Philippine Journal of Public Administration, Vol. XXIV, No. 3 (July 1980)

Why Some Medical Personnel Stay: Correlates of Migration Intentions of Medical Personnel in the Philippines

LEDIVINA V. CARIÑO*

The brain drain of medical personnel is and will be a continuing national problem. The possible correlates of migration intention are investigated to offer recommendations to induce medical personnel to stay. The data come from samples of physicians, nurses, and other medical personnel from Occidental Mindoro, Cebu, and Metro Manila. The samples are described and differentiated according to their geographic location and professional affiliation. The level of satisfaction and the pattern of incentives required are also identified. The sample group tends to point to the intrinsic and intangible rewards of their profession as sources of satisfaction and the lack of material rewards as a reason of dissatisfaction. It is, therefore, these same incentives demanded by the medical personnel including such things as better compensation, more adequate facilities, more research centers, sufficient funds to run hospitals adequately, and more government support which are recommended to keep the remaining medical personnel here and give them peace of mind for their choice.

Introduction

The brain drain of medical personnel from the Philippines is a continuing national problem. The latest statistics show that within the period 1967-1971, 4,567 Filipino physicians, surgeons, and dentists, and 4,650 nurses (including student nurses) were admitted to the United States.[1] It is indeed not uncommon to hear a girl (or, often her parents too) explain her enrollment in a nursing course as the means to go abroad or to be successful, which goals are so conjoined in their minds as to mean the same thing. The nurses outflow is also rather larger during the same period -- 4,650 full-fledged nurses and students emigrated.[2] Laquian points out that nursing is the occupation claimed by the biggest single group of migrant Filipinos in Canada.[3] Still, news reports

*Professor and Director, Research and Publications Program, College of Public Administration, University of the Philippines.

The author is grateful to Rosa Rosete, Victoria Trance, Eleanor Estrada, and Virginia Sering for research assistance and to Anita Delica for typing the manuscript.

[1] M.L. Gupta, "Outflow of High-Level Manpower from the Philippines," *International Labor Review*, Vol. CVII, No. 2 (February 1973), pp. 167-191.

[2] *Ibid.*

[3] Eleanor R. Laquian,, "Administrative and Policy Aspects of Philippine Immigration to Canada," (unpublished masteral thesis, College of Public Administration, University of the Philippines, 1973), p. 27.

drift back to the home country about alleged exploitation, hardships, even unemployment. But few participants of the drain ever make returns of failure; the *balikbayans'* unending *pasalubongs* and their parents' improved housing conditions add to the continuing glamour of living abroad. This is as compared to the medical graduates' plight here: a monthly salary of ₱682 per month given to a physician with at least two years experience; or P350 to a fresh graduate; ₱295 to nurses, even with 2 years of experience after passing the board.[4] If entrance into a profession is regarded as a purely financial investment, then a physician's annual gross income of a little over ₱8,000, which according to recent studies may not be even above the poverty line, is indeed rather low considering that he has made an estimated investment of ₱70,000 for medical schooling, let alone other expenses.[5] Considered on this basis, the problem of the brain drain may be restated from another perspective. The issue, in the case of medical personnel, is not why they leave, but why they stay at all.

This paper will probe into pos sible correlates of migration intentions. Data come from samples of physicians, nurses, and other medical personnel working in selected institutions in Occidental Mindoro, Cebu, and Metropolitan Manila. The manner in which the samples differ from each other by reason of area of present residence and kind of medical occupation will be briefly summarized. In addition, the factors that seem to underlie their level of satisfaction will be investigated and from there proceed into the main tasks at hand: the identification of the migration intention of the samples, and the factors that tend to correlate with such intentions. The factors that would be identified in this connection would then be regarded as incentives. Thus, factors present in a setting that are considered as rewards or benefits will be regarded as "incentives," and those that detract from the enjoyment of rewards or are directly viewed as sanctions or punishments will be viewed as "disincentives."

A study such as this immediately faces several problems. First, while certain rewards, such as income or awards, are generally regarded as incentives, other rewards may be debatable. In the course of this survey, there was occasion to see this problem at work, e.g., the same referent being viewed as an incentive by one respondent and as a disincentive by another. For example, a heavy workload may be considered by some observers as an index of professional recognition - - therefore as an incentive — but may be viewed by others as time away from leisure or as an indicator of low income (as when a person has to maintain several clinics to attain a certain standard of living), thus as a disin-

[4]Wage and Position Classification Office (WAPCO), 1971.

[5]Cuyegkeng estimated the amount of the investment. The Development Academy of the Philippines (DAP) social indicators project uses a figure close to P10,000 as a demarcation line for poverty in Metro Manila from the rest of the country. See Jose Cuyegkeng, "The (External) Migration of Philippine Medical Graduates — Its Magnitude, Causes and Solutions," *The Filipino Family Physician*, Vol. IX, No. 4. (October-December, 1971), pp. 20-23 and the DAP, *Measuring the Quality of Life: Philippine Social Indicators* (Makati, Rizal: DAP, 1974).

centive; or they may be seen by the same observers as having both negative and positive aspects.

Secondly, people are not alike in their valuation of objects and an amount which is sufficient for one may not be enough for another. Such valuation is influenced not only by a person's psychological make-up and aspirations but also by such standards as the acceptable or prevailing level in his community, whether that refers to his geographic location or to his professional membership. Thus, an income of P15,000 per annum may be regarded as low by Manila medical personnel, but adjudged sufficient or even high in other settings, or by other types of workers. Then, too, some persons can work with a minimum of equipment and thus judge their bare clinics as adequate; while others who are used to extensive laboratory facilities may describe even much better furnished hospitals as inadequate. To deal with this problem, incentives are first analyzed within the specific milieu of the respondents who are bounded by their geographic location and professional membership. Both incentives subjectively perceived by respondents and those regarded as objectively required, according to outside observers are also introduced.

A third problem is the identification of patterns of incentives. "Of course," said Cortes in her brain drain study, "we all want these things. But which would influence you most in your choice of a job?"[6] Indeed the central problem of this study is to lay out the package -- not simply to recognize the one or several factors that are positively valued by some — and then to link the pattern to particular characteristics of medical personnel. Based on the pattern of incentives and other characteristics, a profile of different types of medical professionals who serve in our country may be made.

Second, it is submitted that the package of incentives may differ according to important characteristics of the person involved. In this paper, only two of these will be closely examined: the location of practice, and the profession engaged in. Thus, it is expected that a person working in an ultra-modern hospital in a big city requires a different set of rewards as compared to a person who is working in a small municipality with minimum medical facilities. In addition, physicians are also expected to distinguish themselves from nurses, and the latter from doctors and other types of medical personnel since the different work they do impose varying demands.

The study, then, sets the following objectives:

(1) to describe the medical personnel in the sample, and to differentiate them according to their present geographic location and professional affiliation;

(2) to identify the level of their satisfaction and the patterns of incentives required by each type as delineated above;

(3) to analyze migration intentions and their correlates as part of the search for the pattern of incentives; and

[6] Josefina Cortes, "Factors Associated with the Migration of High-Level Persons from the Philippines to the United States," (Ph. D. dissertation, Stanford University, 1970).

(4) to set forth policy recommendations whereby medical personnel may be induced to continue to remain and work in this country.

Limitations of the Study

Sampling problems plague this study. Because it is very difficult to design a sampling frame using lists of individual members of the target population (medical professionals), the author had to look for them through their institutional affiliations. Therefore this study under-represents self-employed doctors, which according to the Physician Manpower Survey (PMS) may be as much as 37 percent of all physicians in the Philippines.[7]

For Occidental Mindoro, all the doctors in San Jose at the time of the survey were interviewed, but this is a fortuitous circumstance aided primarily by the small community familiarity of residents with one another.

The small size of the samples (See Table I) presents another problem. Fine categories could not be made because this would result in very small cells. As it was, analysis of migrants is limited because there were very few who listed themselves as definitely leaving but this is an artifact not of sample size per se but also of the difficulty of sampling individuals according to their intentions. This study would have wanted to over-represent prospective migrants but sampling through hospitals and other offices does not allow this luxury.

[7]Physician Manpower Survey of the Association of Philippine Medical Colleges, 1971.

Table 1. Number of Respondents by Locality and Type of Medical Personnel

	Cebu	Occ. Mindoro	Metro Manila	Total
Physicians	46	23	143	212
Nurses	41	7	251	299
Medical Researchers	0	0	72	72
All Others	32	25	67	124
Total	119	55	533	707

Caution is advised for the use of such terms as "tendencies," "leanings," "what data seem to suggest." This is not only the modesty of the scholar. The author is aware of the small sample sizes and the resulting small cells in their categorizations. Thus, many tables do not warrant the use of statistical tests thereby reducing this study to finding the trend of the data.

Physicians, Nurses, and Other Medical Personnel

This section describes the medical personnel in the sample in terms of their socio-demographic characteristics, profession-related qualities, anchorage, level of satisfaction in their careers, and migration intentions. Each type of medical professional will first be described across all localities in an attempt to determine if the kind of work they do is related to any of the factors listed above. Subsequently, an attempt will be made to compare all medical personnel in each locality, this time to determine if location serves as a unifying factor for

the medical group working therein. The objective here then is to see if the personnel in the sample are distinguishable more in terms of their professional affiliation or of their spatial location. An attempt will then be made to construct types of medical communities as suggested by the data.

