii) http://.thainurse.org/new/index.php/lang=en, (iii) http://www.mua.go.th, (iv) http://www.tnc.or.th, and (v) http://ccne.or.th)

2) Visits to health care facilities/institutions (List of facilities/institutions available in the website): Objective met. The information is provided in the following websites: (i) http://www.eng.moph.go.th; (ii) http://www.thaiph.org (Private hospitals).
3) Attachment programmes (List of institutions offering attachment programmes available in the website): Objective met. The information is available upon request at http:///www.tnc.or.th
4) Exchange of resources among ASEAN member states.
    a) Mechanism for exchange of resources (e.g. experts, students) to facilitate capacity building and training within ASEAN member states: Objective not yet met.
    b) The Professional Regulatory Authority for Nursing in Thailand can provide a temporary licence upon request: No temporary licence is offered by the Thailand Nursing and Midwifery Council. However, the Thailand Nursing and Midwifery Council may consider authorising some qualified experts to practice in Thailand under the "Allowed to Practice" term for a 1-year period. The Thailand Nursing and Midwifery Council allows foreign nurses who have an active licence to practice from their home country without needing a licence to practice issued by the Thailand Nursing and Midwifery Council. The applicant must provide a letter of verification of her/his expertise issued by the relevant governmental agency or public university.
    c) List of experts[33] and their areas of expertise available in the website: In process.
    d) List of possible funding agencies/institutions: Not yet met: To be discussed by the relevant professional regulatory authority for nursing.

1.5 Knowledge, Attitude, and Practice by the Stakeholders Regarding the ASEAN MRA on Nursing Services

Based on the previous study (Wongboonsin et al., 2014a) carried out for local registered nurses in Thailand during the period 2012-2014, concerning the limited knowledge in the ASEAN Economic Community and ASEAN Mutual Recognition Arrangement on Nursing Services. They tend to have a slightly negative attitude against an open labour market in nursing services, particularly from the perspective of the likelihood of a negative impact on the labour market. Accordingly, they recognise the need to improve their proficiency in English. Yet, in practice, if not forced, they are unlikely to have time to attend an English course. Comparatively, nursing students had better knowledge about the ASEAN Economic Community and ASEAN Mutual Recognition Arrangement for Nursing Services than that of practicing nurses. Their knowledge on such matters seemed to increase over time. Therefore, they were worried that they would be less competent in English proficiency than nurses from the ASEAN member countries, and that

[33] Note: Experts refer to registered nurses who acquired knowledge and experiences in clinical specialties in nursing practice or midwifery and have provided nursing services in those specialised areas for at least 9 years for those holding a Bachelor Degree, or at least 6 years for those holding a Master Degree; or at least 5 years for those holding a Doctoral Degree.

the labour market would be more competitive given their notion for nurses from ASEAN member countries who come to provide services in Thailand; looking to their school to help improve English; did not want to study further or work abroad; wanted to return to work as a registered nurse in workplaces in their hometown, so that they could live with their family and not have to compete with foreign nurses.

In this regard, both the Thailand Nursing and Midwifery Council and nursing school administrators were found to share a recognition during the period 2012-2014 of the need to prepare the nursing workforce and students in foreign language proficiency and foreign culture literacy, particularly English, and the language and culture of the ASEAN member countries. The Thailand Nursing and Midwifery Council has been trying to promote on-the-job training for staff at the Ministry of Public Health to be proficient in English, to provide knowledge about the AEC, liberalise the trade in services, and the ASEAN Mutual Recognition Arrangement for Nursing Services on an extensive basis to the staff, the nursing workforce, and students. Meanwhile, nursing school administrators have adopted the common practice of signing a Memorandum of Understanding (MOU) with nursing schools in ASEAN member countries, especially Indonesia, Brunei Darussalam, and the Philippines, for scholarships and student exchanges, in order to overcome the problems relevant to credit transfers and knowledge about ASEAN in general education. Extra-curricular activities are provided to strengthen the students' English proficiency (Wongboonsin et al., 2014a).

Another previous and follow-up study (Wongboonsin et al. 2015b) found the knowledge by the stakeholders about the ASEAN Economic Community and ASEAN Mutual Recognition Arrangement for Nursing Services had increased and expanded in scope. Even so, there was a low level of awareness among practicing nurses of the impact of the ASEAN Mutual Recognition Arrangement for Nursing Services at both individual and societal levels. However, their level of awareness was also found to be higher than that in other ASEAN member countries, particularly Indonesia, during the investigation period in 2014. In comparison, nursing students in Thailand during that time were aware of the MRA and the impact of liberalisation of the trade in nursing services in a more competitive labour market and the need for registered nurses to be proficient in foreign languages as well as foreign cultures. Given this, they tended to be interested in working abroad temporarily if opportunities were available in a relatively advanced economy, for capacity building and knowledge transfer to provide better nursing services in their homeland. On the other hand, many practicing nurses in Thailand were found to lack the interest to migrate and work abroad. Meanwhile, some practicing nurses in Thailand were of the opinion that they may go abroad for a few years, if opportunities were available for more income and capacity building. Yet, the study found the latter not actively searching for an opportunity at any destination. The destinations of interest included Singapore, Brunei Darussalam, and Japan.

In the meantime, Wongboonsin et al. (2015b) found nursing school administrators, policy makers, the Thailand Nursing and Midwifery Council, and the private sector well aware of the ASEAN Economic Community and ASEAN Mutual Recognition Arrangement for Nursing Services, while adopting a demand-driven approach for Thailand as the regional hub for medical services and nursing education. Wongboonsin et al. (2015b) argued that a better awareness of the ASEAN Mutual Recognition Arrangement for Nursing Services played a role in encouraging registered nurses and students to improve their professional knowledge and skills, self-discipline, personal dignity, and career opportunities (e.g. becoming a supervisor and/or administrator) among the service providers.

1.6 Future Prospects

Given the above notions, the current study opines that compared with Singapore, the major destination for foreign nurses, Thailand is relatively restrictive in the regulatory regime governing the recruitment of foreign nurses. One of the major barriers against recruiting foreign nursing workers to provide nursing services in Thailand is a lack proficiency in the Thai language. Such a barrier can be expected to function effectively until the nursing licence examination is successfully provided in the English as well as the Thai version.

Despite the fact that Thailand has maintained the barrier of the national nursing licence examination in the Thai language, this study does identify the existence of some foreign nursing workers with Thai nursing licences. This study also found that such foreign holders of a Thai nursing licence had been raised in Thailand and thereby achieved proficiency in the Thai language.

One may also wonder why no official record of foreign nursing workers in Thailand has been found so far, and why the Thailand Nursing and Midwifery Council entered “None” in the “Number of foreign registered nurses in Thailand,” in the information provided to other ASEAN member states. This does not mean that there are no foreign registered nurses in Thailand. However, as mentioned earlier, the current study argues that there are some foreign registered nurses in Thailand, both ASEAN nationals and non-ASEAN nationals. An in-depth interview with a human resource person at the Thailand Nursing and Midwifery Council for the current study revealed that despite that person being aware of the existence of these foreign registered nurses in Thailand that particular resource person admitted that the system itself could not trace their records. One explanation is that the nursing licence examination at that time was carried out in the Thai language, and that the system has not been modified to differentiate Thai and foreigners who participated in and passed the examination. Thereby, the foreigners, who have passed the Thai nursing licence examination, were granted a licence as if they were Thai nationals.

The current study is of the opinion that the Thailand Nursing and Midwifery Council has recognised this technical problem with data collection. The current study also opines that the Thailand Nursing and Midwifery Council will try to fix it within five years from now, which should be before these foreign registered nurses to apply for renewal of their Thai nursing licence.

One may also note that Thailand is now in the process of facilitating foreign nurses to practice in Thailand. Part of the effort was for the paper-based licence examination to be conducted in English, according to the President of the Thailand Nursing and Midwifery Council as reported in the Bangkok Post (2014). However, the process has been slow, given the fact that when this study was about to finalise (2016), the examination remains only in the Thai language. Meanwhile, Thailand still has to construct the criteria to recognise foreign nurses.

Accordingly, the current study argues that in five years' time from now Thailand cannot expect a significant increase in the number of foreign registered nurses passing the nursing licence examination and being granted a Thai nursing licence. Meanwhile, this study expects a remarkable increase in the number of foreign workers without a Thai nursing licence to support the medical services in response to the demand from the private sector in Thailand.

2 Nursing Education in Thailand

2.1 Introduction

Nursing education in Thailand is making strides to catch up with the health care needs and economic changes in society throughout the region and around the world. Thailand has achieved progress with nursing education that typically prepares nurses who have specific skill at each level to support the health care problems of the people, not only Thais, but also international and ASEAN people. Therefore, nursing education in Thailand is increasingly focused to improve the standard of nursing professionals, including promoting the Kingdom as the medical and education hub for ASEAN and the global community. This chapter discusses the evolution of nursing education in Thailand, the educational system, curriculum, nursing institutions and educators, accreditation, history of the Thai Nursing and Midwifery Council, and the challenges facing nursing education in the ASEAN community.

2.2 The Evolution of Nursing Education in Thailand

Thailand is one of the eastern countries that provides professional nursing education. The King's mother made Thailand's nursing education standard develop quicker than in most other countries. Moreover, Thailand is a tourist country and it has provided multicultural nursing care for tourists from all walks of life. This facilitated the development of nursing education to deliver multicultural nursing care and achieve international standard nursing services.

Nursing education in Thailand has over one hundred twenty year of history (See Table 4). In 1896, Queen Sripatchariantra of King Rama V established the first School of Nursing and Midwifery at Siriraj Hospital. Due to the Queen's wish to reduce maternal deaths and the infant mortality rate, the nursing curriculum emphasised midwifery skills, and the initial courses were taught by physicians from foreign countries. However, all the nursing courses were hospital based at diploma level. When Prince Mahidol returned after graduating from Harvard University, he developed the knowledge-based nursing education programme.

