OVERVIEW AND CRITICAL ISSUES
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CIRCULAR MIGRATION OF HEALTH PROFESSIONALS

POLICY BRIEF 1

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Abstract: Circular and return migration are the globally endorsed preferred models for health workforce mobility. Australia is the sole country to date to record emigration as well as immigration flows, including data permitting analysis of migration dynamics and scale in specific vocational fields. Within this context, the prevalence and health workforce impacts of circular and return migration remain largely unknown. This will continue to be the case until more comprehensive migration data capture systems have been introduced, recording immigration, emigration and re-entry data for health professionals in both sending and receiving countries.

Different perspectives on the circular migration of health professionals

Debate on health workforce mobility has intensified in the past decade, in a context where the International Labour Organization has affirmed workers' right to leave their country of origin, regardless of field of qualification. The World Health Organization's 2010 Global Code of Practice on the International Recruitment of Health Personnel 'emphatically does not aim to stop migration' - despite concern for health workforce shortages in developing countries (Siyam & Dal Poz 2014). Intra-OECD health workforce mobility is rarely deemed problematic. A range of global and national studies, including those commissioned by the OECD, WHO and ASEAN, have discovered minimal negative impacts associated with health worker migration – concluding (with rare exceptions) that emigration is not a primary cause of the developing world's health human resources crisis. Research once 'stuck in traditional and limiting paradigms' has been replaced by emerging positive evidence. Reported benefits for developing countries include remittance-generation, trade expansion, capital flows and technology transfers. Further, 'successes abroad motivate young people to seek higher education at home… (resulting in) net gain because not all the newly educated will emigrate, thus raising welfare and growth, increasing domestic human capital and social benefits for all' (Tyson 2011, 89).

While governments and international bodies encourage this 'new circularity', characterized by 'return and repetition', three key points should be noted (Zapata-Barrero et al. 2009, 5):

1. **Empirical data:** Despite the scale of global rhetoric affirming the value of circular and return migration, little is yet clear regarding its prevalence or health workforce impacts in sending or receiving countries.
2. **Worker preference**: Circular and return migration are *not* the preferred outcomes for the majority of migrant health professionals from developing countries. For most this is the default option if permanent residence in OECD countries cannot be obtained. By contrast intra-OECD workers have multiple options, the phenomena occurring with a high degree of fluidity (Zurn & Dumont 2008, 63).
3. **Mode**: While definitions of circular and return migration traditionally assume physical relocation, it is clear in the future this will not be required to facilitate knowledge, economic and social capital transfer, given the multiple virtual options now available.

The Reality of Circular Migration of Professionals

Attraction to and Retention in OECD Countries

Workforce misdistribution, undersupply, and segmented labour markets drive host country demand for migrant health professionals. Even OECD countries with permanent skilled migration programs cannot guarantee retention. For example by 2008 New Zealand had the highest degree of reliance on migrant health professionals of any OECD country. In 2011, 42% of the medical workforce was overseas-born. Retention however was a persistent issue. A third of international medical graduates left within a year, and more than two-thirds within three years of registration. Those most likely to leave were younger medical migrants trained in comparable OECD systems (such as the UK, Ireland, North America and Australia). Those most likely to be retained are older medical migrants from the Middle East, Asia and Africa (Medical Council of New Zealand Annual Report 2013). An Australian study found over 60% of international medical graduates employed in regional Australia had made six or more major geographic moves prior to their current position. A typical migration

trajectory could involve relocation from India (place of training) to the Gulf States (fixed term contract) to the UK (NHS shortages) to South Africa (security issues) to New Zealand (until eligible for Trans-Tasman mobility), then to regional Australia. Onward migration could occur to further destinations, in a context where around 15,000 health professionals emigrate from Australia every five years, including 52 percent who first entered as immigrants (Hawthorne 2013).

Defining the Reality of Circular Migration

While much is claimed, little is known about circular migration, in any field including health. Australia is the sole country to date to capture emigration as well as immigration data by field, including for multiple entries. According to the Philippine Overseas Employment Administration (POEA), from 1992 to 2010 160,146 new nurse hires were deployed, primarily to Saudi Arabia (94,467), the US (17,107), the UK (15,701), UAE (6,205), and Singapore (5,215) (POEA 2012). Many could not become permanent residents, given migration policy. Despite POEA's commitment to monitoring flows, however, it has no capacity to define circularity. Return migrants are excluded from national immigration and labor databases and data on non-resident population are not routinely reported in censuses (Asis 2008).

Transforming Data Needs – Emerging Sending Countries

Global data challenges are compounded as more countries convert to sending personnel – the rapidity of change illustrated here in relation to Malaysia. A decade back Malaysia imported migrant doctors to meet workforce shortages, including from India and Eastern Europe. Rapidly accelerated domestic production however is currently underway, certain to fuel circular and return migration. By 2014, Malaysia had 30 private medical schools in addition to 10 public universities offering degrees. A further 20 undergraduate medical schools seek medical accreditation. A 'flood' of future doctors will result, boosted by returning Malaysian students qualified overseas (Malaysian Medical Council 2013). In a context where patients as well as health professionals are mobile, the Malaysian government plans to expand medical tourism as an employment source (replicating the lucrative industry developed by India and Thailand). As early as 2007, 341,288 medical tourists were treated in Malaysia. Growing numbers of Malaysian doctors however will seek temporary or permanent medical employment offshore, compounding the challenge of securing accurate data.

Private-sector colleges drive such over-production in multiple countries. This process is sanctioned by export-oriented governments, associated with variable levels of quality assurance, and facilitated by private or public agents. The scale and direction of flows however is typically opaque.

Circular and Return Migration – A Forced Choice?

Intra-OECD health workforce migration, as noted, occurs with a high degree of flexibility. By contrast, circular or return migration is not the preferred choice for migrant health professionals relocating to developed from developing countries.