Throughout this study, the terms "medical personnel," "medical professionals," and "medical practitioners" shall be used interchangeably to refer to practicing physicians and physician-administrators, nurses, and all other workers in the medical group, including those who may be more technically referred to as "paraprofessionals." The "other medical personnel" in this study include a wide assortment of workers, including midwives, medical technologists, pharmacists, nutritionists, and dentists.

The socio-demographic characteristics of interest include: sex, age, religion, place of birth, internal migration status, and income. Under "place of birth," the interest is in whether they have been born in a poor or rich municipality according to the Department of Finance classification of local governments by income classes. This would in turn provide an index of rural or urban upbringing; and combined with "internal migration status," would give some idea of the geographic and implied social mobility that the respondents have undergone.

"Internal migration status" compares the province of birth with present residence to determine interprovincial moves since birth. As would be made clearer by the data, internal migration status provides information on geographic mobility required, or at least, spurred by the location of a job.

Professional-related factors include the school of graduation, rank in graduating class, membership in professional associations, and level of professionalism. Professionalism was measured using the Hall-Snizek scale.[8] As modified and shortened by William Snizek, Richard Hall's index combined the following five dimensions:

(1) Use of professional organization as a major referent (e.g., "I believe that my professional organization should be supported").

(2) Belief in public service (e.g., "Some other occupations are actually more important to society than is mine").

(3) Belief in self-regulation (e.g., "My colleagues pretty well know how well we all do in our work")

(4) Sense of calling to the field (e.g., "Most people would stay in the profession even if their incomes were reduced").

(5) Autonomy (e.g., "I make my own decisions with regards to what is to be done in my work").

In addition, the anchorage and comparative opportunities scales devised by Josefina Cortes[9] were combined to gauge a sense of identification with Philippine cultural values,

[8]W.E. Snizek, "Hall's Professionalism Scale: An Empirical Reassessment," *American Sociological Review*, Vol. XXXVII, No. 1 (1972) pp. 113-114.

[9]Cortes, *op. cit.*,

persons, institutions, national problems, and so on and their strength and quality. The "anchorage scale" used here includes questions such as those concerning attachments to these.

" I believe that my professional training is wasted in the Philippines."

"All advantages and disadvantages considered, I would prefer the Filipino family system over all others that I know."

A person's level of satisfaction was taken as his direct response to the query: "Would you say that your satisfaction is greater than your dissatisfaction with the job you now have?"

Migration intentions were determined by asking the question: "Have you at any point in your life considered emigrating to another country?" Respondents were classified into definite leavers, definite stayers, and "uncertain." The latter have been further categorized into those who have not left because of problems at point of destination, and those whose departures were delayed by factors at point of origin.

Doctors

On the whole, the doctors in the samples appear to be a highly satisfied and highly professionalized group. However, there are certain differentiating characteristics that may be considered a start towards constructing a weak or strong medical community syndrome. Occidental Mindoro is different from Cebu and Manila in that its physicians tend to be middle-aged, migrants from poor areas outside the province, and have studied in private schools and graduated with the second quartile of their classes. In addition, their modal income is higher than those of Manila and Cebu doctors. Nevertheless, income is not a sharp basis of stratification here since almost everyone is at the mode.

Cebu doctors tend to be distinguished mainly by the fact that most of them are native Cebuanos who were born and schooled there. There are also more female physicians than males. Their modal income is lower than that of Mindoro doctors but they also have a wider range of earnings.

Metro Manila, like Occidental Mindoro, has physicians who are migrants, but like Cebu, they tend to come from richer and more urban areas. The range of incomes is wider than in the other two areas, and more than half receive incomes above ₱50,000. Both Cebu and Manila doctors, perhaps reflecting their urban location, are only moderately anchored to the society.

Nurses

The differences among the nurses' sample across localities are similar to the differences among their physicians. On the whole, they are young, Catholic, and highly professional. Unlike doctors, however, they are mostly single women who have graduated from private schools. Moreover, their level of income is lower than physicians. Anchorage tends to be moderate, except among the nurses of Occidental Mindoro.

The Manila nurses have several important points of difference from the other two groups in that a large mi-

nority of them feel dissatisfaction in their work. However, they are also the least prone to migrate.

All Other Medical Personnel

To summarize, the other medical personnel tend to be young, Catholic, and private-educated women. They are satisfied with their career. Those from Cebu and Occidental Mindoro tend to be married; those from Manila and Cebu score as moderately professional and moderately anchored to Philippine society unlike the Occidental Mindoro personnel who would score high in both scales.

The other medical personnel tend to be like the doctors and nurses from their own areas, e.g., the Occidental Mindoro group alone showed strong anchorage to the society, the personnel in Cebu are natives born in rich towns. Their main difference as a group apart from nurses and doctors seems to lie in the lower range of their incomes.

Comparison of All Medical Personnel Among Localities

Occidental Mindoro

In Occidental Mindoro, all medical personnel tend to be Catholics, migrants to that province, and originally from municipalities with low incomes. They are also very likely to be highly anchored to Philippine society. They tend to be trained in private schools and to score high in professionalism. All claim to be members of a professional association. Satisfaction in their work is high.

The physicians distinguish themselves in that they tend to be male and middle-aged, to receive a higher income, and to be capable of earning much higher (up to ₱70,000) than the nurses (whose highest income receiver gets only ₱10,000) and the other medical personnel (up to ₱30,000).

Nurses differ from the Occidental Mindoro physicians and other personnel in that they tend to be single. They receive very low incomes with the highest earners found in the modal bracket, over ₱5,000-10,000. Their intentions are clearly toward migration, with 86 percent definitely leaving, compared to only 22 percent of the doctors and 40 percent of the others in the province. No nurse wants to stay permanently in the country; yet 40 percent of the two other types of personnel are decided stayers.

The other medical personnel are distinctive in that most of them graduated at the higher second half of their class while the doctors and nurses ranked at the upper half. They are also the only group with low scores in terms of anchorage level. However, their intentions regarding migration vary considerably: most nurses are surely leaving; physicians will do so only if problems at home are resolved; the others, if destination issues get cleared up. There is a large minority (40 percent) of Philippine permanent residents in the latter two professional groups.

Cebu

The samples of Cebu tend to be a much more homogeneous group: young, Catholics, females, native Cebuanos, originally from rich localities, trained in the same province, and moderately anchored to the so-

ciety. They are likely to be members of their professional organizations and highly satisfied in their career.

Areas of differentiation lie in income, rank in graduating class, professionalism, and migration intentions. Surprisingly, it is the nurse who gets the highest modal income (over ₱10,000). However, 9 percent of the physicians receive incomes beyond ₱100,000 while the highest income for the other two groups is only up to ₱70,000. The modal income for doctors is over ₱5,000 and 29 percent earn incomes below P5,000. Meanwhile one-fifth of other medical professionals receive incomes below P5,000. They also graduated at the third quartile (the doctors and nurses cluster at the second) and score moderately in professionalism (again with both physician and nurses scoring high).

Their intentions on migration are also varied, with physicians tending to be least migratory. Problems at the Philippine end, more than any other, hold up the professionals' flight from the homeland. Among all three types of respondents, those making definite migration plans are around 20 percent of the sample (except for all others which is at 9 percent).

Manila

The Manila medical professionals among the respondents tend to be young, Catholics, born outside Manila, graduates of the higher quartile, moderately anchored to the country, and members of professional associations. Both doctors and nurses in Manila tend to come from rich areas, and to have a large group of University of the Philippines (UP) graduates. Except for physicians, the Manila group tends to be female, married, moderately professional (doctors are highly professionalized) and only about half feel satisfaction in their career (physicians: almost 70 percent). The typical income is over ₱5,000 for nurses and other personnel, but is over ₱10,000 for the physicians. In Manila, one can hope to get over P100,000 annually regardless of one's medical occupation, but only physicians have a very small proportion (4 percent) earning below P5,000 income earned by 16 percent and 42 percent of the nurses and other personnel, respectively.

As regards migration, the three groups are alike in the proportion who are definitely staying. Almost one-fourth of the nurses and other medical professionals are certain migrants, compared to only 7 percent of the physicians. Obstructions at the point of origin hold another bigger group back.

As may be noted, the medical professionals in a single area tend to exhibit many similarities despite the wide range of their specific professional affiliations. It may be observed, for example, that Cebu professionals tend to be more alike than Cebu physicians and their counterparts in the other two areas. This development appears to be in line with the hypothesis that different types will settle in localities which best fit their social and professional background, attitudes, and goals. Yet, because of limitations in the sampling and the various migration intentions that can redistribute the sample across space radically, it is too early to state that the package of individual characteristics that would tend to set-

tle in weak or strong medical communities has in fact been identified.