In 1956, the first baccalaureate degree programme in nursing education was established at the School of Nursing and Midwifery at Siriraj by Mahidol University. After World War II, the number of nursing schools was increased due to the shortage of nurses. In 1971, with the establishment of the first Nursing Faculty at Khon Kaen University, nursing became an independent profession. In addition, the master's degree level of education was developed during this time. The first master's degree programme in nursing was established at the Faculty of Education, Chulalongkorn University in 1973 (Anders & Kunaviktikul, 1999).

The International doctoral nursing programme began in 1990, by collaboration among the Faculty of Nursing at Mahidol University, Chiang Mai University, and Khon Kaen University. The students attending the programme had the opportunity to study at Mahidol University, Chiang Mai University, or Khon Kaen University, and a selected overseas university. When the students studied abroad, they were monitored by supervisors with expertise in the area related to their dissertation. However, establishment of the international doctoral nursing programme raised the highest level of nursing education development in Thailand.

=== Table 3.4 ===

Nursing education institutions are the source providing nurses; thus, it is essential to know the history of nursing education, which includes the emergence and establishment of the nursing education programmes. The initial history of nursing education that influenced the current nursing education programmes in Thailand enhance nurses international academic communication and the design of effective nursing programmes in the future.

2.3 Nursing Education System and Curriculum

In Thailand, nursing and midwifery are included in a pre-registration programme. Graduates will be issued with nursing and midwifery licences. The level of nursing education in Thailand is illustrated in Figure 3.11.

=== Figure 3.11 ===

2.3.1 Nursing programmes in Thailand

a. Bachelor of Nursing Science Programme (B.N.S.)

Currently, the lowest level-nursing programme in Thailand is the four-year baccalaureate programme. Every B.N.S. programme must meet the Standard of the Professional Nursing Programme set by the Office of Higher Education Commission and the Thailand Nursing and Midwifery Council. Total credits for the B.N.S. programme range between 140 and 150 (Thai Qualification framework for Nursing Education, 2009), and the programme comprises a minimum of 30 credits in general education, 24 credits in pre-professional courses, 70 credits in professional courses, and 6 credits for electives. Most programmes are organised to achieve 144 to 147 credits. The required courses include philosophy, sociology, biology, physiology, economics, microbiology, statistics, biochemistry, English, and Thai. The courses include nursing fundamentals, obstetrics and gynaecology, paediatrics, adult health care, geriatrics, psychiatric mental health, and public health care. The graduates from the B.N.S. programme are qualified to practice as professional nurses in all environments. However, they must obtain the Professional Nurses Licence granted by the Thailand Nursing and Midwifery Council prior to practicing.

b. Master of Nursing Science Programme (M.N.S.)

All M.N.S. programmes require two years of study for a total of 36 credits (Thai Qualification framework for Nursing Education, 2012). The curriculum varies from institution to institution. Most programmes organise course work into four groups: core courses, major courses, elective courses, and theses. Nine credits for the core courses, 12 credits for the major courses, 3 credits for the elective courses, and 12 credits for the thesis. For resources, such as applied statistics, leadership, health care economics, innovation in nursing, nursing theory, nursing assessment, etc., the applicants must hold a bachelor's degree in nursing with a GPA not less than 2.50, hold the Nursing Licence for First Class Nursing Professional and Midwifery, and have a minimum of 1-2 years of experience in nursing practice.

c. Doctor of Philosophy Programme in Nursing Science (Ph.D.)

This programme prepares nursing scholars with academic and research capabilities and develops nursing knowledge leading to quality improvement of nursing services, education, research, administration, as well as the health care system. The Doctor of Philosophy (Ph.D.) in nursing science is an international post-baccalaureate programme designed for international and Thai nurses, in collaboration with other well-developed overseas nursing schools.

The applicant must hold a master's degree in nursing with a GPA not less than 3.50, and hold the Nursing Licences First Class for Nursing Professional and Midwifery. In addition, the applicant must be proficient in the English language with a TOEFL score of 525 or over (based on the

university's requirement). All doctoral degree programmes require at least three years of study. There are two types of doctoral nursing education in Thailand. Type I, is the dissertation without coursework. For students with a master's degree, 48 credits are required. Type II, is the dissertation with coursework. For students with a master's degree, 16 credits are needed for the coursework and 36 credits are required for the dissertation. For students with a bachelor's degree, 32 credits are required for the coursework and 48 credits are required for the dissertation (Thai Qualification framework for Nursing Education, 2012). The PhD courses includes nursing theory development, philosophy for nursing science development, health care policy and systems, advanced statistics, nursing research seminars, advanced qualitative and quantitative in nursing practice, etc.

d. Programme for Nursing Specialty (4-month programme)

The Nursing Specialty Programme is designed as a four-month programme. Coursework is organised for a minimum of 15 credits. There are 2 credits for the core courses, 8 credits for the nursing specialty courses, and 5 credits in the practicum courses (or practice ≥ 300 hrs). Currently, Thailand has 135 programmes for nursing specialty (Centre for Continuing Nursing Education, 2013), such as 62 programs in nursing fields i.e., Critical care, Emergency, trauma and disaster preparedness, Chronic care, Renal dialysis, CAPD, Wound care, ostomy and urinary incontinence, and Cardiovascular nursing

2 programmes for nursing administration/management

6 programmes for nursing education

38 programmes for nursing practitioners, and

27 programmes in other fields

Qualified applicants require a bachelor's degree in nursing, hold the Nursing License First Class for Nursing Professional and Midwifery, and have a minimum of 2 years of experience in nursing practice.

e. Advanced Practice Nurse (post-master's)

The Thai Nursing and Midwifery Council (TNMC, 2013*)* has specified 10 areas:

- Medical-Surgical Nursing
- Paediatric Nursing
- Psychiatric and Mental Health Nursing
- Gerontological Nursing
- Midwifery Nursing
- Community Health Nurse Practitioner
- Nursing Care for Infectious Disease and Infection Control
- Anaesthesia Nursing
- Maternal, New born and Infants

- Community Nursing

The aim of this programme is to develop professional nursing and midwifery nurses with experience and advanced knowledge of health care, treatment, and rehabilitation for patients with complex problems, through continuous training in both academic and practical aspects that comply with international standards.

Applicants must possess a master's degree in nursing as specified by the TNMC, or hold the Nursing License First Class for Nursing Professional and Midwifery. The applicant must also possess a letter for approval of training from their original affiliation. For this course, 92 credits must be completed within 3 years and not longer than 5 years. This course is divided into 18 credits for theory; 50 credits or 3,000 hours of practice; and 24 credits for research integration and practice. Upon completing the course, students must participate in direct practice within the time frame specified by the guidelines set prior to taking the examination and receiving the diploma (Diplomat Thai Board of Advanced Practice in Nursing). The examination consists of two parts: written and oral. The written exam covers advanced knowledge of nursing, such as leadership and practical nursing for patients with complex health issues, evidence-based practice, health care systems, health care policy, health care information systems, measurement and management, and health care outcomes. The written part also includes knowledge of specific nursing related issues including the relevant laws, attitudes, nursing and midwifery ethic. The oral examination involves case studies of actual patients.

Categories of Nursing and Midwifery

- Registered Professional Nurse
- Certified Nurse Practitioner (4-months of training)
- Nurse with specialty (4-month programmes)
- Advanced Practice Nurse (post-master's)

Today, few educational institutions develop multiple programmes to suit the needs of hospitals and nurses. Some develop in-house training programmes that are short and convenient programmes for nurses to practice and advance their career paths.

Nursing Licence

After graduating, all nurses are required to take the nursing licence examination before going into the field. The licence is awarded to professional nurses graduating from the 4-year programme (bachelor level). All graduate nurse-midwives and nurses from accredited nursing schools passing the national licensing examination are registered and awarded the licence to practice by the Nursing and Midwifery Council. The Nursing and Midwifery Council requires renewal of the

license every 5 years, and the renewal requirement is 50 unit-hours of continuous education. All licenses are signed by the General Secretary and President of the Council (Thailand and Midwifery Council, 2017).

2.4 Nursing Institutions and Nursing Educators

2.4.1 The Number of Nursing Institutions in Thailand

Nursing education in Thailand provided by several sectors (Table 3.5). These are:

- The Ministry of Education (at the Bachelor, Master's and Doctoral levels provided by universities)
- The Ministry of Public Health (at the certificate level and equivalent to the bachelor degree level)
- Private universities and colleges
- Military nursing schools
- Police Department
- Bangkok Metropolitan

There are now 82 nursing schools that provide different levels of nursing education in Thailand. Currently, 81 nursing schools provide educational programmes at BSN level, 7 schools that provide graduate and undergraduate nursing programmes, and 1 school (Faculty of Nursing, Chulalongkorn University) that provides only the graduate nursing programme.

=== Table 3.5 ===

2.4.2 Demand and Supply of Nursing Educators

The Thailand Nursing and Midwifery Council (TNC) asserted that the nursing workforce should increase from 163,500 in 2010 to 170,000 nurses by 2019, in order to provide health care services to citizens and foreigners, with a projected ratio of 2.5 RNs per 1,000 of population. At least 39,612 new RNs will be needed by 2019. However, in 2010, there were only 130,388 RNs under the age of 60 years, which indicates that 33,112 more RNs were in fact required in that year.

On the other hand, a study regarding the supply and requirement projection for professional nurses in Thailand found that future demand for nursing educators in 2015 was 6,833 (4.95%) (Srisuphan et al., 1998) (Table 3.6).

=== Table 3.6 ===

However, according to the Thai Nursing Council, the estimated number of qualified nurses in 2014 and 2017 had increased to 215,584 by 2017. (See Table 3.7)

=== Table 3.7 ===

To cover the demand and increase the supply of nurses, the Thai Nursing and Midwifery Council has implemented the following strategies:

- To propose that the government supports the recruitment of qualified instructors, by providing fellowships and assistantships for higher education to the Ph.D. level to nurses interested in teaching positions. Also, prepare these instructors with teaching and evaluation strategies and encourage quality research and publications / dissemination of the research results.
- To provide information on the process to open new nursing education programmes at universities. To provide the list of accredited nursing schools offering information for students, teachers, and parents through the media about study choices and the selection process.
- To propose an increase in the production of nurses in order to reduce the shortage of nurses, and nursing-instructors as shown in Tables 2 and 3.
- To propose training programmes for specialisation and advanced practice for nurses to support the medical hubs and excellence centres and the quality of health care in the country.
- To create a new career path for clinical nurses through a 3-years training programme after master's degree graduation, called the APN programme, which will become the Doctor in Nursing Practice (DNP) programme in the near future.