The UK is a case in point. Major health workforce shortages were identified by the National Health Service in the late 1990s. Staff growth targets set by 2005 included 22,000 additional nurses and midwives, and 9,500 consultants and general practitioners with domestic training ramped up. Migration was adopted as a stop-gap strategy (including through bilateral agreements negotiated with India, the Philippines and Spain). In 2001-02, 15,064 newly registered nurses/midwives had trained outside the UK/EEA, also the case in 2005 for 63% of staff grade doctors, 59% of associate specialists and 43% of house officers. The NHS shortfall was temporary however. By 2005-06 non UK/EEA nurse registrations had halved, a process replicated in relation to medicine. Considerable migrant health professional displacement inevitably occurred (much involuntary). According to a 2014 WHO review, 'The number of health-care professionals coming to the United Kingdom on work visas has plummeted since the mid-decade, although most of this decline pre-dated the economic crisis' (Sumption & Young 2014, 161). The UK has sharply contracted recent skilled migration intakes.

The Impact of Qualification Recognition on Permanent Residence Status

Securing full registration in a host country may determine migrant professionals' strategy to 'category-switch' and stay, while failure can force return or circular migration. Japan for example negotiated bilateral agreements to import Indonesian and Filipino nurses, following a 2006 prediction of a 41,600 nurse shortfall within five years to care for its 'super-ageing' society. Exceptionally low registration pass rates however were achieved by Filipino and Indonesian nurses in the national exam (1-2%), despite

intensive in-country language training (compared to 90% pass rates for Japanese and 80% for Chinese nurses respectively). Contract renewal could not be assured (Wako 2012). Credential barriers exist in multiple countries. In Australia, 34,870 temporary health professionals were admitted from 2005-06 to 2009-10, with an additional 9,030 working on temporary visas in 2014. Many would be ineligible to switch to permanent resident status. Just 54% of Indian doctors passed Australia's MCQ test of medical knowledge in 2013 on first or subsequent attempts, compared to 45% of candidates from Egypt, 42% from China and 33% from the Philippines. Comparable trends existed in Canada (Hawthorne 2013).

Successful experiences of circular migration of health professionals?

Return migration occurs organically for workers participating in intra-OECD flows (for example UK nurses returning from New Zealand, or recent British and Scandinavian medical graduates returning from Australia or Canada following two years of 'adventure medicine'). Incentives to return are also effectively pursued by Asian countries such as Singapore, Korea, India and China, which can absorb and utilise the skills of returning expatriates in the context of economic growth, prosperity, infrastructure and industrial development. China has developed a sophisticated suite of strategies designed to engage with and lure its global diaspora back, supported by carefully targeted career and social incentives. India has developed four key strategies representing 'one of the most comprehensive efforts by an emigration country to develop a coherent set of institutions and policies… to maximize the development dividend to India' (Hugo 2010).[1]

In such cases however few but increasing absorption strategies are reported for health – business, IT, technical and scientific research being the primary sectors, with economic growth a critical pre-condition. Serious reabsorption challenges exist for developing countries, in a context where minimal positive strategies have been documented to date for health:

- The IOM, for example, subsidised the return of African health professionals from 1983, but 'numerous analysts concluded that (the assisted return programs) were "expensive failures"'. The Zimbabwean initiative resulted in the return of just 27 professionals within 3 years, including 11 doctors (Packer et al. 2007, 38).
- A Malaysian Brain-Gain Scheme, introduced from 1995, was 'not very successful given wage and working condition differentials'. Reintroduced in 2001 it offered a wide range incentives, resulting by 2006 in the return of '300 experts' (all fields, of whom a third were doctors). However by 2008 there was 'no coordinated approach towards the collection, dissemination and sharing of international migration data' and limited proof of efficacy (Kanapathy 2008).
- A scan of strategies to utilise returning diaspora skills compared initiatives in China (focused on international graduates qualified in science, technology, engineering and mathematics), India (focused on the IT diaspora)[1] and the Philippines (all fields). While describing the Filipino Transfer of Knowledge Through Expatriate Professionals (TOKTEN)[2] voluntary initiative as a major success, it found 'data on the actual number of expatriate professionals deployed in the Philippines as well as the actual impact of the program… lacking', while the program itself was discontinued in 1998. Health was one of multiple fields involved. By contrast the well-resourced China and India programs, at a time of buoyant economic growth, were demonstrably successful (Siar 2013).
- A National Reintegration Center of Overseas Foreign Workers in the Philippines Department of Labor and Employment was established, but with limited success. The Commission on Filipinos Overseas has recently introduced Balik-Turo, an educational exchange program targeting teachers and nurses to provide continuing education programs in the Philippines, through the provision of short courses and seminars at their alumni schools, with no evaluation of funding or outcomes yet available.
- On a more positive note, Malaysia and Singapore provide medical housemanship training places to returning citizens qualified overseas.

Within the above context, with few exceptions, proof of efficacy and definition of best practice models in the absorption of migrant health professionals lies in the future. Tapping 'the disembodied knowledge' of the diaspora 'through social and professional networks linked to the home country' may prove a more feasible strategic model (Siar 2013).

[1] *See* also Federation of Indian Chambers of Commerce and Industry – Deloitte Touche Tohmatsu India Pvt Ltd. 2014.

[2] The TOKTEN program, globally introduced and funded by the United Nations Development Programme from 1977, subsidised expatriates to return on a voluntary base for 2-12 weeks to support home country development.

Policy Recommendations and Future Research

The circular and return migration of health professionals is intuitively attractive. It has been hailed as the preferred model by national and international bodies, however its scale and health workforce impacts remain unknown. Some policy action needs to be taken to facilitate its viability, and improvements in data collection and harmonization are necessary.