However, certain characteristics tend to stand out among personnel in each sample area that may be considered in constructing a syndrome. For instance, the Occidental Mindoro group tends to consist of migrants from poor areas. They are trained in private schools but were not outstanding students. All are in professional societies; they are high in professionalism, satisfaction, and anchorage. Perhaps individuals with these qualities would thrive best in a weak medical community. In fact, the "missionary model" may elucidate the relationships here. Thus, the migration to Mindoro may be seen as the completion of the professional degree itself, as a response to a challenge to make good in a difficult situation. The dedication may be manifested in both the satisfaction and high professionalism of the sample, and further reenforced in the anchorage scores which show a desire to be closely linked to Philippine society which still has largely rural values. Mindoro as a largely rural society would then be a hospitable place for a person with such an attitude. On the other hand, 100 percent membership in professional organizations may be necessary to forestall the sense of isolation that could emerge when one is away from the mainstream of the professional, also more urbanized, community.

It is harder to label the "medical types" in Cebu and Metro Manila. The former is dominated by natives who come from its rich areas and who have been educated there. Anchorage is moderate, perhaps because Cebu is urbanized and exhibits characteristics which are unlike the "essence" of Filipino society. The anchorage level found may be a manifestation of the conflict inherent in a problem many Cebuanos face — their emigration plans are held up largely because of family and other obligations at the Philippine end.

The Manilans, on the other hand, like the Occidental Mindoroans, also tend to be migrants; like Cebuanos, they come from rich municipalities. Their academic record is good, and while a number are members of professional organizations, their proportion is lower than that of Cebu and Occidental Mindoro. This may signify a desire to make a go at it alone, because one's competence is attested to by academic performance. Thus, professionalism tends to be moderate, except for physicians. The sharp disparity of incomes may further make individual achievement, rather than closeness with a professional association, an important factor. Anchorage may have the same meaning as in Cebu. For these reasons, Manila may be used to exemplify the "entrepreneur" type — a highly individualized performer — but the characterization is less convincing than that of the Occidental Mindoro "missionary." Further research would be necessary to really determine if "types" do tend to settle in certain places.

Satisfaction and Dissatisfaction: Sources and Correlates

The level of satisfaction of a medical professional is essentially his psychological perception of the incentives he is receiving (or disincentives he is missing) and may differ radically from an outsider's objective assessment of his need for such values,

and the amount and quality that he is receiving of each. It has been mentioned that most of the respondents have registered a high level of satisfaction in their work. Here that finding will be probed more closely by looking at the sources of satisfaction and dissatisfaction from both objective and subjective viewpoints. Using the first perspective, members of the sample were presented with a list of incentives that have generally been assumed to be requisites for satisfactory professional careers and asked to state which of these they are already receiving. The list was compiled by Arguelles; it included the following seventeen incentives:

(1) Good compensation
(2) Meritorious awards
(3) Adequate laboratory facilities
(4) Sufficient funds
(5) Freedom of action and thought
(6) Fellowship award abroad
(7) Good and adequate library
(8) Understanding superior
(9) Permanent jobs or security of tenure
(10) Freedom from red tape
(11) Sufficient assistants
(12) Publicity of science
(13) Adequate shops
(14) Good environment
(15) Retirement pension
(16) Contacts in industry
(17) More research centers.[10]

These were coded both singly — i.e., counting each incentive by itself and as part of the six-dimensioned package of incentives which are discussed more fully below under "sources of satisfaction." While respondents were allowed to have as many answers as they wished, only the highest three benefits checked by all the respondents are discussed.

In turning to the second perspective, the respondents were asked to classify the Arguelles list according to their assessment of their personal need for those values, whether or not they have actually enjoyed them. In addition, they were allowed in two open-ended questions to state in their own words their own notions of what constitute sources of satisfaction and dissatisfaction in their work.

The two questions were the following:

"What is it about your present work . . . that you like?"

"What, in your own experience, are . . . the sources of satisfaction (of individuals in your profession in the Philippines)?"

Both questions were open-ended. The responses were categorized as follows:

(1) *Non-work related factors.* These include answers pointing largely to family and other socio-cultural conditions and other items not otherwise classified.

(2) *Material factors.* These cover answers relating to compensation, fringe benefits, availability of funding and other direct financial rewards.

(3) *Working conditions.* These include the facilities and equipment

[10] M.V. Arguelles, J. Marañon, and A. Villa-Abrille, "Results of a Questionnaire on the Present Status of Scientific Research and Development in the Philippines" (Manila: Bureau of Printing, 1954).

available to the respondent, e.g., laboratory, medical supplies, etc., as well as the organizational set up in which he operates (e.g., understanding superior, number of subordinates, collegial structure).

(4) *Prestige and social recognition.* Responses here are of two types: (a) the recognition given to the individual physician for his work, and (b) the recognition given to the medical profession as a whole. The latter gains more importance as a source of dissatisfaction, i.e., physicians complain that the people prefer folk medical methods or that the profession is not valued as highly as it deserves.

(5) *Opportunities for professional and intellectual growth.* Some answers here are in fact a type of working condition, but the respondents emphasize the future value and individual growth possible in, say, the presence of high-powered consultants, the availability of training seminars, and so on. Other responses coded here include those that mention opportunities and the quality of medical schools.

(6) *Professionalism.* This covers the five Hall-Snizek categories plus one labelled "type of work." In the latter, the answers describe aspects of the profession and working conditions different from presence of facilities and equipment organizational structure and opportunities for learning, and highlight the *experience* of practicing medicine and doctor-patient relationships.

Similar questions were made to find out sources of dissatisfaction.

"What is it about your present work . . . that you dislike?"

"What, in your own experience, are the greatest sources of frustration and dissatisfaction . . .?"

The same codes as in satisfaction sources were used but the responses have a negative tone. The examples below may elucidate:

Category	*Examples of Response*
(1) Non-work related	"Poor communication, transportation facilities."
(2) Material factors	"Doctors are underpaid yet working like slaves."
(3) Working condition	"In the hospital in which I am employed, I strongly dislike the way the chief of hospital manages staff and personnel."
(4) Prestige and social recognition	"There are many in the Philippines who do not believe in medical science; they go to herbolarios."
(5) Opportunities for intellectual growth	"Lack of good training hospital."
(6) Professionalism	
(6.1) Professional organization	"Inadequate communication among local physicians."

(6.2) Belief in public service	"The poor people need medical attention but because they don't have money they fail to see a doctor."
(6.3) Belief in self-regulation	"Unethical and illegal practices."
(6.4) Sense of calling	"Lack of challenge and monotony."
(6.5) Autonomy	"Being asked to issue a false medical certificate."
(6.6) Type of work	"Calls from patients in the middle of the night."
(7) Perception of Inequity/ Exploitation	"People tend to go to American-trained physicians and look down on locally-trained ones. It's hard to compete with stateside doctors who have already established themselves."

As in the Arguelles' results, only the top three responses are discussed. This decision is made not only for reasons of economy in space, but because generally there appeared to be a natural cutoff between the third and fourth responses anyway.

In general, the medical personnel of Mindoro are highly satisfied in their careers. The satisfaction tends to be rooted in sense of calling, public service, and, surprisingly, material rewards. All groups receive benefits. They agree on the three things they can do without: meritorious awards, fellowships abroad, and contacts in industry. Their demands also tend to be the same, most of them citing better compensation and more adequate laboratory facilities.

All groups tend to be similar in their sources of satisfaction/dissatisfaction and in benefits received and demanded but have differences in individual items. In addition to public service, sense of calling and material rewards, both nurses and other personnel cite type of work, and nurses also mention working conditions. Among the benefits currently being enjoyed, two are shared by all three: freedom of action and thought, and good environment. Physicians, however, report the enjoyment of security of tenure; nurses, of understanding superior; and the others, of sufficient assistants.

Dissatisfaction hinges on low material rewards and poor working conditions. Physicians and other personnel likewise cite the difficult nature of their work; and nurses, the inadequate offices. Physicians also report some malaise about exploitation. The incentives they demand consist of better compensation and more adequate laboratory facilities. Doctors and nurses, moreover, seek sufficient funds for their programs, and doctors and other personnel ask for more research centers.

The sources of satisfaction of Cebu doctors and nurses are the performance of public service, sense of calling, and enjoyment of the kind of work they do. The other personnel likewise cite public service, but men-

tion also good working conditions and material incentives; the latter, a surprise in view of the low pay actually received. They also claim to receive slightly more benefits than the physicians and nurses. These are headed by freedom, good environment, and, for the first two professional groups, understanding superiors. Security of tenure is underscored by the other professionals. The three groups can do without awards and fellowships; nurses and other personnel also need not have contacts in industry. However, physicians do not care for more research centers. The low material incentives and inadequate working conditions are the main roots of dissatisfaction. The other personnel add to this list the lack of social recognition, opportunity for intellectual growth and type of work. However, their demands are less than the other groups: 7 vis-a-vis 8 and 8.5 for doctors and nurses, respectively. The first two demands are better compensation and sufficient funds; physicians also ask for laboratory facilities, and the remaining two go for more research centers.

Satisfaction is felt by Manila doctors and nurses when they render public service. In addtion, doctors emphasize a sense of calling and the opportunity for intellectual growth and achievement; nurses, the intrinsic liking of the type of work and good working conditions. The other personnel cite the opportunities for intellectual growth, working conditions, and type of work.

Doctors list the smallest number of benefits enjoyed; while the other personnel, the most. Freedom, understanding superiors, and awards are particularly mentioned. Nurses, for their part, stress security of tenure, compensation, good environment, laboratory facilities, and freedom. The other personnel claim to enjoy good environment, security of tenure and good superiors. All the groups aver they can do without awards, fellowships, and contacts in industry.