The Thai Nursing Council plans to increase the production of nurses in 2017 by 10,128 nursing students; add 2,439 qualified nursing instructors by 2020; replace 1,173 ageing nursing instructors. The total budget of 5,716.8 million Baht was approved by the Cabineton May 14, 2013 (Tables 3.8 and 3.9)

=== Table 3.8 ===

=== Table 3.9 ===

2.4.3 Qualification of Nursing Educators

In Thailand, the qualifications for nursing educators are designed to ensure the quality of the instructors. For the Bachelor of Nursing Science Programme**,** nursing educators must have at least a bachelor degree in nursing or a related field, hold the Nursing Licence for First Class for Nursing Professional and Midwifery. For the Master of Nursing Science Programme**,** nursing educators must have at least a master's degree in nursing or a related field, hold the Nursing Licence for First Class for Nursing Professional and Midwifery.

For the Doctor of Philosophy Programme in Nursing Science, nursing educators must have a doctoral degree in nursing or a related field, hold the Nursing Licence First Class for

Nursing Professional and Midwifery. In addition, and English language knowledge with a TOEFL score over 550 (based on the university's requirement). On the other hand, for the Nursing Specialty Programme, nursing educators must have at least a master's degree in nursing or a related field in the specialty's area, hold the Nursing Licence First Class for Nursing Professional and Midwifery, and have a minimum of 5 years of experience in nursing practice in the specialty area.

Currently, Thailand has 4,054 nursing educators, with a master's degree is 69.46%, doctoral degree 20.28%, and bachelor degree 10.26% (Table 3.10).

=== Table 3.10 ===

Selected indicators for the quality of nursing education include;

1) Percentage passing the nursing licensing examination
2) Percentage with job placement
3) Evaluation by the employers
4) Evaluation by the students and graduates
5) Number of publications by teaching staff per capita, and
6) Student awards and faculty awards at national or international level

2.5 History of the Thailand Nursing and Midwifery Council (TNMC)

The Thailand Nursing and Midwifery Council (TNMC) was initiated by the Nurses Association of Thailand in 1968', and established by the Royal Decree of Professional Nursing and Midwifery Act BE 2528, on September 28, 1985, and the revised Act approved by parliament on December 23, 1997. The Act was revised as follows: 1) Definition of nursing and midwifery practice, 2) Scope of the practice, 3) Increase in the number of committee members, 4) A nurse appointed as the President of the Council, and 5) Renewal of Licences.

Çommittees' Accreditation of the Nursing Institution, and Recognition of the curriculum, Examination for licensure, Registration and licencing, Credentialing and Certification for Advanced Nursing Practice, Journals and publications, Nursing Ethics and Conduct/Complaints, Professional and standards' development, Nursing service development and quality assurance, National Nursing System Research Institute, International Affairs and Research supports, Finance and budget, Continuing Nursing/Midwifery Education and Relicensing Board, Continuing Nursing/Midwifery Education Programme's Evaluation and Approval, Nursing Information Systems, and the Nurse of the Year Award.

Moreover, the TNC has an important role to protect the public: Patient Safety Through Quality Assurance. By this role, the TNC takes responsibility for "*Accreditation", A*ccreditation of nursing educational institutions, and the nursing service in hospitals and primary health care units.

In addition, the professional organisations need to be concerned with "**Ethics and conduct**" as follows: Professional code of ethics; Rules and Regulations; Complaints of conduct/malpractice; Penalties. The responsibility for "**Professional development**" includes Formulating policy and planning involvement at all levels; Support the advancement of nurses at Post-basic certificate level, Master's and Doctoral degrees; Leadership and management training; Research-evidence based practices, decision making; Career development/advancement; Planning and evaluation of the nursing workforce (Adequacy, competency, distribution, deployment, and evaluation); Negotiation of salary, compensation, and welfare benefits; Formulate the National Development Plan for NM; Propose plans for nursing development to the government.

2.6 Nursing Education Accreditation

Every institution must complete the accreditation process set by The Thailand Nursing and Midwifery Council to ensure the quality of nursing education practice. The Nursing and Midwifery Council is responsible for accrediting the pre-registration programmes, continuing education, training, and the graduate programmes. The Nursing and Midwifery Curriculum and the programme is approved by the University Council before submission to the Nursing and Midwifery Council for approval. Once approved, it is sent to the Higher Education Office of the Ministry of Education for approval and recognition. For new institutions, the Nursing and Midwifery Council conducts an audit regarding the readiness of the institutions according to the accreditation criteria and standards before opening or admitting students.

The accreditation process starts by reviewing the self-study report submitted by each nursing institutions including the curriculum. Site visit to clarify, verify, and amplify the written programme materials. Review and assessment of the teacher-student ratio, qualifications of the nursing teachers, curriculum components, teaching-learning process, local hospitals and communities for the practice and evaluation process, learning equipment and materials, libraries: (books and journals, audio-visual material, computers). If able to meet the requirements, the TNC will grant accreditation (1 to 5 years according to the standards). Recommendations for further development will be offered by the assessment team. Every year, each nursing institution shall conduct an internal audit, which requires external expertise or the school networks. Students graduate from accredited schools may apply for the licensing examination. Every 5 years the Office for National Education Standards and Quality Assurance (Public Organisations) will assess the quality and standards of each educational institution and review the new approval accordingly.

All nurse-midwives or nurses graduating from accredited nursing schools who pass the national licensing examination will be registered and awarded licence to practice by the Nursing Council. The Nursing Council requires renewal of the licence every 5 years; requirement for renewal is 50

hours of continuous education. Nurses holding active licence may work anywhere in the country. For Regulation of foreign-qualified nurses, the applicant must hold the nursing licence from their home country and submit all credentials and the transcript of records. The Reviewing Committee evaluates and if appropriate the Nursing Council authorises a special permit to work as a registered nurse for a certain period of volunteer work, or to take the licensing examination for professional work in Thailand.

2.7 Educational Service in the ASEAN Community

Education is expected to play a key role in narrowing the development gap in ASEAN while the region move towards the ASEAN Community. ASEAN member countries have tabled their commitments to minimise the restrictions on the provision of educational and nursing services across the region. It is expected that they will progressively intensify the integration commitment for the free flow of education services and free flow of professionals in the region, in order that ASEAN as a whole becomes an important player in the global supply chain (Wongboonsin, 2013).

The ASEAN Vision 2020 for the Partnership in Dynamic Development, the ASEAN Mutual Recognition Arrangement on Nursing Services, is now in place. The MRA notes that the Article V of AFAS provides that ASEAN Member Countries may recognise the education or experience obtained, requirements met, and licence or certification granted by other ASEAN Member Countries, for the purpose of licensing or certification of service suppliers. The objectives intended under this MRA are four-fold. That is to:

1. Facilitate the mobility of nursing professionals within ASEAN
2. Exchange information and expertise regarding the standards and qualifications
3. Promote adoption of the best practice for professional nursing services
4. Provide opportunities for capacity building and training of nurses

According to the MRA, a Foreign Nurse may apply for registration or the licence in the Host Country and be recognised and allowed to practice nursing in accordance with the laws and regulations of the Host Country, subject to complying with the following 6 conditions:

1. Has a Nursing Qualification.

2. Has a valid professional registration and/or licence from the Country of Origin, and a current practicing licence or certificate, or a relevant certifying document.

3. Has a minimum practical experience in the practice of nursing of not less than three (3) continuous years prior to submitting the application.

4. Complies by satisfactory continuous professional development in accordance with the Policy on Continuous Professional Development in Nursing as mandated by the NRA in the Country of Origin.

5. Certification by the NRA of the Country of Origin of no record or pending investigation

of having violated any technical, professional, or ethical standards, local or international, in the practice of nursing.

6. Complies with any other requirements, such as to submit to a personal medical examination, or undergo an induction programme, or a competency assessment, as may be imposed on such applicant for registration and/or licence as deemed fit by the NRA, or another relevant authority, or the Government of the Host Country concerned.

The Practice of Nursing refers to the provision of nursing care by a nurse that encompasses promotive, preventive, curative, and rehabilitative practices that may include education and research.

The notions are particularly relevant to the role of nursing education and the role of research universities in the region to hold hand-in-hand for both the stock and flow of nurses in order to reap the benefits integration will achieve, and face the challenges it will create, as well as perform their appropriate role to contribute proactively and efficiently to the well-being of people from all walks of life in the region.

2.8 Intra-Regional Cooperation for Nursing Education

As we have realised, a number of countries across the globe are moving through educational generations of higher education, from Education 1.0 to Education 4.0 (Wongboonsin, 2013).

Although they are comparatively very different, they are interactive. As noted by Moravec and Harkins at the University of Minnesota, Education 1.0 is a largely a one-way process of teaching and learning. Students are largely consumers of information resources. They engage in activities based around information delivered to them by lecturers and gain experience by memorisation (Wongboonsin, 2013).

Education 2.0 takes places when the technology of Web 2.0 is used to enhance the traditional approach to education. The process of education itself is not transformed significantly from Education 1.0, although the groundwork for broader transformation is established.

Education 3.0 empowers students to produce, not merely consume, knowledge. It is made possible by Education 2.0, and by centuries of experience with memorisation. It is characterised by rich, cross-institutional, cross-cultural educational opportunities within which the students play a key role as creators of shared knowledge artefacts, and where social networking and social benefits outside the immediate scope of activity play a strong role.

Education 4.0 empowers students to innovate, the follow-on substantiation of knowledge

production. Students are a major source of technology evolution in the service of innovation production.

As one may note, Education 2.0 is the stepping stone to Education 3.0 and Education 4.0. Although parts of the education programme in ASEAN are moving toward Education 2.0, it is necessary for the higher education institutions across the region to leapfrog toward Education 3.0 and Education 4.0 and collaborate to empower students toward human capital skill in knowledge production, innovation production, and innovative knowledge application in the field as nursing services (Wongboonsin, 2013).