1. Policy dialogue

Specific aspects related to circular migration need to be addressed, such as options for dual citizenship, facilitation of visa requirements, mutual recognition agreements on skills, and portability of social entitlements. The policy dialogue can be formalized through bilateral and multilateral agreements.

2. Data collection and harmonization

Global advocacy should be undertaken to facilitate more comprehensive data collection on migration flows by national governments, capturing all relevant information to ascertain the consistency of circular migration. Improved global and regional data harmonization should be encouraged, as fundamental to the effective management of migration.

3. Research and evaluation:

Where adequate data exist, evaluation of the scale and impacts of circular and return migration should be undertaken in relation to specific health fields:

- Exploring the merits of virtual compared to physical circular and return migration modes.
- Defining best practice knowledge transfer strategies in select developed compared to developing countries.
- Evaluating the role of incentives, and the sustainability of key initiatives, in relation to effective knowledge transfer.

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INTEGRATION IN HOST COUNTRIES

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CIRCULAR MIGRATION OF HEALTH PROFESSIONALS

POLICY BRIEF 2

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Abstract: International and national organizations have formulated various codes of practice to promote good conduct in recruiting migrant healthcare professionals. These guides advocate for adequate integration of migrants into the host countries as well as for enhanced circular migration. This policy brief suggests that, in many cases, integration policies and circular migration are orthogonal issues; that is, they are often unrelated. Some integration policies appear to reduce the likelihood of circular migration. However, this brief outlines two integration strategies that have the potential of enhancing circular migration: advanced training requirements and flexible long-term residency policy in host countries. These policies can induce circular migration by altering migrant incentives to remain in host countries.

How can integration help promote circular migration?

Healthcare professionals are part of the rising tide of high skilled migrants in the contemporary global economy. However, the migration of healthcare professionals from developing nations may rob these countries of a valuable resource. Recognizing the needs of developing countries for healthcare professionals, international and national organizations have developed codes of ethics for developed countries that recruit healthcare professionals from the developing world. For example, the World Health Organization formulated the Global Code of Practice on the International Recruitment of Health Personnel, which delineates policies to mitigate the negative effects of healthcare professional migration on the health systems of developing countries as well as to ease the migrants' transition into life in host countries.

One possible – and popular – solution to mitigating the negative impact of healthcare professional migration is circular migration, i.e., international, temporary, repeated migration for economic reasons. This brief evaluates the role of host country integration on the potential for circular migration. We argue that there are significant barriers to circular migration for this specific group of migrants, among which is the critical and lengthy acquisition of cultural practices connected to the delivery of health care; host country integration generally serves to decrease the likelihood of return to the home country. However, we provide two policy recommendations that work in conjunction with integration processes to help align individual migrant incentives with return to the home country: mandatory skill advancement and training programs for healthcare professionals in the host countries and flexible long-term residency status policy.

The first section of the brief outlines migrant healthcare professional preferences for long term or permanent migration. The next section presents a wide array of integration policies promulgated by wealthy western democracies and provides evidence of the impact on circular or return migration. The next two sections examine additional barriers to circular migration emanating from home and host countries. The fifth section elaborates the two policies that align host country, home country and migrant incentives for circular migration. We conclude with a caveat that additional research is warranted.

Incongruent Incentives

Migrant Incentives. Healthcare professionals from the developing world are likely to prefer long-term or permanent migration, regardless of levels of integration in the host country. When individuals migrate, it is typically due to external pull factors and the internal push factors. Country-specific studies find that migrants' incentives to remain in host countries are primarily driven by higher wages and better living and working conditions whereas migrants' incentives to return to home countries are influenced by emotional and familial ties to home country. Evidence from various survey-based studies shows that this pattern holds for the healthcare sector as well (e.g. Brown and Connell 2004, Kingma 2007).

In the short-run, the difference in wages, working conditions, and living conditions between wealthy and poorer countries is unlikely to change dramatically. And high skilled migrants are more likely to be able to bring their nuclear families with them. As a result, migrants prefer to remain in the host country. Over the longer term, convergence of wages, working condi-

tions and standard of living incentivizes emigrants to return home (Biondo, 2012). Home country conditions can change through improvements such as increased economic development, better professional opportunities, improvement in the domestic education system and/or policy changes that provide specific incentives for returning migrants. For example, rapid economic growth in China combined with Chinese government policies that introduced preferential policies for returnees, such as increasing support for scientific research, successfully stimulated both circular and return migration (Zweig, 2006).

Integration as a barrier or facilitator of circular migration. Immigrant integration processes can be defined from two perspectives, those of the immigrant and the receiving society, both of which must adapt to ensure migrant acceptance into the host society. Without any government intervention, settling in the host country diminishes uncertainty and increases familiarity with the host country. In turn, this reduces the incentives for migrants to return to their home countries (Mai and Paladini, 2013). In other words, self-integration in the host country promotes permanent rather than circular migration.

In addition, many host country governments adopt an array of policies that affect the integration of migrant healthcare professionals. The Migrant Integration Policy Index (MIPEX, 2014) provides a compendium of best practices for seven categories of integration, including labor market mobility, family reunion, education, political participation, long-term residence, access to nationality, and anti-discrimination policies. These policies are categorized into two types. Structural integration pertains to the acquisition of rights and status, for example, access to citizenship and skill advancement training. Sociocultural integration pertains to behavioral and attitudinal changes in the host society. De Haas et al. (2014) surveyed a large group of Moroccan migrants in the European Union and found that sociocultural integration in host countries had a negative effect on migrants' return. However, structural integration did not significantly affect migrants' intention to return to home country. This study is the first to evaluate integration as a determinant of migrant return intentions, based on a survey of a large group of migrants, so the findings must be confirmed in other settings and with other migrants.