Poor material incentives are the overwhelming source of dissatisfaction. Doctors add poor working conditions and the high demands on the type of service they perform. Nurses cite, along with the latter, a feeling of exploitation.

Demands are three times the number of benefits already enjoyed by physicians but are less than twice the number of incentives received by the other two groups. The three most important demands coincide with one another: better compensation, more funds, and the establishment of research centers.

The groups, whether classified by sample area or profession differ less in their sources of satisfaction and dissatisfaction than in the social background and professional factors described in the previous chapter. Whether "missionary" or "enterpreneur" they tend to point to the intrinsic and intangible rewards of their profession as their main sources of satisfaction, and to decry the low compensation and other material factors as the bases of their dissatisfaction. However, the contrasting models do find some validation. Meanwhile, a striking difference is the fact that all kinds of personnel in Mindoro, as well as Cebu's other medical workers, list material rewards as the basis of satisfaction, despite their generally

low pay, both objectively and relative to the three counterparts in the other sample areas. Meanwhile, Manila physicians and other medical personnel tend to mention opportunity for intellectual growth as a source of satisfaction, which is omitted by all other groups.

These differences may point to differing packages of incentives for these two groups — on the one hand, for Manilans, the concededly greater opportunities for academic and intellectual advancement; and in Mindoro, their satisfaction with objectively low pay, perhaps because they are already high relative to other incomes in the province, or perhaps because as the missionary model would suggest, income is not their main goal.

Correlates of Satisfaction

Doctors, nurses, and other medical professionals in all areas receive relatively low rewards. Among the 17 imperative benefits for scientific and technological personnel identified by Arguelles, for instance, most of them report as actually receiving a little over three or 16 percent of what should be available. Incomes also tend to be low except for the small elite at the top of a very sharp pyramid. Yet this must be viewed against a backdrop of a generally high level of satisfaction in their present work and careers. Among all the groups, this appraisal seems to be rooted not so much in tangible sources as facilities, income, and the like. Instead, satisfaction reflects an appreciation of intrinsic professional rewards and psychic income — public service, sense of calling, the opportunity for intellectual (professional) growth, the delight in the demands of the profession they have joined. This is not a total surprise. When this research was started, it was expected that some individuals would value more the intangible rewards than the material rewards. However, it was expected that these would be true only to the missionary types who would go to weaker medical communities, for those who were more interested in material rewards— the enterpreneur types — they would tend to settle in the big cities. It was found, however, that there is more widespread priority given to psychic income. Otherwise the result which is a high level of satisfaction in the face of intrinsic professional rewards and much dissatisfaction on the poor material benefits cannot be explained.

In this section, the factors that seem to be related to the fact that most of the respondents declare satisfaction in their work and career are explored. Inasmuch as the medical personnel in each sample area tend to be like each other in their level of satisfaction and other attitudes, they were combined here. Analysis will therefore proceed by sample areas. The following discussion touches only on those factors whose relationship with satisfaction is either clear (in that some strength and direction can be discussed even at lower significance levels) or surprising.

There is a significant difference in the level of satisfaction among different types of medical personnel. Physicians tend to be the most satisfied, followed by the other medical professionals, with the nurses showing the least satisfaction (see Table 2). This result may show that while objective rewards for all are relatively small, the higher status of physicians in the profession, as well as in the

Table 2. Level of Satisfaction by Type of Respondent and By Sample Area

Type of Respondent	High No.	%	Medium No.	%	Low No.	%	Total
Cebu							
Doctor	31	(72.1)	11	(25.6)	1	(2.3)	43
Nurse	28	(66.7)	10	(23.8)	4	(9.5)	42
All Others	17	(56.7)	11	(36.7)	2	(6.7)	30
Total	76		32		7		115
Mindoro Occidental							
Doctor	16	(72.7)	3	(13.6)	3	(13.6)	22
Nurse	6	(75.0)	0		2	(25.0)	8
All Others	20	(80.0)	3	(12.0)	2	(8.0)	25
Total	42		6		7		55
Metro Manila							
Doctor	99	(68.8)	37	(25.7)	8	(5.5)	144
Nurse	131	(52.6)	96	(38.6)	22	(8.8)	249
Medical Researchers	44	(62.0)	22	(31.0)	5	(7.0)	71
All Others	33	(53.2)	24	(38.7)	5	(8.1)	62
Total	307		179		40		526
All Areas							
Doctor	146	(69.9)	51	(24.4)	12	(5.7)	209
Nurse	165	(55.2)	106	(35.5)	28	(9.4)	299
Medical Researchers	44	(62.0)	22	(31.0)	5	(7.0)	71
All Others	70	(59.8)	38	(32.5)	9	(7.7)	117
Total	425		217		54		696

society at large, may be an important psychic income. It may also be recalled here that nurses are the respondents who also called attention to "exploitation" as a source of dissatisfaction, and indeed forced its recognition as a major category. Table 3 shows the distribution of personnel in our sample areas by level of satisfaction. As in the distribution of medical personnel, most

Table 3. Level of Satisfaction by Sample Area

	High		Medium		Low		Total
	No.	%	No.	%	No.	%	
Occ. Mindoro	42	(76.4)	6	(10.9)	7	(12.7)	55
Cebu	76	(66.1)	32	(27.8)	7	(6.1)	115
M. Manila	307	(58.4)	179	(34.0)	40	(7.6)	526
Total	425		217		54		696

are in the high satisfaction category, only very few identify themselves as dissatisfied with their work. Yet as much as 76 percent of those from Mindoro as against 66 percent and 58 percent of Cebu and Manila, respectively, score on the plus side of satisfaction. The difference is highly significant.

It is also interesting to look at the relationship between satisfaction and the *number of benefits enjoyed* (see Table 4). Manila and Cebu showed the expected pattern that the satisfied group would tend to receive more incentives than the dissatisfied. Yet some reversal is evident in Occidental Mindoro, with the most satisfied having been provided with less rewards than the others. This is difficult to explain unless we broaden our picture of the "missionary-types" to include a need of "doing-without," a notion that may be far-fetched without a firmer empirical base.

Professionalism is positively related to level of satisfaction, significant in Manila and Cebu, and repeated in Occidental Mindoro (Table 5). This is expected, given the knowledge that profession-based sources of satisfaction dominate the sample. Again, this reinforces the idea that the respondents have so internalized the values of their professions that public service and sense of calling become transformed into important rewards that overcome the negative effects of inadequate compensation.

Table 4. Level of Satisfaction and Average Number of Benefits Enjoyed by Sample Area

	High	Medium	Low	All Respondents
Occ. Mindoro	3.4	2.5	4.4	3.4
Cebu	4.3	3.2	1.4	3.8
Metro Manila	5.1	3.5	3.1	4.5
All Areas	4.8	3.5	3.1	4.2

The *age* of the medical professional appears to be positively related to sat-

Table 5. Levels of Satisfaction by Professionalism and Sample Area

Level of Professionalism	High No.	%	Medium No.	%	Low No.	%	Total
Occ. Mindoro							
High	26	(78.8)	4	(12.1)	3	(9.1)	33
Medium	16	(72.7)	2	(9.1)	4	(18.2)	22
Low	0		0		0		0
Total	42		6		7		55
Cebu							
High	47	(78.3)	12	(20.0)	1	(1.7)	60
Medium	29	(52.7)	20	(36.4)	6	(10.9)	55
Low	0		0		0		0
Total	76		32		7		115
M. Manila							
High	165	(69.0)	59	(24.7)	15	(6.3)	239
Medium	141	(50.0)	116	(41.1)	25	(8.9)	282
Low	1	(20.0)	4	(80.0)	0		5
Total	307		179		40		526
All Areas							
High	238	(71.7)	75	(22.6)	19	(5.7)	332
Medium	186	(51.8)	138	(38.4)	35	(9.7)	359
Low	1	(20.0)	4	(80.0)	0		5
Total	425		217		54		696

isfaction (Table 6), and is highly significant in Metro Manila. Even in Cebu and Occidental Mindoro, however, a clear trend is noticeable. For instance, all those aged 55 years or above report more satisfaction than dissatisfaction. Even in Manila, only one in this age bracket was in the dissatisfied category. While the young medical professionals tend to dominate all categories of satisfaction, their proportion is less among the highly satisfied and decreases among the dissatisfied. This finding can be explained by looking at age as a dummy variable for success. Thus, the old medical professionals may be satisfied because they have attained high status and compensations. On the other hand, the younger people are still starting and may in fact be blocked in their ascent by the complace older professionals.