So far, we have seen how important research is, particularly at the community, regional, national, and international level, and that it is becoming vital for the development of students and faculties, as it contributes to expanding their knowledge and understanding, which will lead to acceptance by their peers, colleagues, and the institutions around the nation and the world. Accordingly, it is imperative to explore collaboration strategies on a network basis. A symposium should encourage in order to achieve collaborative research projects that contribute to a healthy ASEAN population (Wongboonsin, 2013).

It could be said that development of scientific research is vital to provide teaching methods based on evidence, develop critical thinking, as well as teaching strategies/learning to suit the current development status. The problem solving and critical thinking skills applied to the educational programmss help students process their nursing applications. The results from clinical studies are covered by lectures in order to help students understand the importance of nursing research as well as the value of evidence-based practice. E-learning, problem-based learning, and self-learning are increasingly encouraged. Nursing ethics are also included in the process of teaching / learning (Kunaviktikul, 2006).

2.9 Challenges for Nursing Education in the ASEAN Community

Ten member countries of the Association of Southeast Asian Nations or ASEAN have entered the ASEAN Economic Community or AEC since 2015, which has led to the liberalisation of the trade in services, investment, labour mobility, and greater harmonisation of the rules and regulations. In this regard, a mutual recognition arrangement has been established to facilitate nurses' mobility, the exchange of knowledge and best practice that has provided a scheme to develop nursing skills in Thailand.

Education is expected to be a cross-cutting element that supports successful formation of the ASEAN Community. However, there are some challenges and needs required to implement the ASEAN MRA for the nursing education system in Thailand as follows:

- Ongoing research is vital to meet the new challenges and the curricula need to be analysed and revised periodically to ensure appropriately prepared graduates. This includes curricula development and implementation at the undergraduate and graduate levels. Moreover, there should be more doctoral prepared nurses and APNs, in order to improve the quality standard of health care education as a whole.

- Curricula development should emphasised the ASEAN/Global health needs and outcomes and achieve the international standard. In addition, add an ASEAN/Global language, culture, and health care standard to the elective courses.

- Develop an International Training Programme.

- Faculty development.

- Research and knowledge building should be concerned with the ASEAN/Global health care needs and outcomes. Linking research, education, and practice in nursing is of vital importance to raise the standard of nursing. Collaboration between nursing institutions should be actively encouraged to allow cross-cultural research, education, and the sharing of knowledge for the benefit of all involved. Thai nursing leaders and educators must evolve to handle future challenges and ensure that the nursing needs of the Thai and ASEAN/Global community are achieved.

2.10 Challenges in Relation to the Regulatory Body

- Nursing schools have to prepare the Self-assessment Report (SAR) for Quality Assurance (QA) at least once a year. A school receives accreditation for one year by the Thai Nursing and Midwifery Council, they have to prepare the SAR twice in that year, and if the period is the same time as the ONESQA, the organisation has to prepare the SAR 3 times a year, since some of the criteria are different, and this will be a significant burden on nursing colleges and schools.

- Problems due to the shortage of qualified nursing instructors and the existing instructors are ageing. Approximately 25% (or 1,173 persons) of the 4,417 instructors are over 50 years old. Therefore, we need to prepare to replace these instructors.

- Shortage of registered nurses working in both the public and private health service. Currently, Thailand's 82 accredited nursing education institutions produce approximately 8,000 nurses per year to meet. Due to the expanding health care service requirement to improve the quality of health care services, especially after implementation of National Health Security Act in 2002. The shortage of nurses was estimated to exceed 40,000 in 2012. Therefore, the increase in production is necessary.

- Qualifications for nurse-midwife instructors and research publications are according to the requirements set by the Ministry of Education and National Research Council.

- Some misunderstanding has arisen between the universities and the Professional Council. According to the law, the University Council has the authority to open new education

programmes. However, if the new programmes are related to professional education, the University Council has to regulate the programme according to the professional regulations. Unaccredited programmes will encounter problems as graduates will not be able to take the licensure examination.

- Thailand is striving to become the medical hub of Asia.
- In order to serve local people, foreign nurses are required to pass the Thai licence examination in the Thai language in order to work in Thailand.

2.11 Nursing Education in Thailand and the ASEAN Community

Education appears to be the cross-cutting element that supports successful formation of the ASEAN Community, but the mobility of nurses is making slow progress. Thailand has progressively developed the nursing educational system and curriculum to attract international students to study in Thailand. There are 82 accredited nursing institutions that are expected to produce more nurses to fill the demand for nurses in Thailand. The Thailand Nursing and Midwifery Council has proposed strategies to increase the number of nursing educators and instructors.

3. Case Studies

3.1. Overview of Actual Cases of Foreign Nurses in Thailand

This part reviews actual cases concerning the inflow of foreign nationals with a nursing background who are working in Thailand, including how this inflow happened and how the recent environmental changes, such as progress in the ASEAN Economic Community and the promotion of medical tourism, affects these nurses' mobility and human resource development.

With the promotion of medical tourism, it is said that the number of medical tourists has increased, although there are no official statistics. In Thailand, more private hospitals are accepting foreign patients or people travelling abroad; these hospitals are located mainly in Bangkok and its suburbs and some in other places, such as Phuket and Pattaya, where people can undertake treatment and enjoy a holiday (NaRanong and NaRanong 2011, Noree et al 2015).[34] As discussed in Section 1, there are more patients coming from east Asia, and the USA, UK and Middle East, and the neighbouring countries.

To meet the needs of patients from all over the world, hospitals have to build up multilingual systems. Human resources are most critical. Medical doctors, nurses, and the hospital staff should have some ability to speak English and other languages. Translators and interpreters for each

[34] Some public hospitals, such as the hospitals that have close connections with universities, also accept foreign patients who have lived in Thailand for many years as well as foreign patients arriving from the neighbouring countries that have less advanced facilities.

language are necessary to support these patients. It is also necessary to have human resources and employees who can use English to coordinate, prepare insurance documents, answer inquires by email or phone, and so on, if the Thai nurses or staff cannot do so. Thailand, as previously mentioned, has never officially promoted the employment of foreign nurses; however, in the actual field, Filipino nurses who can speak and write in English and have medical knowledge have started working in response to the demand.

Besides providing medical services for foreigners, Thailand plays an important role in nursing education in the region (as mentioned in Section 2), and many students from southeast Asia and southern Asia study in Thailand. In the international courses for the master's and PhD programmes, there are now more nurses coming to study at Thailand's universities. They study for 2–3 years or more and then return to work as nurses in their own countries. The bachelor's course is often taught in the Thai language; however, Cambodian scholarship students are studying at some universities. They study together with Thai students and obtain nursing licences in Thailand, and as a result, some work as nurses in Thailand.

In early 2017, our team used questionnaire surveys and semi-structured interviews with the Thai and foreign nurses and staff working in hospitals that accept foreign patients, as well as with nursing students studying in the faculty of nursing science at universities.

As mentioned in Section 1, there are no official statistics about the number of foreign nurses in Thailand. Therefore, we identified the hospitals that accept more foreign patients and clients, and by means of snowball sampling, our study team obtained access to eleven Filipinos and two Cambodians with nursing backgrounds who are working in Thailand, and some Thai colleagues.[35] The Filipino nurses, even though they have never worked as professional nurses in Thailand, are working in Bangkok and Phuket, while the Cambodian nurses are working in the border provinces close to Cambodia. Besides these foreign nurses, our team also approached forty nursing students, including students from Thailand, Cambodia, and various other countries.

3.2. The Filipino Nurses Community in Thailand

3.2.1. Background of the Filipino Nurses

The eleven Filipinos, who hold nursing licences in their own country and are working in Thailand, are around 26–32 years old (average age 28). Nine are female, and six are single. Three are male, and two are single. They all came to Thailand between 2011 and 2014 (Table 3.11).

=== Table 3.11 ===

[35] Three Filipinos and one Cambodian answered our questions by email, and the others answered directly.

All the participants obtained nursing licences with a bachelor's degree level of education and then worked as nurses in their own country for several years before migrating to Thailand. They have never held licences in Thailand and have never thought of gaining them, because this would take time and money, and they do not speak or read Thai.

3.2.2. Their Role in the Hospitals and the Challenges

Filipino nurses in Thailand usually work in hospitals as coordinators, translators, marketing staff, and as staff preparing insurance documents, or communicating with patients abroad by email, utilising their English and nursing knowledge. They cannot work as nurses in Thailand, because this is prohibited without a Thai licence. The registered Thai nurses who are their colleagues work as nurses, and the Filipino nurses/staff support communication between the patients and the Thai doctors and nurses. Among the eleven Filipino nurses who answered our questions, eight work as coordinators and one as an interpreter in the hospitals, and one works as a college lecturer teaching nursing and public health care in English.

There are communication problems due to language barriers, especially when Filipino nurses are new to the workplace, because Filipino nurses rarely speak Thai; nor is their culture the same. Even though Thai nurses at private hospitals that accept foreign patients can usually speak English and the hospitals encourage them to study English, communication in the beginning is not always easy. They often overcome the problem after a while by communicating in simpler English and by the Filipino nurses learning to understand Thai culture. But the Filipinos' self-evaluation in the Thai language ranks between 1 and 2 on a 5-point scale.

To avoid miscommunication in nursing, one option for Filipino nurses is to gain the registered nursing licence in Thailand; however, the course to become a registered nurse is usually held in the Thai language, and the exam is only given in Thai.[36] For Filipino nurses, it is too big an investment to study for this licence in Thailand, and there is insufficient return. Therefore, they usually do not obtain the required Thai licence.

One Filipino nurse told us that even if she wanted to improve her skills as a nurse while working in Thailand as a coordinator, she cannot obtain any clinical practice experience in Thailand as all the training courses for nurses are in the Thai language and are usually customised for Thai registered nurses. Therefore, Filipino nurses have limited opportunities to improve their skills (even though their experience at Thai hospitals is counted as working experience when they renew the licence in their own country).

[36] There are international courses in English for nursing education; however, these are usually for foreign students and are not designed for the exam in the Thai language.