The preliminary research on host country integration suggests that many integration measures serve as barriers to circular migration: it is the absence of integration that stimulates movement. Studies find that most migrants do not choose to circulate but do so in response to instability surrounding their situation. Where migrant healthcare professionals are not integrated, research suggests onward movement rather than return to the country of origin. In the Irish healthcare sector, the lack of integration, high instability, the mismatch of work and lack of training caused migrant nurses to search for work in a host country with better conditions (Humphries et al. 2009, Mai and Paladini, 2013).

Home country incentives and challenges. The host and home country policies also can alter migrants' incentives. The home countries could employ national policies to encourage the return of migrant healthcare professionals. However, the home country has conflicting objectives when it comes to circular migration. The home country benefits from exporting migrants in three ways (Stewart et al., 2007). First, exporting migrants leads to additional resources for the home country in terms of remittances. Second, the opportunity to emigrate and to increase remittances can stimulate additional public and private investments in human capital in the country of origin. Since not all human capital emigrates, the home country may benefit from the investment. India, China and South Korea are examples of countries that have followed this route. Lastly, the home country may benefit from the diaspora effect, where international migration facilitates and increases international business contacts in the home country.

The obvious cost of the exodus of healthcare professionals is the loss of health resources in the developing nation. This loss affects home countries' ability to provide health services but not all home countries have incentives to resolve the problem. From a political science perspective, providing public goods is not a priority for all governments.

Host country incentives. While host countries may prefer circular migration for low-skilled migrants in agriculture and other labor-intensive sectors, they tend to prefer more permanent migration in highly skilled sectors, such as healthcare (Newland et al., 2008). From the host country perspective, circular migration results in high turnover rates in the healthcare system, or "cyclical brain drain" (Humphries et al., 2013). Circular migration thus generates high replacement costs: recruitment, relocation and training costs that are incurred due to replacing departing workers (Stewart et al., 2007). As a result, host countries often lack incentives to establish and follow effective ethical recruitment practices and are unlikely to adopt policies to encourage the return of the healthcare professional migrants. In fact, host countries of migrant healthcare professionals are doing the opposite; these countries

are working to retain the migrants through integration policies.

Realigning the incentive structure. The idea behind the concept of migration and development is that everyone wins, the host state, the home state and the immigrants. For high-skilled healthcare professionals, the home country confronts the loss of a valuable resource, giving rise to the "brain drain" issue. Circular migration then becomes a solution to rebalance the equation. For this set of migrants, however, there are multiple barriers to circular migration because the migrants prefer long-term or permanent migration and host countries have few incentives to promote circularity. Even home country governments have mixed incentives, and may prefer remittances to return migration. Furthermore, in many cases where the home governments want to retain their healthcare professionals, they may not have the resources to do so because of poverty and state capacity challenges as well as the political will to invest in health.

Facing the above barriers to circular migration, host states can adopt two integration policies that realign the incentives of the migrants, the host state and the home state and increase the probability of circular migration. The first policy is to provide mandatory skill advancement training. The training will benefit the healthcare professionals while they are working in the host countries and will improve retention rate for the host countries. Concomitantly, the training will improve the skills and the earning power of migrants in their home country, increasing the likelihood the migrant will return when the conditions are desirable. The second policy is to introduce flexible long-term residency policies. The policies will allow the migrants to move back and forth easily, thus increasing the chances that they will engage in circular migration.

Good Practices and Policy Recommendations: Realigning Incentive Structures

While studies find evidence that sociocultural integration reduces the incentives of migrants to return to home country, the effect of structural integration on migrants' incentives to return is mixed (de Haas et al., 2014). However, two structural integration measures may work to promote circular migration and induce the return of migrants when the home country conditions improve: skill advancement courses and residency status.

First, skill advancement training increases the value and wages of migrants at home. If knowledge and skills accumulated abroad lead to permanent wage differential then migrants are more likely to return home if the labor market is conducive for it (Lisi and Biondo, 2013). Thus, the host country can provide skill advancement programs and courses for healthcare professional migrants, which serves host country interests as well as facilitating migrant integration in the host country. Essentially, host countries can serve as learning centers where migrants can acquire skills and know-how, especially those that are of value in migrant home countries. Studies find that migrants who return tend to have high endowment of skills that are valuable in home country (Dustmann et al., 2011).

Second, obtaining long-term residency status and ensuring the potential to return to the host country in the future increases circulation because migrants know they can one day return if they choose to do so. If long-term residency or citizenship status is difficult to attain the migrant is likely to remain in the host country longer in order to gain that status. This resulting behavior translates to a lower level of circulation because migrants are compelled to stay in host country until they receive the long-term residency status. Implementing a more flexible residency policy for migrant healthcare professionals would be especially helpful in promoting circular migration.

It is also important to note that once migrants are able to move back and forth they are likely to do so repeatedly. Frequency is cited as an important factor in inducing circular migration. Studies indicate the more an individual migrates, the higher the probability that the individual will migrate again in the future. In essence, long-term residency status can take advantage of the self-perpetuating nature of migration to increase circularity through allowing migrants to acquire migration-specific capital. That is, with each move, migrants learn more about migration and where and how to find jobs and housing. The knowledge, social connections, and experience associated with moving make it easier for migrants to move frequently.

Policies specific to healthcare professionals and circular migration are in their infancy and the impact of these policies is still uncertain. So no best practices exist. However, these policies are promoted in a proposal developed by Fernandez and Parra (2012) in the "Integration of Highly Skilled Third Country Nationals in Europe" project.

The proposal suggests that receiving states should establish flexible long-term residence permits that allow migrants the possibility for temporary exits to return to the country of origin. The proposal argues that by giving highly skilled migrants mobility between countries, migrants will be motivated to engage in activities that promote the development of their home country. An additional component of the project promotes teaching the country of origin language to migrant children to encourage an "integrated circularity."