Another interpretation reinforces the view of the young as idealistic, looking for more from life than what they have already received. On the

Table 6. Level of Satisfaction by Age Level and Sample Area

Age Level	High No.	High %	Medium No.	Medium %	Low No.	Low %	Total
Occ. Mindoro							
Young (Below 35)	17	(68.0)	2	(8.0)	6	(24.0)	25
Middle aged (35-54)	19	(72.2)	4	(16.7)	1	(4.2)	24
Old (55 & above)	4	(100.0)	0		0		4
Total	40		6		7		53
Cebu							
Young (Below 35)	43	(61.4)	21	(30.0)	6	(8.6)	70
Middle aged (35-54)	27	(71.1)	10	(26.3)	1	(2.6)	38
Old (55 & above)	6	(85.7)	1	(14.3)	0		7
Total	76		32		7		115
M. Manila							
Young (Below 35)	222	(53.8)	158	(38.3)	33	(8.0)	413
Middle aged (35-54)	72	(75.0)	18	(18.8)	6	(6.3)	96
Old (55 & above)	13	(76.5)	3	(17.6)	1	(5.9)	17
Total	307		179		40		526
All Areas							
Young (Below 35)	282	(55.5)	181	(35.6)	45	(8.9)	508
Middle aged (35-54)	118	(74.7)	32	(20.3)	8	(5.1)	158
Old (55 & above)	23	(82.1)	4	(14.3)	1	(3.6)	28
Total	423		217		54		694

other hand, the older people's answer may reflect mellowness and the ability to come to terms with the situation, even independent of whether their ambitions have been reached or not.

Migration intentions may be considered as related to satisfaction or effect (Table 7). The relationship is strongest in Occidental Mindoro where most of those definitely not leaving are highly satisfied. To migrate because one's hopes are not fulfilled may be perceived as a rational reaction to the situation. However, the fact that not all the dissatisfied migrate may be an evidence of a rule of inertia in geographic mobility.

Other factors did not reach significance but the tendencies of the data may nonetheless be reported. For instance, *income* is also a positive correlate (Table 8). Again, this is not expected, income being a direct measure of "success." Note, however,

Table 7. Levels of Satisfaction by Migration Plans and Sample Area

Migration Plans	High No.	%	Medium No.	%	Low No.	%	Total
Occ. Mindoro							
Definitely Leaving	15	(71.4)	1	(4.8)	5	(23.8)	21
Uncertain: Origin	8	(66.7)	3	(25.0)	1	(8.3)	12
Destination	0		0		1	(100.0)	1
Not Leaving	18	(90.0)	2	(10.0)	0		20
Total	41		6		7		54
Cebu							
Definitely leaving	15	(65.2)	5	(21.7)	3	(13.0)	23
Uncertain: Origin	25	(67.6)	11	(29.7)	1	(2.7)	37
Destination	6	(54.5)	4	(36.4)	1	(9.1)	11
Not leaving	27	(71.1)	10	(26.3)	1	(2.6)	38
Total	73		30		6		109
Manila							
Definitely leaving	43	(48.3)	37	(41.6)	9	(10.1)	89
Uncertain: Origin	129	(59.7)	70	(32.4)	17	(7.9)	216
Destination	16	(43.2)	14	(37.8)	7	(18.9)	37
Not leaving	111	(65.7)	51	(30.2)	7	(4.1)	169
Total	299		172		40		511
All Areas							
Definitely leaving	73	(54.9)	43	(32.3)	17	(12.8)	133
Uncertain: Origin	162	(61.1)	84	(31.7)	19	(7.2)	265
Destination	22	(44.9)	18	(36.7)	9	(18.4)	49
Not leaving	156	(68.7)	63	(27.8)	8	(3.7)	227
Total	413		208		53		674

the relativity of high income. In Occidental Mindoro, both receivers of income above ₱30,000 — high in that locality — align with the highly satisfied, while in Manila, full satisfaction is not mirrored by almost a quarter of those receiving over ₱70,000. On the other hand, one may also wonder at the strikingly different values of those who earn very low incomes but who still feel a great deal of satisfaction.

Internal migration status seems to be positively related to satisfaction, i.e., internal migrants tend to be more satisfied than persons who work in the province of their birth. This may be traced to the fact that migrants have already taken a positive step towards improving their lot, at least by mobility across space. In addition, having made that step, the declaration of satisfaction may be a means of justifying such a decision. Moreover, migrants may be subject to adjustment problems because of their status and the satisfaction may have its roots in the pleasure of emerging favorably in such struggles.

Table 8. Levels of Satisfaction by Income Levels and Sample Area

	High		Medium		Low		Total
	No.	%	No.	%	No.	%	
Occ.Mindoro							
P5,000 & Below	6	(75.0)	0		2	(25.0)	8
Over P5,000-P30,000	34	(77.3)	5	(11.4)	5	(11.4)	44
Over P30,000-P70,000	2	(66.7)	1	(33.3)	0		3
Above P70,000	0		0		0		0
Total	42		6		7		55
Cebu							
P5,000 & Below	22	(59.5)	12	(32.4)	3	(7.1)	37
Over P5,000-P30,000	45	(69.2)	17	(26.2)	3	(4.6)	65
Over P30,000-P70,000	5	(55.6)	3	(33.3)	1	(11.1)	9
Above P70,000	4	(100.0)	0		0		4
Total	76		32		7		115
M. Manila							
P5,000 & Below	47	(56.6)	28	(33.7)	8	(9.6)	83
Over P5,000-P30,000	172	(55.0)	115	(36.7)	26	(8.3)	313
Over P30,000- P70,000	58	(63.0)	28	(30.4)	6	(6.5)	92
Above P70,000	30	(78.9)	8	(21.1)	0	—	38
Total	307		179		40		526

On the other hand, *anchorage* is not related to satisfaction except in Manila. This is an indication that the respondents have made a distinction between satisfaction with their career and their valuation of the society. While very few tend to be dissatisfied with the culture, a number of respondents are only moderately attuned to it.

The correlates of satisfaction tend to be reinforced in each sample area. However, Occidental Mindoro respondents have few differences from the others which may be worth noting here, especially considering that they tend to be the most highly satisfied. For instance, it appears that those who have less benefits number among the most satisfied, a clear reverse of the result in Cebu and Greater Manila, and a finding that reinforces the notion of a "missionary" model. At the same time, professionalism is not as strong a correlate of satisfaction here as in the other two, a factor, which while not counter to that explanation, provides only a weak support for it. A supplementary explanation may lie in the migration history of the respondents and the justification for them. (Recall that internal migrants tend to be more satisfied than native borns.) The reason could be that since Mindoroans have already pulled up roots in settling in Mindoro, they are now intent on justifying that action by

declaring themselves satisfied. The finding that they are also the least likely to leave for abroad is congruent with this notion.

The analysis shows that satisfaction has both objective and subjective components. In the first instance, position, actual number of benefits already enjoyed, age, and even income, all predispose a person to appraise his present work and career situation favorably. In the second case, professionalism imbues a person with attitudes favorable even to difficult circumstances since these accompany the practice of the profession in the Philippines. It is noteworthy that migration intentions are negatively related to satisfaction. The finding serves warning that some members of the profession are going to take concrete steps to improve on what they consider a poor and inadequate existence.

Migration Intentions

In this section the migration intentions and their correlates are discussed. To find out if the respondents had any plans to emigrate, the following questions were asked:

> "Have you at any point in your life considered emigrating to another country?"

Those who replied positively were asked the obligatory probe:

> Kindly mention what kept or is keeping you from carrying out your desire to emigrate.

Three codes were used:

(1) Definite leavers or "Yes," including unequivocal "yes" responses and those who answered the probe question by stating why they want to leave, e.g., "to earn more," "high standard of professional training," and "high income."

(2) Uncertain leavers or "Yes, but" encompassing those who express the desire to leave, but who cite obstacles that prevent them from doing so. This was further subdivided into two types:

> Type 1: Those who cite need or failure to pass the Educational Commission for Foreign Medical Graduates (ECFMG) examination, lack of jobs overseas, and other problems arising from the point of destination. Most of these problems tend to be temporary and respondents would leave as soon as the obstacles are removed.
>
> Type 2: Those who cite family responsibilities, and other obstacles arising at point of origin. These tend to be more permanent, and often the respondents indicate a resignation to the status quo, i.e., staying in the Philippines.

(3) Definite stayers or "No," including unequivocal negative responses, as well as "yes" answers the probes to which reveal a definite change of mind about the emigration, perhaps because certain demands have been met locally. Note that the question asked is, if the migration solution had ever occurred to the person irrespective of the time frame. Therefore, it is only fair to classify as "non-migratory" those who no longer intend to leave.

At this point the reader may be alerted to an important limitation: the analysis is based on the classifi-

cation of a person's desire to emigrate and may not fully reflect the strength of such intentions. It might be safe to say that those who are definite stayers have clearly been identified since they have asserted it emphatically with their "no," or with their reasons for no longer wanting to leave. However, the uncertain and definite leavers are distinguished by their perception of objective conditions rather than by the degree of their desire to leave. Thus, one may read the classification as simply that of intended leavers (including both definites and uncertains) and stayers. Yet, it may be argued that perception of certain factors may in turn reflect an attitude, and a person who recognizes the problems of leaving his household or passing the ECFMG, may in fact not only be citing problems related to one's departure but also giving reasons for his continued residence here. In any case, the distinction between definite stayers and leavers, on the one hand, and uncertains, on the other, is meaningful if only it contrasts a group that have made up their mind against another who are still in the process of conflict resolution. Although, to take note of the earlier limitation, the reader must bear in mind that the time frame which divides the definite and uncertain migrants is not fixed, i.e., the definite leaver is not necessarily one who has resolved the uncertainties of the latter, because such has not yet occurred to him.