3.2.3. Motivation to Work in Thailand

Ten out of the eleven Filipino nurses answered that they decided to work in Thailand by themselves, and some said that they have the support of family members. Their primary motivation varied. Earning a better salary (three persons) and exploring new experiences in other countries (three persons) were the main motivation factors for coming to work in Thailand. Besides, they pointed out the expectation of acquiring new skills, having stepping stones to move to another country, fewer working hours, working in a safer environment, and so on.

3.2.4. Recruitment Process

Filipinos who work in Thailand rarely use recruitment agencies. If they are going to work in Singapore, they must register with a recruitment agency in their own country before travelling. This usually takes more time and money. But to come to Thailand, they usually do not use an agency, because there is no such agreement between the two governments. Migrants usually have to comply with the Foreigner Employment Act and the Immigration Act of Thailand (see Section 1). Only one among the eleven Filipino nurses answered that she had used an agency. In her case, she did not know the destination country when she applied to the agency, but the agency arranged Thailand as the destination.

Instead of an agency, many Filipino nurses find job opportunities in Thailand through friends or family members who have worked there previously, or they go directly through the recruitment information on the hospitals' websites. Among the eleven Filipinos, four obtained employment information from family members or relatives, and five received this information from friends. Going through these routes saves time and money, compared to migrating to Singapore, according to the Filipino nurses. Unfortunately, there is the risk of human trafficking or cheating; however, saving time and money is a greater concern for these nurses. Because of this practice, the governments of Thailand and the Philippines cannot follow the movement of the Filipino nurses. Eight of the Filipinos travelled to Thailand with passports, non-immigrant visas, and work permits. One Filipino nurse said that she travelled to Thailand with a tourist visa and then, after a while, she got the non-immigrant visa and work permit. Until she gained these official documents, she was worried about her legal status in Thailand.[37]

3.2.5. Future Plan

Usually, the contract with these nurses is for a fixed-term, and they renew it every year or every three years, depending on the conditions. Their satisfaction level is between 3 and 5 (on a 5-point scale); five persons rated it as 3, five persons rated it as 5, and one person rated it as 4. However, this does not mean they will stay in Thailand forever. Some mentioned that working in Thailand

[37] Among such people, it used to be popular to make visa runs across the border to visit a neighbouring country for a few hours for visa renewal.

is a stepping stone; some might go to work in other countries, while others might return to their own country after the current assignment.

The typical pattern by Filipino nurses in Thailand was not clear from the eleven Filipinos' answers. Most Filipino nurses answered that they like their life in Thailand and would like to work in Thailand as long as possible or as long as the hospital needs them. Some would like to go to other countries, some would like to go back home, some would like to study further after the current assignment. Their future plans are ambiguous. Among their previous colleagues, some had gone to work in Australia and New Zealand after working in Thailand for several years.

3.2.6. Mutual Recognition Agreement

Only five of the eleven Filipinos had heard of the ASEAN MRA; people who know about the MRA can expect to have more employment options or chances in the future in Thailand. However, within ASEAN, Singapore, Malaysia, and Thailand are the countries that receive nurses or that have the potential to receive them. There are not many countries that accept Filipino nurses other than Singapore, which has already done so, but there is considerable competition.

3.3. Cambodian Nursing Students and Registered Nurses in Thailand

3.3.1. Scholarship Students from Cambodia

It is very difficult for foreigners to pass the Thai exam because of the language barrier; therefore, foreigners do not usually work as nurses. However, there are several foreign registered nurses working in Thailand. Some are Cambodians who graduated from faculties of nursing science at universities in Thailand.

One of the most important avenues for Cambodian students to study in Thailand is the Royal Scholarship Programme under the Her Royal Highness Princess Maha Chakri Sirindhorn Education Project for the Kingdom of Cambodia. This provides a means for Cambodian students to study higher education in Thailand, ranging from diploma to PhD level, and more than 1,000 Cambodian students have studied under this project since it was initiated in 2001.[38] Human resource development in the public health-related area, including nursing science, is very important for the development of Cambodia; therefore, there have been more students studying in this area in recent years.

For the 2017 scholarship year, 213 students were selected, and 16 of the 151 bachelor's level students will study in the faculty of nursing science at six universities in Thailand, including Mahidol University and Khon Kaen University.[39] Two students will study the international

[38] Princess Maha Chakri Sirindhorn's Education Project for Cambodia, 27 September, 2015 http://thailand.prd.go.th/ewt_news.php?nid=2217&filename=index (accessed on 3 March 2017)

[39] Data is from the website for the Royal Scholarship under Her Royal Highness Princess Maha Chakri Sirindhorn

course offered in English; however, fourteen students will study nursing science in the Thai language together with the Thai students.[40]

Students who study in the Thai language usually study the language for three months before starting their nursing study at each university,[41] even though the scholarship exam is not in Thai but in English. Cambodian students may have some advantage in learning the Thai language compared to other countries' students. The Thai language and the Cambodian language are similar, and Cambodian people enjoy watching Thai TV dramas in Cambodia, even though they are broadcast in a different language. After the language training course, the nurses study with the Thai students. Cambodian students say that even though it is not easy, somehow they can understand the classes in Thai.

3.3.2. Students' Background

For this study, the average age of the ten Cambodian students studying the bachelor's course of nursing science was 22.3 years (20–28 years old), and one Cambodian student in the master's course was 26 years old. Most entered a university in Thailand soon after their high school graduation (Grade 12). Six students were female, and five students, including the master's course student, male. Because this is a rare opportunity for them to study abroad for a bachelor's degree, more male students come to study nursing, even though some of them believe that nursing is a woman's occupation. They come from various provinces in Cambodia, such as Ratanakiri, Mondulkiri, and Stung Treng, which are very remote areas (Table 3.12).

=== Table 3.12 ===

3.3.3. Motivation of the Students

The students' main motivation in choosing to study nursing science includes the ease of finding a job (seven persons), obtaining a better salary (four persons), wanting to take care of sick people (three persons), and wanting to achieve a better social status (two persons).[42]

They chose to study in Thailand because they can acquire professional skills and obtain a better education than studying in Cambodia. Some are interested in gaining new experience in foreign countries. With these various reasons in mind, their school teachers or friends often introduce

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Education Project to the Kingdom of Cambodia.
(http://royalscholarship.buu.ac.th/2016/index.php/MDN8fGxpc3RzY2hvbGFyc2hpcA (accessed on 3 March 2017)).

[40] The total number of students and the breakdown were different each year. At Khon Kaen University, there were more Cambodian students studying in the Thai language in 2016; however, in 2017, only international course students will be admitted.

[41] A former student's information (interviewed on December 20, 2016).

[42] Each Cambodian student raised two main reasons for studying nursing.

them to this scholarship opportunity, and when the students have passed the scholarship exam, they decide to come to study nursing in Thailand.

3.3.4. Future Plan

After completing the bachelor's degree in nursing science, these students take the national examination of Thailand to become registered nurses. Seven out of ten bachelor's level students answered that they would like to work in Cambodia after graduating, because the criteria for this scholarship requires that they shall work in Cambodia to improve public health care. Two students said they would like to work in Thailand for a while, because they need more real practice/experience in Thailand before returning to Cambodia.

3.3.5. Cambodians Working as Registered Nurses

Among the graduates, only a few are registered nurses working in Thailand. The scholarship programme started to accept students for the faculty of nursing a few years ago. Therefore, there are not many graduate nurses yet, but in 2016 a few Cambodian registered nurses were working in Thailand.[43] Two of them are now working in the provinces adjacent to the Cambodian border, where they treat Thai and Cambodian patients as well as patients of other nationalities. They can work as nurses and also utilise their language skill, not only in Thai but also in Cambodian and English, as they take care of a variety of patients.

The number of Cambodian nurses in Thailand is only a few, and this number will never affect the overall demand–supply of registered nurses in Thailand by considering the number of scholarship students. However, their experience will support human resource development in Cambodia and in the Mekong region, and contribute in the long-term to narrow the development gap in the region.

3.4. Other Nationalities

Besides the Cambodian students attending university, there are students of other nationalities studying the international course in English. They usually study the master's or PhD course in order to pursue higher education that is more qualified than the education level in their respective countries. They are from ASEAN and south Asian countries including Indonesia, Vietnam, Nepal, and Bhutan. Those who study the master's and PhD level courses in nursing science in Thailand hold nursing licences in their respective countries and have several years of experience. After working for a while, they come to study in order to improve their skills and knowledge.

Our team accessed eleven foreign nursing students studying the master's course in nursing science. They were from Bhutan, Nepal, Indonesia, and Cambodia. The average age was 34 (24–42 years

[43] In the border provinces in Cambodia, people often travel to Thailand for medical treatment, because it is closer than treatment in the big cities in Cambodia, and there is better treatment in Thailand than in Cambodia (Author's interview in Battambang Province in Cambodia, July 2016).

old), and they are older than the Cambodian bachelor's course students.

They chose to study in Thailand because they can study in English, and scholarship programmes are also available for them. For example, the Buthan and Thai governments have a special agreement supporting Buthan's students studying in Thailand. These students are usually satisfied with the course because of its better quality as well as the better facilities. However, for clinical practice, the language barrier is a concern when they try to communicate with the Thai patients and other colleagues.

For the south Asian students, the ASEAN MRA will not directly affect their employment opportunities. For students from countries with ASEAN membership, it might have an effect, but in our interviews, they were much more interested in working in their respective countries and working close to their parents' home.

3.5 Foreign Nurses in Thailand

Thailand has never accepted foreign nurses with foreign licences; however, due to the demands stemming from the promotion of medical tourism (and also due to the ageing society), more foreign nurses have started working in Thailand; however, not as nurses but as coordinators or interpreters at hospitals. They play the role in cooperation with the Thai registered nurses. Many seem to be satisfied with their work at present, overcoming the language and cultural barriers.

Thailand provides higher and better qualified education opportunities than in the neighbouring countries and other countries. In the master's and PhD courses, more nurses from other countries come to study with the help of various scholarships. The research activities may contribute to their own countries' human resource development and Thailand's human resource development, including Education 4.0 (see Section 2).

The MRA is becoming known by nurses and nursing students little by little; however, their choice of employment opportunities does not yet reflect the MRA's objectives; nor do they have clear information about it. People may have ambiguous expectations, but they do not yet have a clear idea how to utilise the MRA.