Future Research

Research on migration incentive structures for healthcare professionals is currently based on country-specific research that often surveys small numbers of individuals. Additional research is therefore recommended to ensure that the case work to date reflects underlying patterns. There are few surveys that allow us to understand the return intentions of the migrants, or how specific integration policies affect the return intentions. It is also likely that return intentions vary by skill levels of the migrants, so research needs to distinguish among migrant types. As a result, comprehensive cross-country surveys that include the skills of migrants, their return intentions, and how their intentions are influenced by host country policies and by the home country conditions will greatly contribute to the research.

Furthermore, if circular migration is a policy goal, additional research is needed on home country re-integration policies that facilitate the transfer of skills and knowledge gained in the host country as well as on the role of bilateral agreements in facilitating circular migration. First, reintegrating into home country is not always an easy task; thus, it is important to understand the barriers migrants face when they return to their home country. Second, bilateral agreements will be crucial in ensuring that the host country integration policies align with the home country reintegration policies. Research and data on migrant intentions is again an important component in formulating appropriate national and international policies.

Lastly, given the migrant healthcare professionals' incentives to remain in the host state, there may be a significant cost to developing countries that participate in global high-skilled migration flows. This incentive structure places a premium on home and host states to adopt policies that align individual migrant incentives with circular or return migration. Therefore, it is important to evaluate empirically the cost for states to adopt these policies and determine if circular migration is a feasible agenda for global healthcare migration.

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SOCIAL COSTS AND POLICIES TO MITIGATE THEM

CIRCULAR MIGRATION OF HEALTH PROFESSIONALS

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POLICY BRIEF 3

MARUJA M.B. ASIS
SCALABRINI MIGRATION CENTER

Abstract: The outmigration of experienced health workers from developing countries has raised concerns about brain drain and how this loss aggravates the health care crisis. This will continue to be a concern in view of the unabated and growing demand for health workers in the developed countries in the future. Apart from brain drain and its related deleterious impact for origin countries, unmanaged repeat or circular migration of health workers could lengthen the separation of migrants and their families and diminish possibilities for transfer of skills and social remittances. Important developments in policymaking, innovative strategies and cooperation frameworks have emerged in recent years, but further steps are needed to sustain the momentum for ethical recruitment, retention programs and human resources for health planning.

Challenges of unmanaged circular migration

One measure of the wealth of nations is the health of their inhabitants. In general, more developed nations are characterized by lower infant mortality, lower maternal deaths, and longer life expectancy. A key factor contributing to these outcomes is the availability of adequate and trained health workforce which ensures the effective delivery of health services.The 2006 World Health Report indicated a shortage of 4.3 million health workers worldwide and identified 57 countries, mostly in sub-Saharan Africa, as facing a crisis in human health resources because they had less than 23 doctors, nurses and midwives per 10,000 population (WHO, 2006). The shortage is worsened by the uneven distribution of the health workforce, both globally and internally. The migration of health workers contributes to the health worker crisis in developing countries because of the loss of workers in an already understaffed and under-resourced health care system. This issue figured in the early discussions on brain drain in the 1960s and 1970s and it continues to be discussed as a social cost borne by countries of origin.

Circular migration between origin and destination countries is expected to generate mutual benefits to both countries and migrants as well, and the prospects of minimising social costs. To date, managed circular migration of health workers involving origin and destination countries has not been realized; instead, what is in place is spontaneous or unmanaged circulation that takes the form of repeat migration within the context of temporary labor migration. As discussed below, this type of circular migration might not result in the anticipated triple win. Crafting effective policy responses to address health worker migration is challenging because of contending concerns: the responsibility of the state to provide health for all, the ethical responsibility of health workers to take care of the sick, the right to migrate (specifically, the right to leave one's country), the right to decent jobs and so forth. The policy brief outlines the social costs of health worker migration, the policies and interventions to mitigate these social costs, and offers policy and research recommendations that build on existing gains.

Repeat migration does not generate social remittances

Although policies may be designed to keep migration temporary, the migration of health workers tends to be permanent or long-term. As a basic sector, the demand for health care is constant and so is the need for workers. Where destination countries offer a pathway to permanent residence and citizenship, health workers who gain admission as temporary workers can opt to stay. Where destination countries have a policy of keeping labour migration temporary – e.g., Gulf Region and East and Southeast Asia – residency and citizenship are not available to foreign workers in general. To meet their continuing need for health workers, these countries renew or extend the employment contract, resulting in repeat migration or circular migration. Consequently, health workers and employers simply keep on renewing their contracts (typically for two years), rendering the workers "permanently temporary." Their extended employment overseas implies the virtual loss of experienced health workers in origin countries. While their continuing employment abroad means more remittances for their families and countries of origin, social remittances, notably the hoped-for transfer of knowledge to improve human health

resource development and the health care system, are less evident.

Separation of health workers and their families may strain family ties

Unlike migrants in less skilled occupations, professional migrants like health workers may be joined by immediate family members in their countries of employment. However, data are not available on the extent to which migrant health workers avail of this right. Complications may arise when the trailing spouses of health workers may have to leave their jobs in the home countries or child care or children's education may be difficult in the countries of destination. These factors may incline health workers to work overseas while their families remain in the home countries. The long-term separation of migrants and their families can create problems in the relationships between couples, between parents and children, and between migrants and other family members. Studies on the consequences of temporary migration on the "left-behind families" in Asia reveal that the pre-migration conditions of families play an important role in adjusting to the changes wrought by migration. The pain of separation is real and the absence of migrants during the growing-up years of the children haunts migrants and their families. Families which were stable before migration are better able to overcome the difficulties of migration and to manage the financial benefits of migration.

The importance of communication between migrants and their families cannot be overemphasized. As workers in the formal sector, health workers tend to have better working conditions than migrant workers in unprotected sectors. Health workers are also freer to maintain contacts with their family members because they enjoy days off and their off-work activities are not monitored by their employers. These conditions help ease the pain of separation.