The Migration Intentions of the Samples

Table 9 presents a striking finding: only about thirty-four percent of the respondents have no intentions of emigration. The rest — about one-fifth in both Cebu and Manila, and almost double that number in Occidental Mindoro — have varying commitments to leave. Thus, the initial response to the question, "will the brain drain continue?" seems to be a resounding "yes." The answer is only partly mitigated by an analysis of the type of uncertainties reflected in the responses. In all areas, only a small percentage are thwarted by visa, ECFMG, unemployment, and other obstacles at the point of destination. These hindrances are considered to be temporary that can be overcome by time and persistence because they are largely factors that are imposed from out there. If these uncertainties are removed, only a small proportion will be added to the outflow.

The larger bulk of uncertainties pertains to barriers put up at the area of origin. To the extent that they are imposed (by government or others), they may be like the obstacles that can easily be overcome at the receiving end. But these obstacles are objections raised by the family or are hindrances placed by similar primary groups. Since these involve loyalties, commitments, traditions, and similar stubborn psychological attributes, they may be more difficult to ignore. Thus the "uncertains" of this type would probably remain and add to the definite stayers rather than to the brain drain. On further examination, then, the situation may not be as bleak as it is at first glance. Nonetheless, even a staying rate of seventy-three percent, which is the most optimistic one that can be drawn from this sample (i.e., adding together the uncertains due to problems at the origin to definite stayers) implies a departure of twenty-seven percent, which though less alarming still consti-

Table 9. Migration Intentions of the Respondents by Sample Area

	Cebu		Occ. Mindoro		Manila		
	No.	%	No.	%	No.	%	Total
Definite leavers	24	(22)	21	(39)	92	(18)	137
Uncertains:							
Origin	38	(34)	12	(22)	218	(42)	268
Destination	11	(10)	1	(2)	37	(7)	49
Definite Stayers	38	(34)	20	(37)	171	(33)	229
Total	111		54		518		683

tutes a large proportion of our trained medical manpower. Is the brain drain likely to continue? Yes.

For purposes of analysis, the two types of "yes but" respondents are merged since whatever their reasons and whatever numbers they may actually add to the brain drain, they appear at this time to be truly ambivalent about their migration intentions. Despite the notions mentioned above, it may seem arbitrary to lump one with the stayers and the others with the leavers when they themselves have not made a definite decision. One other reason is practical: the uncertains of type 1 are usually too few to allow for the categorization that are needed for the analysis in this study.

The Correlates of Migration Intentions in Occidental Mindoro

Occidental Mindoro is one of the sample areas because it exemplifies what had been called a "weak medical community." Indexed by few physicians and hospitals, low membership in the Philippine Medical Association, and a poor ratio of physicians to population, the concept embodies not a negative judgment as much as a characterization of structural condition. Because these characteristics tend to combine with a low societal development, Occidental Mindoro tends to be an isolated community whose medical personnel will be sustained by their own commitments, the local professional community being too small or too weak to provide support from and communication with the rest of the nation. The present sample shows a preponderance of persons who were not born in Occidental Mindoro and who seem to have migrated into the province only at the start of their professional lives. Occidental Mindoro has almost as many definite leavers as stayers.

The factors related to the desire of Occidental Mindoro medical personnel to emigrate or to stay put reflect not only their characteristics but also their attitudes. On the whole, it is the young single individual who has plans for emigrating. He is not too well-established professionally, as his length of membership in the professional community and his income attest. While he does not consider himself completely free of the society, his links are weaker than those felt by the stayers and his analysis of comparative opportunities tends to favor the destination areas. The stayers are in many ways the opposite of the

certain leavers: older, married, with higher incomes, more firmly anchored and more receptive to chances for advancement within the country. Their desire for a job is more influenced by the desire for self-fulfillment since for many of them material benefits have already been attained.

As expected, the uncertains are ambivalent. In age, membership in the society and income, they are like the definite stayers. However, in civil status, anchorage, and in the comparison of opportunities and job appraisal, they are more akin to the definite leavers. They are the people who although already established, keep striving for better chances ahead.

The Correlates of Migration Intentions in Cebu

Cebu was selected as a sample area because it combined within itself the characteristics of a strong medical community. By its big number of physicians — the leaders of the medical personnel anywhere — by its strong membership in the medical professional association, favorable physician population, ratio, and good number of hospitals, Cebu exemplified an area where members of the medical profession can feel they belong to an active medical community. As mentioned above. Cebu was also distinguished from the other two sample areas in that most of its medical personnel are natives of the province. They were not only born in Cebu but they also grew up there, where they had their medical, nursing and similar college work and where they spent most of their professional life. In view of these, it was somewhat surprising to find Cebu nurturing a possible migration rate as high as that of Occidental Mindoro and Metro Manila.

There were no socio-demographic characteristics that marked off a migrant from a non-migrant. The distributions of the various categories by age, civil status, sex, income, and so on were largely similar. One must therefore study other characteristics in order to try to explain the attitudes toward migration in Cebu.

The migration intentions of Cebu medical personnel are linked not with any socio-demographic variables but with a particular predisposition like anchorage, certain push factors such as the absence of particular incentives, and a pull factor which is the presence of relatives abroad. The importance of anchorage and relatives abroad seems to be foreshadowed by the earlier description of the Cebu sample as very much rooted in their home province. The other factors underscore the need of this medical personnel group to work under favorable conditions, particularly those characterized by sympathetic superiors and an environment that allows one to think and work freely.

The Correlates of Migration Intentions in Metro Manila.

Metropolitan Manila was an automatic sample area because it is unquestionably the center of the medical profession. The sample here is predominantly taken from the more established hospitals and medical establishments in the country — Makati Medical Center, Medical Center Manila, and Philippine General Hospital. (The sample also includes medical personnel from small hospitals, such as Mt. Banaue Hospital and Mary

Immaculate Hospital.) As such, the sample may not be representative of the medical personnel now working in the capital. Nevertheless, because this groups tends to come from the premier training institutions in the medical field and particularly because most of them (79 percent) graduated at the upper half of their class, their intentions vis-a-vis migration may be instructive of the kind of attitudes and behavior expected of better-trained medical professionals.

The Metropolitan Manila sample reiterates some of the findings of the Cebu and Occidental Mindoro groups and few of its own insights. Three factors differentiate Manila samples from the samples in other areas: pre-migrants, who are probably not natives of Manila and who tend to come from the private sector, are likely to be nurses; they tend to show lower satisfaction of their current positions. Yet, like the Mindoroans, the decided stayers tend to be more established in the profession as shown in variances along socio-demographic lines, as well as in profession-related factors and in some items in the professionalism scale. As in Cebu, the stayers also owned to receiving more benefits currently than the uncertain and definite leavers. These includes an appraisal of the environment, like allowing for freedom despite martial law. In addition to the Cebuano's benefits, however, the Manilan stayers show a marked advantage in terms of social recognition. All the three area samples showed firmer anchorage and more favorable comparison of opportunities among the non-migrants.

Conclusion on Migration Intentions

In this section, some of the ways in which those who have no desire to emigrate differ from those who intend to leave have been explored. Although some earth-shaking findings were expected, the results are rather mundane and not completely integrated since significant factors differ across areas. However, by issuing the clues supplied by all three samples, a picture of the medical stayers may be formed. The non-leaver tends to be an older practitioner, probably middle-aged, and has been in the profession for more than five years. His roots and his chosen vocation are deep, as indicated in various ways: by his higher income, by his having specialized, and by his stronger professional attitudes. He is also likely to be the recipient of more benefits than the leaver, although these tend to be in the form of better working conditions (good superior, permanent tenure, and adequate laboratory) or social recognition rather than by any direct material benefits. He may also be less sensitive to the restrictions of a martial law regime, or may simply feel that these do not intrude upon his professional practice. By and large, he deems himself satisfied with his current status and work in the Philippines.

The non-leaver is also, on the whole, strongly attached to the society, and he finds its values and practices better than those of other cultures. Moreover, and along the same line, he regards the opportunities available or attainable within the country as better than any he will find abroad. This perception of more favorable comparative opportunities, whether accurate or not, appears to be a strong deterrent to entertaining any concrete dreams of settling elsewhere; or it could be a rationalization born out of an earlier decision to stay.

The picture of the situation is a refreshing one because it shows how a group of established professionally-oriented men who love their country and who are asking for hardly any concessions have decided not to leave this country.

However, if the lens were focused on the other individuals in the group, the image may be less complacent. First, the proportion of medical personnel who have expressed some desire to leave is high; those who see no hindrances to their departure — the definite leavers — though smaller in number, still constitute a sizeable minority in the population. Thus, in the years 1973 and 1974, the brain drain tide does not appear to show signs of being abated.

Second, the group which is leaving is young — although not established, they show signs that they could become important contributors to the professional community. Except for a few factors, they are as professionally-oriented as the non-leavers, and while the intensity of their feelings do not match the latter, the leavers also maintain some emotional and conscious links to the Philippine society. Thus, the country is losing not simply a bunch of unpatriotic juveniles.