4. Concluding Remarks

The transition of the Thai economy and society, the progress of the policy level agreements which support the free flow of skilled workers in the region, the promotion of medical tourism in Thailand, and the environment surrounding registered nurses in Thailand is now facing a big change. The demand for registered nurses in Thailand is increasing and the nursing education system is trying to respond to this new trend and the various demands as a member of the ASEAN

Community.

Language is often a barrier in education and at hospitals, because human communication is an important aspect of nursing care. It will take more time until the MRAs have a real impact on Thai society, and human resource development will also take longer.

Taking advantage of this timing, more foreign nationals, mainly Filipinos who have nursing licences in the Philippines, are migrating to work in private hospitals as coordinators or to handle non-professional nursing tasks in recent years. To utilise this human resource in nursing effectively in Thailand and the ASEAN Community, studying the actual current situation of the foreign workforce in the medical sector is really necessary.

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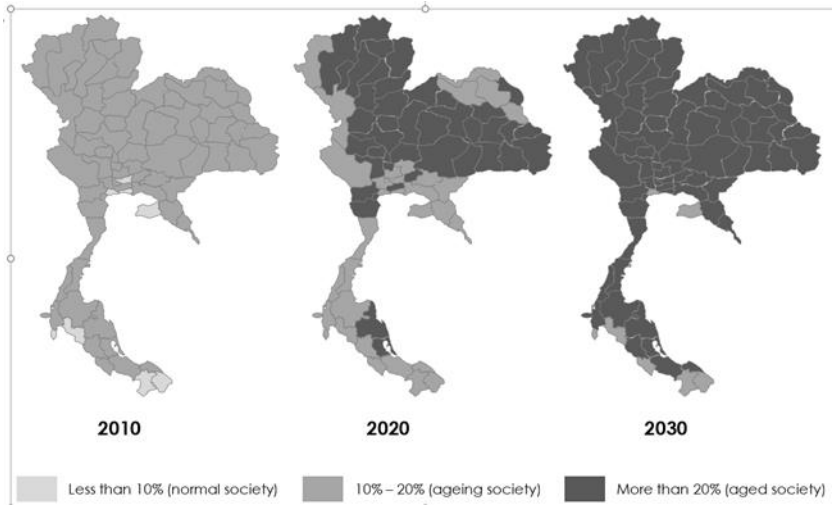
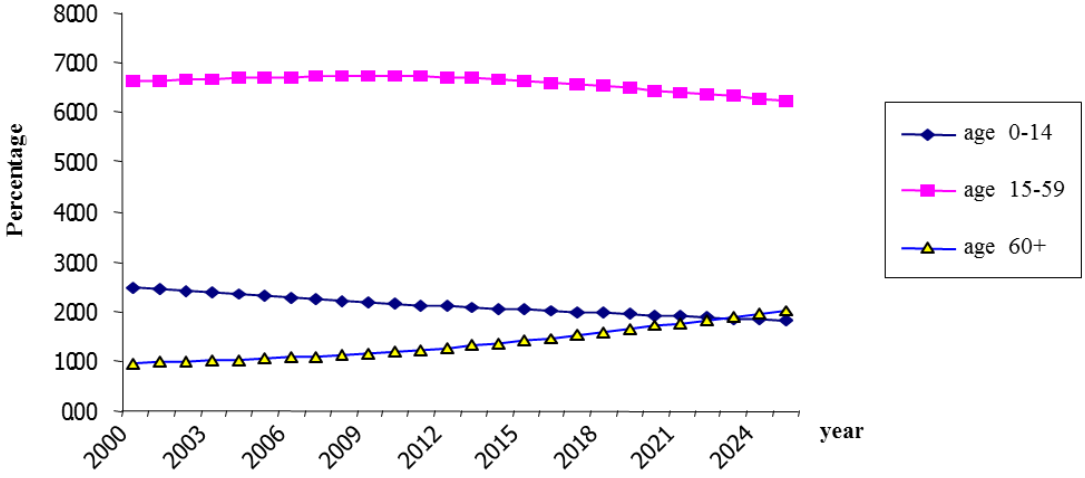
Figure 3.1 Share of Elderly People in Thailand in 2010, 2020, and 2030



Source: Patcharawalai Wongboonsin et al. (2014a), based on NESDB, 2013a..

Note: Data for 2020 and 2030 is a projection

Figure 3.2 Thailand: Percentage of the Population below 15, 15-59, and 60 years and above (Medium Fertility Assumption)



Source: Wongboonsin, K. (2004).

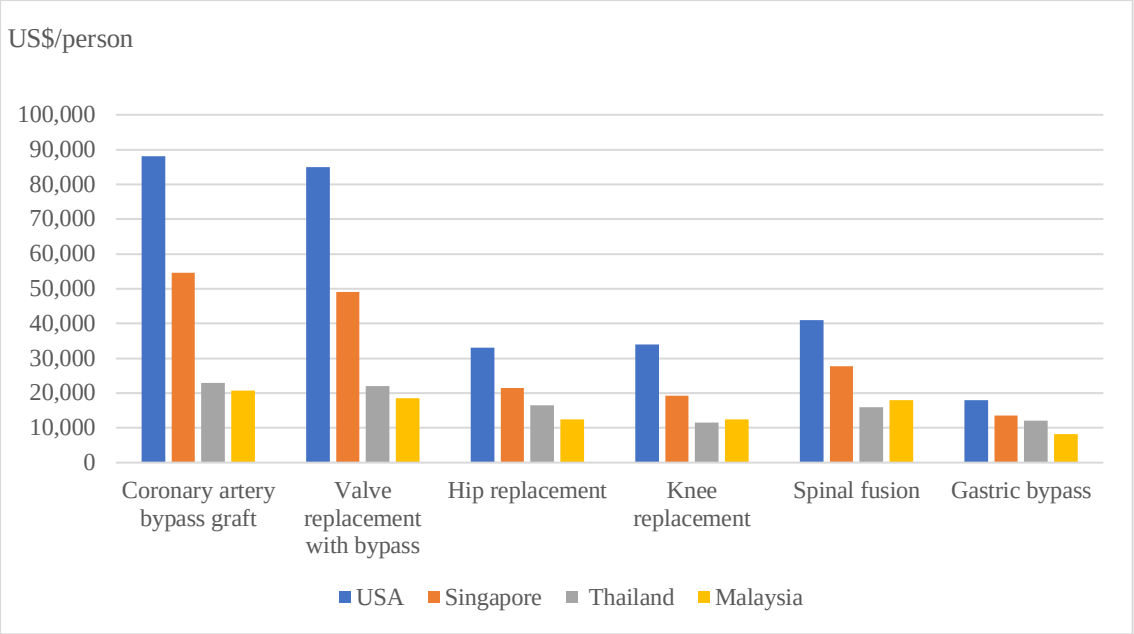
Table3.1 Medical Tourism Comparison in Thailand, Singapore, and Malaysia

	Thailand	Singapore	Malaysia
Positioning	High quality; friendly services	High-end, specialty	For Muslims
Medical tourism (million times in 2015), exclusive of expats	2.25	1.15	1.0
No. of JCI accredited hospitals*	54	22	13
Medical services	Medical check-up; cosmetic surgery & derma care; dental care; cardio; orthopaedic treatment	Complicated: oncology & tumour; neuro	Medical check-up; dental care; cardio; tumour

Sources: Kasikorn Research Center, 2016: Ministry of Public Health, 2016; Thailand Board of Investment, 2017a

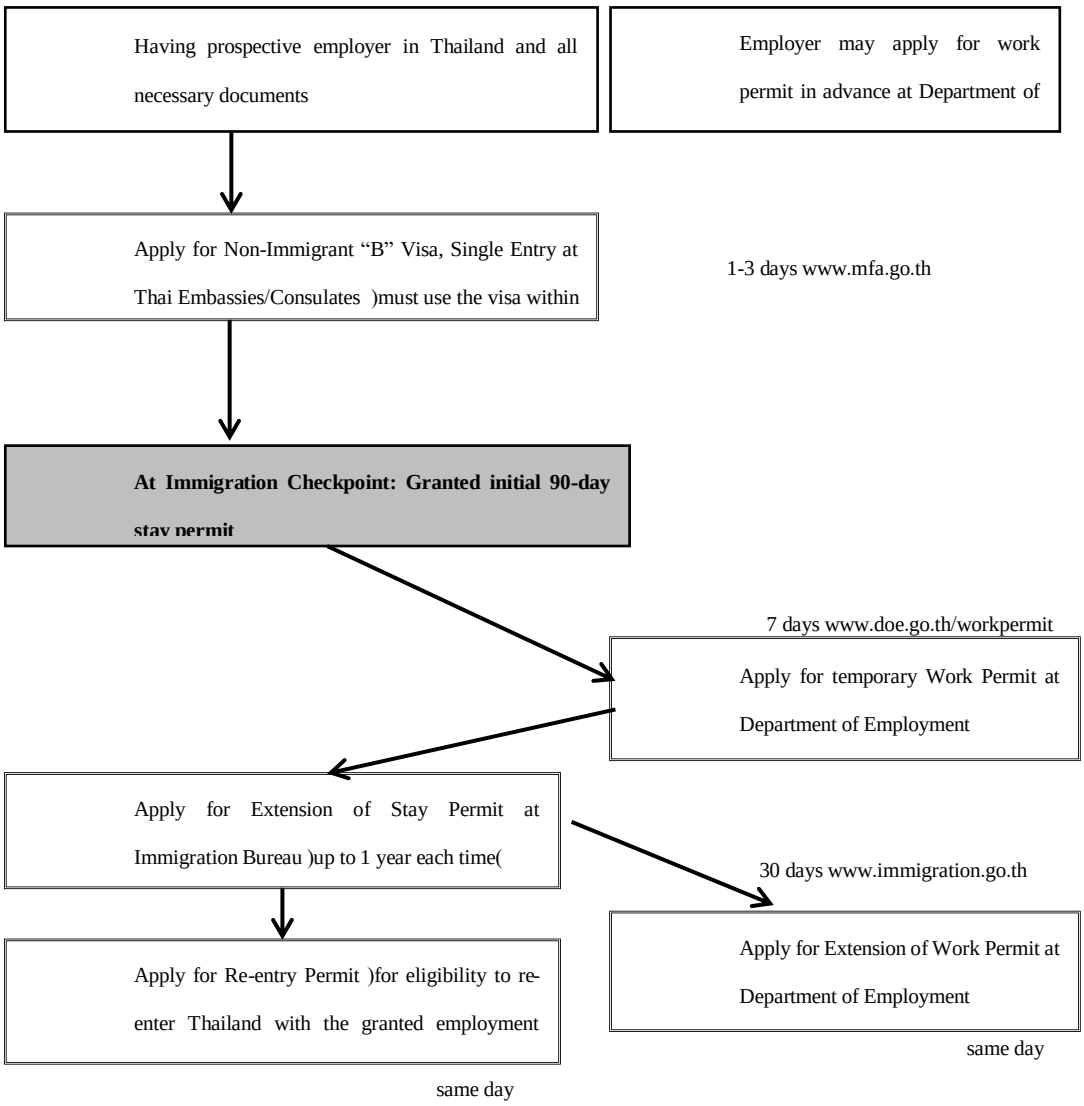
Note: * Four hospitals have received the advanced HA accreditation and are among the first to receive this accreditation in Asia.