Return migration and transfer of skills may be delayed or may not happen

Not much is known about the scale and the consequences of the return of health workers to their home countries. In the case of nurses, what has been documented by some research is the reluctance to return home in the face of financial uncertainties. In destinations where permanent residence or citizenship is impossible, health workers may start as temporary migrants to one destination but may later engage in onward migration to other destinations. The research of Marie Percot in Kerala, India noted the evolution of the migration plans of nurses. Initially, nurses migrated to the Gulf countries in the 1970s-1980s as temporary, but after two decades, nurse migration to the Middle East has become part of their overall migration strategy. The better life promised by migration changed perceptions of nursing from a lowly to a prized occupation. Also worth noting was the shift in how nurse migrants view Middle East destinations, i.e., from a temporary destination to an important stepping stone to other destinations. In the process, return migration has been postponed or morphed into further migration to new destinations.

In recent years, some evidence of return migration by health workers has been observed. For example, Indian specialist doctors from the United States and the United Kingdom are returning home. Some found lucrative employment in hospitals participating in medical tourism, while others put up their own hospitals. Also, health workers who have become immigrants or citizens of other countries temporarily return to their home countries by organizing medical missions. For health workers who have become immigrants or citizens of other countries, temporary returns to their home countries to share their expertise or to carry out or support medical missions are forms of migrant giving as well as means that somehow reverse the loss of health personnel through migration. The permanent return of doctors and other health professionals and medical missions have positive contributions. However, concerns have been raised on whether they have significantly reduce inequalities in the local health system. Medical tourism, for example, may bring in revenues and retain health workers, but it does little to enhance the local population's access to quality health care. It may even create two unequal health systems that cater to medical tourists and locals. The temporary return of nurses who share their expertise with home-based nurses or nursing students seems to be a promising initiative. This is discussed further in the section on good practices.

Health worker migration could result in brain drain

The issue of brain drain has been debated for decades. According to one view, the migration of the highly skilled or professionals does not necessarily reflect nor result in brain drain – rather, these people have to migrate because they could not find work that is commensurate with their training and/or experience. The other view argues that when the highly skilled migrate, they leave a void which cannot be easily filled. In relation to health workers, the evidence suggests that the conditions in the origin countries matter. In many African countries where the supply of the health workforce is scarce, the migration of health workers could seriously jeopardize the capacity of these countries to respond to public health issues, such as HIV/

AIDS. Similarly, small island states, such as the Pacific Islands, are more likely to feel the brunt of the departure of health workers. In contrast, countries which produce large numbers of health workers (and which have a policy to export health workers) – China, India and the Philippines – do not experience a shortage of workers per se because of the large pool of trained personnel. However, they could lose the more experienced health care providers, which could weaken the health care system and experienced mentors, which could undermine the training and mentoring of students.

Addressing the loss of health workers through ethical recruitment

The continued recruitment of foreign-trained health workers by developed countries has received a great deal of policy attention. The need for a code to govern the process started in 2004 when the World Health Assembly asked the World Health Organization (WHO) to work on this. In 2010, the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by 193 countries, a landmark in addressing the health worker shortage and improving the health system in an international cooperation framework. An assessment, based on the National Reporting Instrument sent by 56 countries, found that countries have already taken steps to implement the Code. However, only a few countries have a database on policies and laws on health worker recruitment and migration; also, only a few countries have technical agreements or have received financial assistance in connection with health worker recruitment (Siyam and dal Poz, 2014).

The WHO Global Code built on earlier initiatives, notably the 2003 Commonwealth and the 2007 Pacific Codes of Practice for the International Recruitment of Health Workers. These efforts highlighted the need for region-wide actions to face the challenges facing individual countries grappling with the departure of health workers. In all, these efforts underscore the need for multi-level actions and multi-stakeholder participation. Moreover, the discussions now include ethical dimensions, mutuality of benefits, the protection of the rights of health workers, reducing the negative impact of health worker recruitment on origin countries, and the attention given to human resource for health planning.

Examples of good practices

The regional approach developed in the Caribbean region is highlighted here because of the valuable lessons it offers. The unabated out-migration of nurses has produced unprecedented challenges – e.g., the difficulty of replacing those who leave, the loss of more experienced nurses and educators, the inability to reintegrate returnees, and the increased demand for quality care by those in the region, among others – that contribute to the complexity of the current situation (Salmon et al., 2007: 1357). The leadership of the Pan-American Health Organization Office of Caribbean Program Coordination (PAHO/CPC) in health-related matters, initiatives in partnership with institutions outside of the region and the contributions of individual nurses have been relevant in the crafting of the regional approach. The existence of regional organizations – PAHO/CPC, the Caribbean Nursing Board and the Caribbean Nursing Organization – facilitated regional collaboration. Following the study on nurse migration in the region, PAHO/CPC created a steering committee which proposed the Managed Migration in the Caribbean "as a regional strategy for retaining an adequate number of competent nursing personnel to deliver health programs and services to the Caribbean nationals" (Deyal, 2003 as cited in Salmon et al., 2007: 1362).

Some innovations were developed under the Managed Migration Program. One example is the scheme where Jamaican nurses work two weeks each in Miami, Florida and Jamaica – this enables nurses to gain more skills and earn more money without compromising the staffing needs of Jamaica. Another innovative scheme is regional cooperation in the training of nursing students. With the establishment of the Regional Examination for Nurses Registration and the Common Nursing Education Standards in the region, Antiguan nursing students can study in Grenada and return to practice in their home country upon completing their training program (*see* Salmon et al., 2007: 1364-1365). Further studies are needed to have firmer bases on how the programme is faring.