So why do they leave? It appears from the study that the leavers tend to receive very few material benefits — they tend to have low incomes, and inadequate working conditions. To be sure, even the non-leavers face these problems. Almost everyone regardless of migration intention complains of the low income, the poor working conditions, and the lack of opportunities for intellectual growth. The non-leavers stay on despite some of these problems, perhaps because they have already overcome them or because they have simply learned to tolerate them. (For instance, they seem to have ignored any constraints on freedom of which the prospective migrants complain.) The need for positive measures to keep the rest here, and to give those who are staying peace with their choice is clear.

Conclusions and Policy Recommendations

This section briefly recapitulates the findings presented earlier and then proceeds to policy recommendations for the continued satisfaction of medical personnel as they live out their careers in the Philippines.

Missionaries and Entrepreneurs

The primary reasons for using three locales for the sample is to enable comparison of medical professional in "strong" and "weak" medical communities. For sampling purposes, therefore, the two provinces that provide the biggest contrasts in terms of size of professional community (indexed by number of physicians, size of Philippine Medical Association chapter, and physician/population ratio) and number of hospitals, a crude indicator of the availability of openings for professional work were chosen. The provinces chosen based on these criteria were Occidental Mindoro (for the "weak") and Cebu (for the "strong"). Designations of type of medical community refer to designations that attempt to describe the type of structure within which professionals work. There is no intention here of evaluating the professionals, or indeed, their communities. Metro Manila was added because it is where the biggest

number of medical professionals congregate with an extremely strong medical community by Philippine standards. There are, thus, three points in the scale: Occidental Mindoro on the extreme left and Cebu and Manila on the right side, with the latter at the polar position.

The first finding is that the main contrasts that emerge are between Occidental Mindoro and Metro Manila, with Cebu much more in the middle than what was expected from the typology of medical communities in this study. While the members of the sample originally were also differentiated according to their actual profession, subsequent findings showed that professionals are similar to their *co-provincianos* (provincemates). They will be discussed by province.

The characteristics of the professionals in Occidental Mindoro suggest the possible presence of a "missionary."

The Mindoro personnel appear to be people who have made good despite many difficulties. They originated from poor areas outside Mindoro and their presence there now indicates a view of the province as the locus of a better life. At the same time, their anchorage scores show their desire to be closely linked to Philippine society, which might explain their choice of rural Mindoro rather than of Metropolitan Manila, which is the destination of most professional migrants. They were trained in private schools and although they did not stand out in school, nor showed outstanding performance they nevertheless finished their degrees and are now practicing their professions with much vigor and appreciation. The respondents from Mindoro are highly professional in their attitude and are closely attached to the professional societies. They are also very satisfied with their careers and their satisfaction is based on a strong sense of calling and public service, as well as (and this is significant) in its material rewards. However, the compensation received by the Mindoro medical personnel is not high by national standards, although a salary of ₱10,000-30,000, the modal income class of physicians and nurses, may be high for their largely rural province. This may also indicate a low threshold of satisfaction. Indeed, the most satisfied are those who have received fewer benefits, something like a need for "doing without." In addition, the benefits they cited are subjective intangibles, with freedom of action and thought, and good environment heading the list.

Dissatisfaction centers on lack of material rewards, poor working conditions, and a feeling of exploitation. Except for the latter, these are not different from the plaints of Cebuanos and Manilans. These also show that while Mindoro medical professionals claim satisfaction with less, they are not living in a dream world which does not recognize material inadequacies.

In Metro Manila, the medical professional might be labeled as individual operator or entrepreneur. Like the Mindoroan, he is a migrant, but from generally rich municipalities, and his choice of destination is the most urbanized area in the country. Perhaps for this reason, his anchorage to the society is moderate. In turn, this might indicate more Westernized personality which is less tied to family

and other social obligations and encouraging of more individualism.

The medical professional in Metro Manila tends to have a better than average academic record perhaps because he has to have a good start in order to compete with other medical practitioners in the city. The greater competition in the metropolis is indicated for instance by the high disparity of incomes within the sample, with the elite in the sample being clearly above the rest. (This would not be true, for instance, among the Mindoroans whose highest income-earners would only earn a few pesos more than the average professional.) The competition itself may explain why the Manilan maintains a certain distance from his professional community — membership in professional associations is lower than it is in both Mindoro and Cebu, and is usually for a shorter period. His score in professionalism also tends to be moderate (except for physicians, which is high). Thus, individual achievement, rather than acceptance of the professional community, may define success for the Manila medical professional. Less of the medical professionals in Manila are satisfied with their career: the percentage of those satisfied among both physicians and other medical personnel is smaller than that of their counterparts in the other localities. Among the nurses, there are as many who are dissatisfied as those who are satisfied. Satisfaction still hinges on intrinsic professional sources, like sense of calling and public service and the love for the kind of work they perform. However, it is also increasingly based on instrumental, not financial rewards, such as opportunity for intellectual growth and working conditions.

Cebu stands between the two other localities. Most of the samples are out-and-out Cebuanos, having been born, schooled, and employed in Cebu. However, they exhibit only moderate anchorage to the society as indicated by the rapid urbanization taking place in the province. Their academic record is high like the Manilans, but their devotion to the professional community approximates that of the Mindoroans; so does their satisfaction with their careers which is based again on a mix of the two — for physicians, the intrinsic professional rewards of public service, sense of calling and love for the work; for nurses, the first two joined by an instrumental reward like working conditions, and for the others, the first two in addition to material rewards.

It is difficult to draw up a package of incentives based on the differing needs of the two types of professionals. Both "missionary" and "entrepreneur" essentially underscore professional rewards as the main sources of their satisfaction. The only possible differences have already been referred to above: Mindoro personnel tend to be satisfied with income that is low relative to other locales, and they tend to be satisfied with less benefits. Meanwhile, Manilans tend to underscore the opportunity for intellectual growth provided by the profession, one, however, which they seem to have found as individual practitioners rather than as members of professional associations (which many have not joined).

What the professionals require as incentives may be more easily seen based on what they have decried as missing; the sources of dissatisfaction. Here, however, the focus is on mate-

rial and instrumental rewards and there is a little difference among all groups. Thus,it may be concluded that medical professionals do differ in important social and professional characteristics according to where they live, but the needs and demands they project for their continued stay in the country are the same wherever they may be. The package of incentives to be drawn would be the same whether the medical professional lives in Cebu or Occidental Mindoro, although his choice of residence would differentiate him in other important ways from his counterparts elsewhere.

A Package of Incentives

What then are these needs and demands that medical professionals regard as necessary? The interview asked these of the respondents directly:

> "What in your opinion are the five main incentives that should be given to Filipino medical personnel so they can be induced to remain in the country?"

The answers, like the sources of satisfaction, i.e., categories for non-work related factors, material factors, working conditions, prestige and social recognition, opportunities for intellectual growth, professionalism measures against inequity and exploitation,were coded. An additional category was added because of its persistence in the open-ended replies: the demand for more government support. Table 10 shows the ranking of the three main responses by type of personnel and location.

As may be readily noted, the demand for higher material rewards which, for most respondents meant better pay and more adequate working conditions, have been cited by all groups as two of the three leading incentives. These are also the very same factors whose absence was considered as the greatest source of dissatisfaction. The consistency with which it appears is therefore not all surprising.

The third main factor, government support, had not been directly mentioned as a basis of restlessness in the profession. Yet, it was implied earlier in the responses of the nurses and the Mindoro physicians, as well as in the responses of other groups who identified "exploitation by their employers" as some of the unattractive aspects of their work. Government support may then be translated as a demand for greater regulation of the conditions under which medical personnel work. At the same time, it may also be seen as almost like a new panacea, which would allow professionals not only to have more intrinsic professional satisfaction, but also greater material rewards. For instance, some responses implied that better compensation can only come about if government were to decree it, almost like a call for the minimum wage for medical professionals. For those who work in government hospitals, government support calls for a revamp of the WAPCO compensation levels. Those in private clinics, on the other hand, call for salaries and hours on par with the civil servants, since average standards in the private sector, especially for low-level employees, compare unfavorably with conditions in government agencies.

A fourth factor showed up only among the Mindoro and the Cebu

physicians. Metro Manila doctors, perhaps reflecting the fact that many find opportunities for intellectual growth already available where they work (it is listed among the incentives they enjoy), no longer listed it as a top priority. The search of the provincial physicians for intellectual growth may signify their perception of themselves as somewhat isolated from the scientific trends in their profession because their location does not allow them to immediately learn new developments. Table 11 showing access to publications for all personnel by geographic area reflects some evidence of this problem.

Table 10. Incentives Claimed by Respondents to be Necessary To Induce Medical Personnel to Remain in the Country By Medical Group and Sample area

	Material Factors	Working Conditions	Government Support	Intellectual Growth
Physicians				
Occ. Mindoro	1	2		3
Cebu	1	2		3
Manila	1	2	3	
Nurses				
Mindoro	1	2	3	
Cebu	1	2	3	
Manila	1	3	2	
Other Personnel				
Mindoro	1	2	3	
Cebu	1	2	3	
Manila	1	3	2	

While all groups apparently have access to publications, Metro Manila personnel tend not only to have more regular access, but also to have more variety in their professional reading, having proportionately more chances to read both foreign and local journals, while the other two groups especially that from Occidental Mindoro, are likely to have local periodicals only. This explains why intellectual growth is strongly felt by the Cebu and Mindoro physicians. These two groups more than the other groups are assumed to have needs for being on top of the fast-changing medical profession.