Figure 3.3 Cost of Services



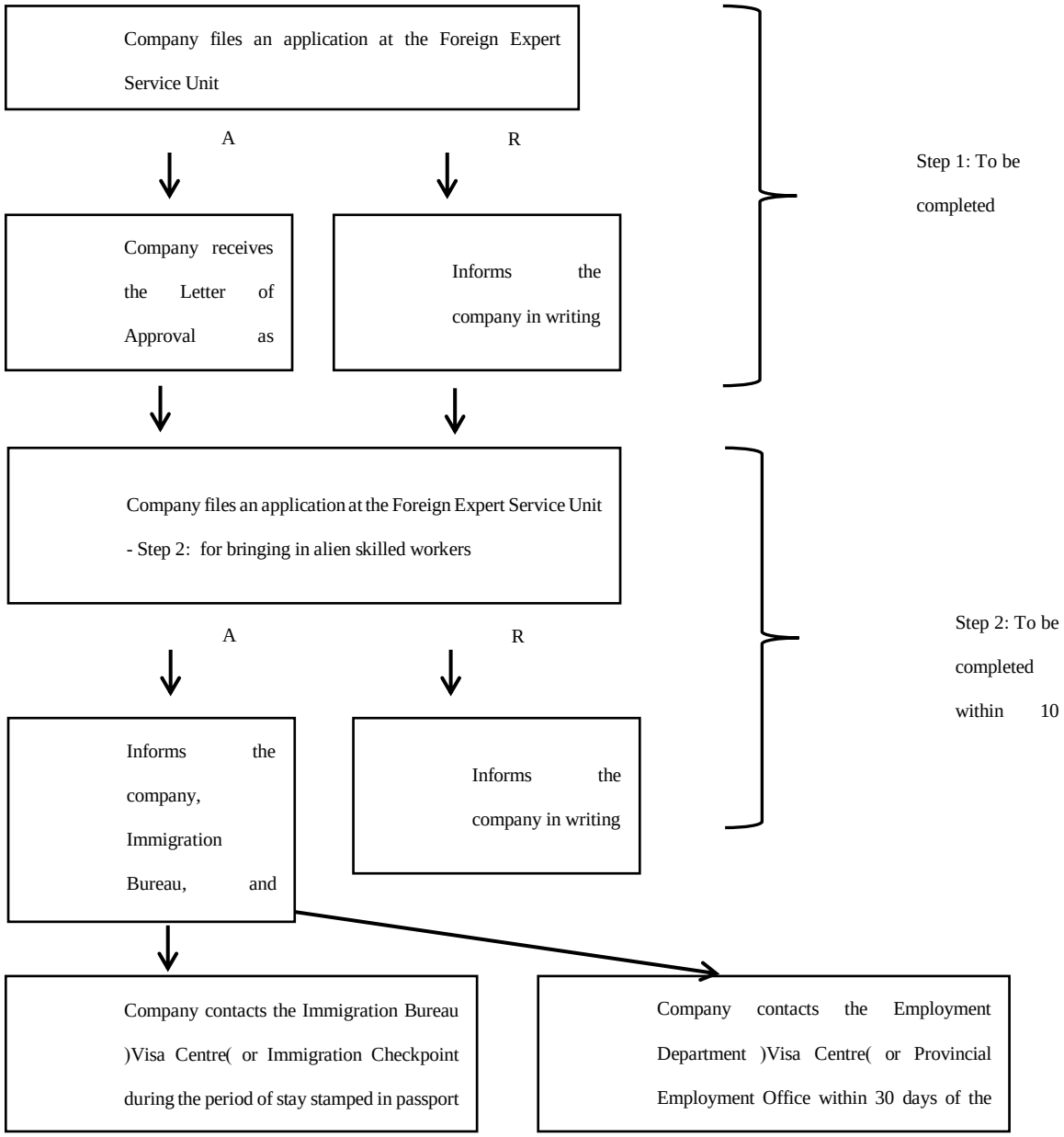
Source: Calculated from Woodman (2015) Patients Beyond Borders.

Figure 3.4 Standard Process for Foreign Nationals who Wish to Work in Thailand



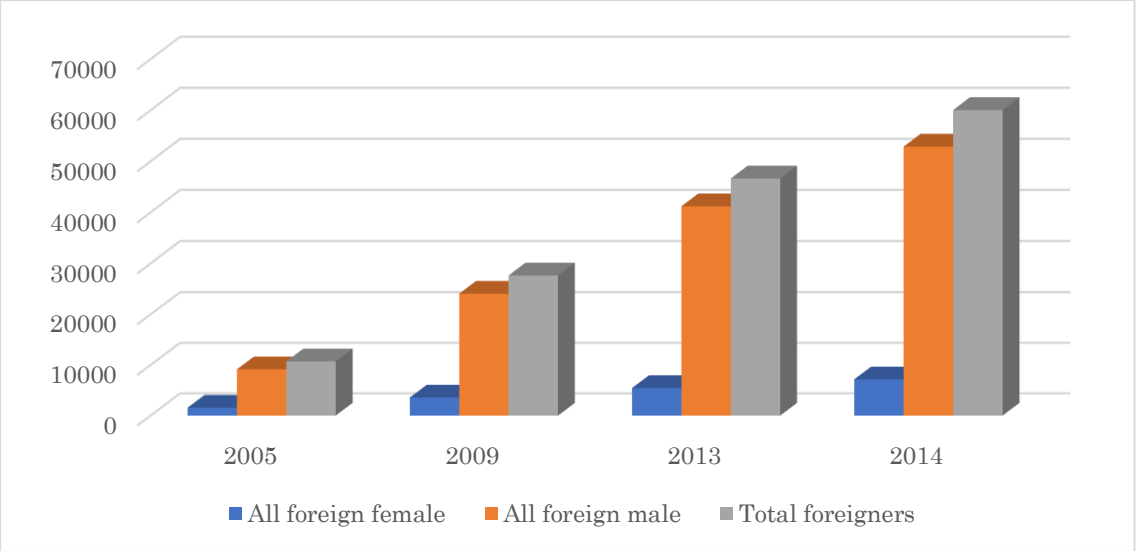
Source: Ministry of Foreign Affairs (2008), available from http://www.mfa.go.th/main/contents/files/consular-services-20120410-204531-918186.pdf

Figure 3.5 One-Stop Service Procedure for Foreign Nationals who Wish to Work in Thailand



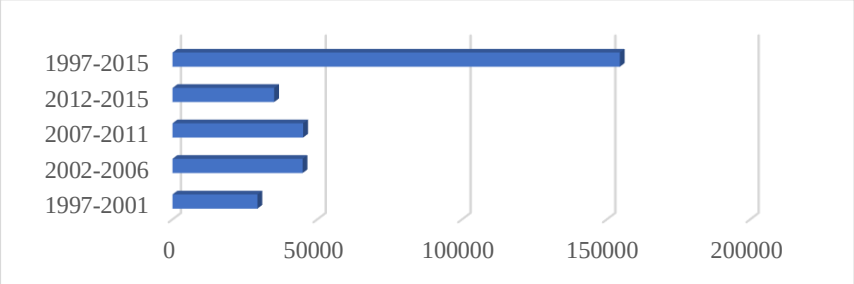
Source: Thailand Board of Investment (2017b).

Figure 3.6 Number of Applications for a Temporary Stay in Thailand under the "Retirement" Category by Gender



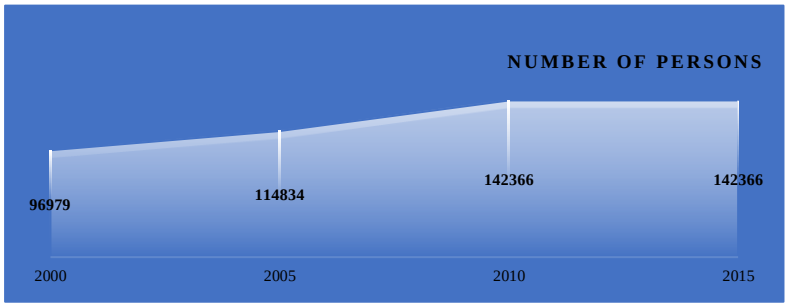
Source: Immigration Bureau, Thailand (2014).