An interesting scheme to promote the sharing of expertise by overseas-based nurses is the Balik-Turo (Teach-Back) Program of the Philippine Nurses Association of America (PNAA). Launched at the national convention of the PNAA in 2006, the program has five main objectives: "provide and impart state-of-the art clinical expertise and knowledge; improve exchange of clinical information between individuals and schools of the two countries; enhance education of colleagues in the homeland; gain a rewarding experience from the

exchange; and sustain partnerships with collaborating associations and schools of nursing" (Mayor and Rivera, 2012). Following the initial visits in 2006, the program has evolved over the years. It established a partnership with the Philippine Nursing Association and the Association of Deans of Philippine Colleges of Nursing; it expanded and targeted nine health care settings and nursing schools in Manila in 2008; it conducted a teach-back program in Cebu in 2010; and in 2012, it implemented the program with the collaboration of the Philippine Nursing Association and several schools of nursing. The experience, thus far, according to Mayor and Rivera (2012), has been beneficial to participants. Filipino-American nurses volunteer to share latest developments in nursing and health care to nursing students and faculty in the Philippines. When they return to the United States, they bring back with them more knowledge of the trends, issues and challenges facing nurses in the Philippines.

Policy recommendations

Health worker recruitment and migration is expected to continue, and is likely to increase, in the future. Concerns over the social costs of unmanaged circulation migration of health workers, human resources who are critical in meeting health care needs, have not been addressed sufficiently. Nonetheless, there had been important developments in policy thinking, innovative strategies and cooperation frameworks that represent important strides (*see also* Bach, 2006). The need to link recruitment, migration and human resources for health planning is crucial. To move forward, the following recommendations are advanced:

- It is necessary to sustain the momentum towards ethical recruitment at all levels. There is a need to develop implementing rules and guidelines to translate the WHO Global Code and similar codes into relevant national, sub-national and organizational contexts. This will require multi-pronged efforts involving information dissemination, advocacy, capacity-building, and consensus-building of the different stakeholders.
- The Managed Migration Program of the Caribbean offers insights on how to strengthen regional cooperation. Regional institutions (e.g., the Regional Nursing Board) and mechanisms for the training and licensing of nurses (Common Nursing Education Standards and the Regional Examination for Nurses Registration) could facilitate the harmonization of nurse training and standards, mutual recognition of skills, and the creation of a regional pool of health workers.
- Various proposals have been put forward to strengthen retention programs and human resources for health planning. It would be constructive to determine which of these programs have been implemented and to assess their effectiveness in achieving their objectives.

Recommendations for further research

Studies on health worker recruitment and migration flourished in the 2000s; nonetheless, some basic questions for further research remain.

- Given the importance of an effective health system for human development, can managed circular migration minimize the social costs of health worker migration?
- What would this scheme require of governments, employers, private recruitment agencies, civil society organizations, international organizations, migrants and other stakeholders?
- Beyond evidence-based knowledge, how can the ethical dimension of the issue of health worker recruitment, migration and health policy be strengthened?

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ACCESS TO SOCIAL PROTECTION
AND PORTABILITY OF SOCIAL ENTITLEMENTS

CIRCULAR MIGRATION
OF HEALTH PROFESSIONALS

International Labour Organization

Policy brief series edited by Graziano Battistella

POLICY BRIEF 4

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Abstract: This policy brief highlights the right of migrant workers to receive social security protections and in particular the need to ensure that long-term social security entitlements that migrants contribute are made portable between two or more countries. This is necessary in order to facilitate and encourage circular migration. This brief explains how social security benefits can be made portable through international social security arrangements and the hindrances faced by developing countries in the signing of such agreements. Examples of bilateral, multilateral and regional initiatives are also included.

Portability of Benefits: A Prerequisite for Health Professionals

One of the characteristics of the term 'circular migration' which makes it appealing to policy-makers is its goal to foster a triple-win outcome. It promises to benefit the migrant workers, who are able to access gainful employment; it benefits the receiving countries by satisfying their labour market needs; and it also benefits the sending countries by way of remittances, the transfer of skills and expertise, and the professional networks that migrants can create. Hence, in addition to financial flows, circular migrants can contribute to the development of their home countries through temporary and permanent returns to share the skills they have acquired abroad with individuals and institutions in their countries of origin. This is why circular migration is commonly associated with high-skilled migration. However, in order to facilitate the wins of circular migration, migrants require at least residency rights and assurances that the social protection benefits they have gained or are accruing will not be compromised by engaging in circular movement.

This policy brief will highlight the rights of migrants to access social protection and the importance of and possibilities for the portability of social security entitlements. Such issues affect the decision to migrate, the level of vulnerability migrants face when they are abroad, and greatly contribute to the decision to return to the country of origin, temporarily or permanently. However, social protection coverage is a complicated facet of migration and this stems from the tensions between the ever-increasing mobility of labour and the non-mobility of traditional social security entitlements. These are designed to protect the people residing in the country (the principle of territoriality). Thus, migrants who work in another country are often not entitled to benefits in their country of origin, while restrictions may also apply to temporary residents, resulting in the exclusion of migrant workers. The policy objectives of the International Labour Organization (ILO) are to ensure equality of treatment in social security for migrant workers and to safeguard that migrant workers can enjoy their entitlements through social security agreements whereby social security rights are maintained and which provide for the export of benefits (Kulke 2006). These apply to migrants working in all sectors, including health care professionals.