A second means of finding out this package is to again use the Arguelles

Table 11. Access to Publications by Sample Area

	Occidental Mindoro	Cebu	Metro Manila
Percent claiming access to medical publications	72.7 %	70.6 %	71.9 %
Percent claiming regular access	40.0	50.4	59.3
Percent claiming access to local publications only	58.2	34.5	35.6
Percent claiming access to both local and foreign publications	14.5	20.2	32.6

list of seventeen incentives. This time, the respondents were asked to indicate which incentives they feel they personally "need badly." Table 12 shows the results.

The first thing one notices is the sheer number of these demands, averaging over eight for all groups as compared to the incentives they claim to be already enjoying, which is only a little over three. Nevertheless, the demands this time are similar to the previous open-ended remarks but with some rearrangements. Because the answers were so close together, it did not seem appropriate to make much of the ranking as they appear below. The referents will be directly looked into.

It is interesting that better compensation is the only incentive that was mentioned in the top three by all types of respondents. Note that it is also the only benefit among those that made the priority list that accrues directly to the person. The other incentives of this type actually dominate Arguelles listing, including meritorious awards, fellowship award abroad, understanding superior, security of tenure, freedom of action and thought, freedom from red tape, sufficient assistants, retirement pension and contacts in industry, a total of ten of the 17 benefits enumerated.

All the others require structural changes that would benefit the profession, or at least the medical personnel as a whole, though individual benefits would only be indirect. Among these, more research centers head the list. These would open up more employment opportunities and, at the same time, provide opportunities for intellectual growth mentioned earlier. Given, however, the outlay required for building such research centers, it is almost axiomatic that government support would be needed.

The demand for more funds, unspecified, is again taken as a call for

Table 12. Incentives Respondents Claim to Need Badly (Using Arguelles List)

	Average Number of Incentives	Good Compensation	More Funds	More Research Center	Adequate Laboratory	Adequate Library
Occ. Mindoro						
Physicians	8.1	2	3	1		
Nurses	9.6	1		3	2	
Others	8.1	2	3	1		
Cebu						
Physicians	8.0	3.5	1		2	3.5
Nurses	8.5	1	2	3		
Others		1	2		3	
Metro Manila						
Physicians	9.5	3	1	2		
Nurses	9.8	2	1	3		
Others	6.6	2	3	1		

government assistance. This was, in any case, the content of the few informal probes on its referent. Many respondents felt that what is wrong with working conditions cannot be adequately pinpointed by adding or beefing up existing laboratory, library, or other facilities but must touch on all points affecting a medical person's career. Hence, the popularity of the vague call for "more funds" in their responses. This would then encompass not only separate improvements on those facilities but also a restructuring of pay scales, the provision of more assistants, and greater office space to allow for more autonomy in working. Moreover, these are expected to be improved simultaneously, hence, just "more funds."

Policy Recommendations

One main idea has been recurring throughout this paper: There is a group of medical personnel who are satisfied primarily because of their strong commitment to the values of their profession. This satisfaction persists in the absence of many conditions that most professionals seek, e.g., ample compensation, adequate facilities, and satisfactory working conditions. It also persists despite such perceived obstacles as exploitation, lack of government support, some difficult conditions that accompany medical practice, and by some measure of dislodgement from society. Satisfaction is also helped along, however, by the generally favorable image that respondents have about society and its relationship to the profession — that it provides freedom of action and thought for medical professionals.

In the face of this situation, what recommendations may be suggested? The respondents themselves under-

scored several suggestions that the government and other bodies interested in medical personnel may consider. These include:

(1) Better compensation, not only higher income but one commensurate to the responsibility attached to one's performance and relative to medical status.

(2) More adequate facilities, especially those in the laboratory, offices, and library.

(3) The establishment of more research centers, so that the country can provide continuing opportunities for intellectual and professional growth.

(4) Sufficient funds to run hospitals more adequately and to finance needed programs towards a more healthy nation.

(5) Finally, more government support, the recognition that their work is important, and that the country cares that they continue to practice their profession here.

The fact that these are the same incentives demanded by rural or urban practitioner is an important datum. It signifies that rural medical practice must be attractive, but not by simplistic answers such as wage differential for those willing to go to "weak" medical communities, for the fact seems to be that a few will go to those areas despite lower pay obtaining therein, and be satisfied with it. Neither is lower compensation advocated for these people, because they too find their stations unfavorable relative to those working in other areas, and, as the Mindoro physicians have expressed, they already consider themselves victims of an exploitative system that gives lower rewards to those working in already poorer conditions.

All these do not deny that direct measures to help physicians, nurses, and other medical personnel are necessary. Income is the main factor, particularly one which is sufficient, that is, one that does not require a physician to maintain several clinics, or a nurse to continually seek overtime work. It also implies a comparison with other similarly trained professionals. It may be recalled that government rates in 1971 provided a physician with salaries equal only to bookkeepers who had only two years of college education. Income, after all, is still the major factor sought in emigration according to the respondents of this study.

In addition, the demand for all encompassing benefits like "more funds" and "government support" should indicate that simultaneous attacks on all fronts may be necessary: more office space, more assistance, understanding superiors, security of tenure, and other individualized incentives. In addition, a climate that encourages autonomy and professional service should be maintained. It appears, for instance, that freedom of thought and action, and good environment are not obtained by many who are now seeking to emigrate.

However direct individualized benefits alone will not work, whereever one decides to practice. Rather there must be a community, or at least a structure, that would support the professional. The hunger for intellectual growth signified by the cry for more research centers and lab-

oratory facilities is voiced in almost rural San Jose as much as in Metropolitan Manila. While research centers cannot be built everywhere, opportunities for intellectual growth that can make up for the absence of research centers may be provided. And here, indeed "sufficient funds" and "government support" are again major requirements.

This could mean providing for roving seminars to keep the medical personnel in touch with scientific developments which they do not have and are not familiar with. Regular access to these developments may also mean the strengthening of professional associations, particularly the chapters, so that they are not mere "social clubs" but are instead true learned (and learning) societies for their members. This author, in an earlier study, has found that the main activities of professional associations tend to be social rather than professional events.[11] This may be also provided directly by government to its medical personnel by giving them time off for research pursuits or further study if the professionals so desire. Beyond direct measures, however there is a need to go back to the medical, nursing, and the other curricula that place emphasis on the important causes of mortality that they are likely to meet in their practice. The new emphasis by the medical schools on public or community health and family health medicine is a manifestation of this. The demand for research centers is in part an expression of the feeling of powerlessness of a physician when he is confronted daily by a disease that has been underemphasized in his training because it is lacking in glamor, or of potential wealthy patients, or is not requiring the innovative facilities which American medicine has just developed. This judgement is, of course, not expressed but is subtly communicated by Western-trained and Western-oriented instructors. A research center, then, on infectious respiratory diseases which is still the leading cause of mortality in the Philippines is the most required. While it may require a large facility, such center would give the medical professionals the advantage of keeping in touch with the disease conditions of the country.

Another program that seems to be called for is one that confronts the challenges of folk medicine. Many of the sources of dissatisfaction categorized as "type of work" and "lack of social recognition" have the competition with herb doctors, faith healers and other so-called "quackeries" as their main referent. The issue is rather involved. Partly, there is the danger posed by these alternatives and the consequent inability by the Western-trained physicians and nurses to save the patient when he comes to them already seriously ill. But aside from efficacy, there is also the continuing confidence on the folk healers as shown by the numbers who first seek their assistance. The reason is partly ignorance, partly its inexpensiveness, partly "rationality" on the part of the patients — "rational," that is, because it accords with the latter's system of beliefs and values. A program that can learn from these advantages of folk medicine can help in the recognition of Western-trained medical personnel

[11] Ledivina V. Cariño, *Philippines: Patterns from the U.S.A.* (Canberra: Australian National University, 1977).

as valuable people in the society. A continuing study by the College of Pharmacy of UP that tests the efficacy of traditional treatments, particularly herbs, is a program in this direction. Additionally, an understanding of the psychological and sociological needs they answer may also be important. Moreover, a program that will help these healers use minimum sanitary requirements may also help control the spread of diseases. In some countries, a working partnership, whereby each respects the other and folk physicians refer patients to medical doctors for diseases they do not know about, has already been tried. A program of this type does not require a huge outlay, but could be set up in decentralized locations where they can most help not only the community, but also the medical personnel working therein. Perhaps an approach of sympathy and understanding rather than all-out war against folk and faith healing, such as the Philippine Medical Association has tended to wage, will go a long way in helping secure for medical professionals the social recognition they deserve.

The country is blessed by the presence of a dedicated corps of medical professionals who are attached to both their profession and the society. The rewards they have received so far do not seem to be commensurate with their appraisal of the worth of medical services, but they remain satisfied and committed to stay in this country. Yet complacency is arrested because a number – though much less than would be expected considering the general stereotype of medical education as major export -- are leaving and a bigger group does want to leave but is held up by problems at either the point of origin or destination. These, then, should alert everyone to the need for a well-thought-out package of incentives that would increase both their intrinsic satisfaction and their material rewards.