Figure 3.7 Number of Local Registered Nurses: Incremental Supply from 1997-2015



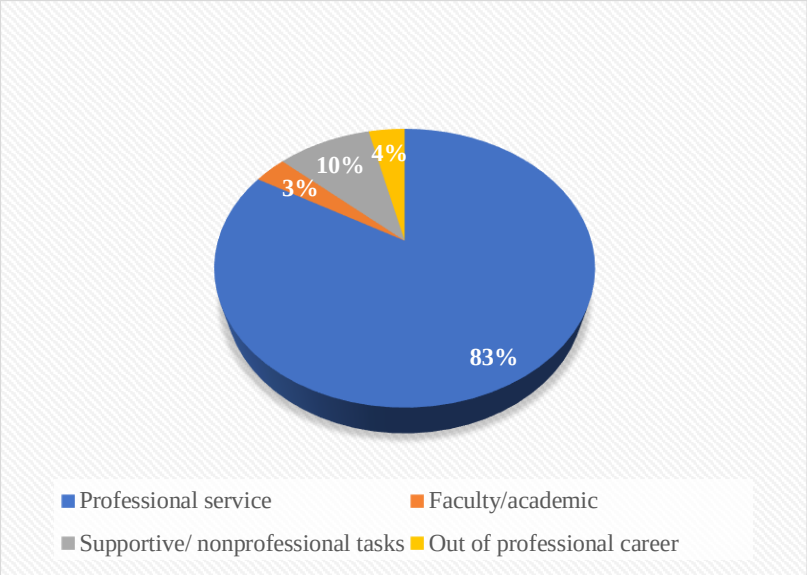
Source: Based on data from the Health System Research Institute (1997, P. 89-167); Chalamwong and Tansaewee (2005: 21)

Figure 3.8 Projection of the Demand for Registered Nurses



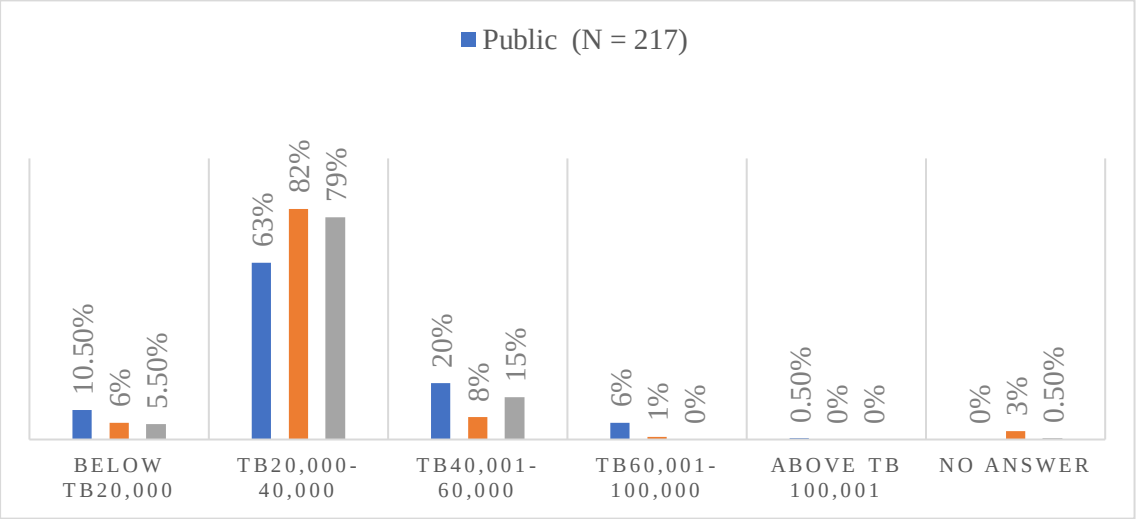
Source: Based on data from Health System Research Institute (1997, P. 89-167); Chalamwong and Tansaewee (2005: 21)

Figure 3.9 Local Registered Nurses in Thailand by Job Category



Source: Own calculation based on data from the National Health Commission Office of Thailand (2011).

Figure 3.10 Local Monthly Salary for Registered Nurses in Thailand



Source: Based on Wongboonsin et al., 2014b.

Table 3.2 Foreign Workers from ASEAN Member Countries with a Work Permit in Health Care Services and Social Welfare under Section 9 of the 2008 Foreign Workers Employment Act Remaining as of November 2016

Nationality	Number
Indonesian	20
Malaysian	23
Filipino	513
Singaporean	41
Vietnamese	46
Laotian	12
Cambodian	59
Myanmar	235

Source: Immigration Bureau, November 2016.

Table 3.3 Foreign Workers from ASEAN Member Countries with a Work Permit in Health Care Services and Social Welfare in BoI-promoted Businesses Remaining as of November 2016

Nationality	Number
Filipino	24
Singaporean	1
Vietnamese	2
Cambodian	1

Source: Immigration Bureau, November 2016.

Table 3.4 History of Nursing Education in Thailand

Year	Description
1896	The first nursing school in Thailand was established at Siriraj hospital
1956	The first baccalaureate degree programme in nursing education was established at the School of Nursing and Midwifery, Siriraj at Mahodol University
1967	The first 2-year post-basic baccalaureate degree programme in nursing education was established at Chulalongkorn University
1971	Khon Kean University established nursing as an independent professional development with the creation of the first Faculty of Nursing
1973	The first master's degree programme in nursing administration was established at the Faculty of Education, Chulalongkorn University
1978	All nursing colleges required four years of education. Then, in response to the shortage of nurses, particularly in rural areas, the two -year technical programme was established
1984	The Faculty of Public Health of Mahidol University began the first doctoral programme in public health nursing
1990	A collaborative Doctor of nursing science degree programme involving four public universities was created
1997	The first PhD degree in nursing was started at Chiang Mai University
1999	The international PhD programme began
2002	The first Flexible Learning for the Master's in Nursing Science began at Chulalongkorn University
2007	The second Flexible Learning for the Master's in Nursing Administration began at Chulalongkorn University
2014	Diploma, Thai Board of Advanced Practice Nursing Certificate in Adult Nursing and Psychological and Mental Health Nursing at Mahidol University and Chulalongkorn University

Figure 3.11 Level of Nursing Education in Thailand

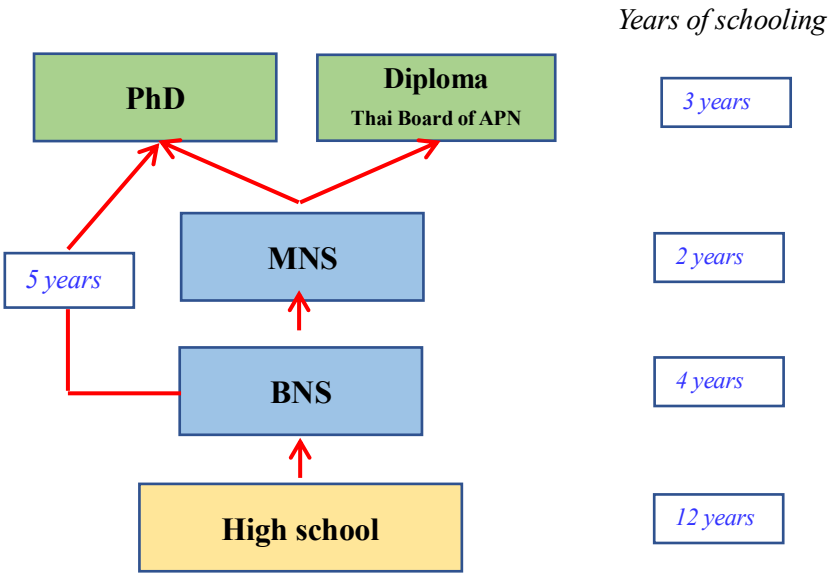


Table 3.5 Nursing Education Institutions in Thailand (The Thailand Nursing & Midwifery Council, 2017)

Organizations	**Number**
The Ministry of Education *Undergraduate programme* *Undergraduate + Graduate* *Graduate programme only*	25 *24* *7* *1*
The Ministry of Public Health	29
Private university and college	21
Military nursing school	3
Police Department	1
Bangkok Metropolitan	1
Total	82

Table 3.6 Future Requirements for Thai Professional Nurses by Health Care Demand Methods.

Demand Components	**Year**			
	2000	**2005**	**2010**	**2015**
Nursing services	54,986 (85.41%)*	110,075 (91.02%)	115,722 (90.28%)	123,640 (89.60%)
Teaching	6,333 (9.84%)	6,833 (5.65%)	6,833 (5.33%)	6,833 (4.95%)
Occupational health care nursing	1,000 (1.55%)	1,000 (0.83%)	1,000 (0.78%)	1,000 (0.73%)
Mental health care nursing	1,209 (1.88%)	2,122 (1.76%)	3,678 (2.87%)	5,524 (4.00%)
Management and technical	850 (1.32%)	900 (0.74%)	950 (0.74%)	1,000 (0.73%)
Total	**64,378**	**120,930**	**128,183**	**137,997**

Table 3.7 Estimated Number of Qualified Professional Nurses 2014-2017

Category	Number
Number existing in 2013	173,456 persons
Regular production (2014-2017) (8,000 nurses/year)	32,000 persons
Increased production (2014-2017)	10,128* persons
Total number of professional nurses	215,584 persons

Table3.8 Plan to Increase the Production of Nurses 2014-2017

Year	2015	2016	2017	2018	2019	Total
Increase Students	2,520	2,536	2,536	2,536	2,536	10,128

Table 3.9 Plan to Increase the Number of Qualified Nurse Instructors in 2014-2020

Year	2014	2015	2016	2017	2018	2019	2020	Total
Increased Instructors	435	435	440	445	450	180	54	2,439*

Table 3.10 Qualifications of Nursing Educators in Thailand, 2013

Organisation	Number	%
Doctoral Degree	822	20.28
Master's Degree	2,816	69.46
Bachelor Degree	416	10.26
Total	4,054	100

Table 3.11 Background of the Filipino Nurses Working in Thailand

Age	26-32 (Average 29.3)
Gender	Female 9: Male 3
Education	BNS 8: MNS 2 (NA 1)
Marriage	Single 8: Married 3
License	Thailand 0 Philippine 11 US 1
Thai Language	Speaking 1-3 (Average 2.2points) Listening 1-3 (Average 2.1points) Reading 1-3 (Average 1.4points) Writing 1-3 (Average 1.3points)
Stay in Thailand	0.5- 5.5 years (Average 3.7 years)

Table 3.11 Background of the Cambodian Students Studying Nurse Science in Thailand

Age	Bachelor 20-28 (Average 22.3) Master 26
Gender	Female 6: Male 5
Motivation of Studying Nurse	Easiness to find a job (7) Better salary (4) Wanting to take care of sick people (3) wanting to achieve better social status (2)
Main source of finance besides scholarship	Family saving (7) Bank loan (3)