Safeguarding Social Rights

Temporary and circular migrants sometimes face difficulties in accessing social protection while abroad; this should not be the case. Social security is a human right, enshrined in the 1948 Universal Declaration of Human Rights (articles 22 and 25) and in the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (article 27). The right to social security for migrant workers is further enshrined in ILO conventions, beginning with the Equality of Treatment (Accident Compensation) Convention, 1925 (No 19) which provided for equal treatment to non-nationals in respect of workers' compensation. The Migration for Employment Convention (Revised), 1949 (No.97) emphasises equal treatment between nationals and migrants, including access to social security programmes (article 6). This right is further reinforced by article 68 of the Social Security (Minimum Standards) Convention, 1952 (No. 102). The Equality of Treatment (Social Security) Convention of 1962 (No.118) further commits ratifying countries to endeavour to conclude bilateral or multilateral social security agreements between them to provide for the totalizing and export of benefits to nationals of the ratifying countries. Finally, the Maintenance of Social Security Rights Convention, 1982 (No.157) and Recommendation No.167 represents an ambitious attempt at establishing a global regime of portability of benefits,

applicable to all branches of social security and to all social security schemes. Most provisions can only be implemented through bilateral or multilateral social security agreements between the countries concerned and model agreements are provided for in the annexes of R167. However, to date only four countries (Sweden, Spain, Philippines and Kyrgyzstan) have ratified this convention.

Circular migrants, those that travel between two or more countries during the course of their lives, are often those most at risk. They face restricted access to social security coverage in destination countries due to the length of their periods of employment and residence, which is designed for permanent residents; they also risk the loss of entitlement to social security benefits in their country of origin due to their absence. Finally, they may lose entitlements if there are no agreements to ensure the portability of entitlements they have contributed to and accrued either at home or abroad. All these contribute to their vulnerability, and hence are important factors in life-cycle planning. Often their ability to migrate is hindered by their need to access long-term social security entitlements in the country of residence and this prevents circularity, with the consequent loss of potential benefits to countries of origin. This is particularly relevant for health professionals who find themselves contributing to the social security system in the host country.

In order to increase the social protection of circular migrants, the social security entitlements that they have contributed to must be made portable between two or more countries. Portability is defined as the ability to preserve, maintain, and transfer vested social security rights or rights in the process of being vested, independent of nationality and country of residence (Avato, Koettl and Sabates-Wheeler, 2009:5). This allows international migrants who have contributed to a social security scheme for some time in a particular country to maintain acquired benefits or benefits in the process of being acquired when moving to another country, and hence avoid losing accrued entitlements. The lack of portability of social security contributions and benefits are obstacles to circular and return migration.

Portability mainly affects long-term benefits that have a pre-saving element; most portability arrangements between countries are focused on old-age pensions and related benefits (survivors and disability) and very few on health care and other benefits. Avato et al. (2009:6) suggest that health care has a pre-saving element: younger contributors are typically net-contributors while older contributors pay less than they receive in benefits due to high demand for health services when old. If these benefits are not portable then returning migrant would rely on the origin county's health system – although they have spent most of their productive life working abroad and contributing to a foreign social system. This places an unfair burden on the sending country's health care system. With portable social benefits, return migrants do not strain the resources of the origin country.

Migrants can have their access to social security ensured through international social security agreements. The basic principles of such agreements are coordination and reciprocity. Coordination means establishing mechanisms through which the social security schemes of the signatory countries can work together to achieve mutually agreed objectives. Coordination does not require harmonisation of different definitions and rules but should involve mutual administrative assistance. Reciprocity requires all parties to apply the same obligations and mechanisms to make their social security benefits more accessible to migrant workers. This also requires that the contracting parties have similar systems. In other words, agreements should only include existing social security branches in the systems of the contracting parties. If one contracting party has no branch for health, then the other party will not accept to include the health branch in the material scope.

The objectives of social security agreements, as laid down in the ILO Conventions and Recommendations, include: 1) Equality of treatment (it allows migrants the same coverage and entitlement to benefits and obligations as nationals). 2) Determination of applicable legislation (it consists of rules to determine which country's system applies to the migrant worker, particularly to avoid double benefits or double obligation to pay social security contributions). 3) Maintenance of acquired rights. 4) Maintenance of rights in the course of acquisition (totalising), which allows periods of contributions in both countries to be combined to determine eligibility for benefits. 5) Provision of benefits abroad, which means there should be no restriction in the payment of benefits irrespective of the place of residence of the beneficiary.

Bilateral agreements on pensions vary in scope. Often they focus on preventing double coverage for temporary migrants only, waiving the contribution requirement to the pension scheme in the host country while making such contributions mandatory in the home country. However, such agreements ideally prevent vesting losses, which occur when the individual leaves a country before completing the minimum years of contributions required to receive benefits, by combining the contribution periods in home and host (sometimes more than one) countries (totalisation). Such bilateral agreements cover all formally employed migrants, including health care professionals. Equally, enabling the portability of social security benefits is

beneficial to all migrants, regardless of employment sector, and would greatly facilitate migrant workers' ability to engage in circular migration.

However, such agreements permitting full portability are predominantly found between high-income countries. Indeed, Holzmann, Koettl, and Chernetsky (2005:65) find that the share of migrants enjoying indiscriminate access to social services and who have full portability of accrued benefits increases with the income level of the origin country. This is mainly due to the capacity of high-income countries to develop the required bureaucracies to coordinate it.

Difficulties faced by developing countries in signing such agreements stem largely from the incompatibility of the legal frameworks and social security infrastructures of the countries of origin with the countries of employment (Holzmann and Koettl, 2011:7). Poorer countries have less developed social security systems and this reduces their ability to negotiate and administer social security agreements that are based on the principle of reciprocity. This situation is reflected in the number of social security arrangements (SSAs) signed across regions: European countries have concluded 1,628 bilateral or multilateral agreements, of which 1,034 are intra-EU arrangements. East Asian and Pacific countries, on the other hand, have concluded only 181 such arrangements, although they provided the highest share (22 percent) of all migrants worldwide as of 2000 while South Asian countries only concluded three arrangements (Avato et al., 2009:13). Nonetheless, there is strong interest from sending countries to sign more bilateral SSAs to prepare for the impending retirement of their expatriate workers. In the Philippines the Center for Migrant Advocacy (2010:9) observed: "Negotiating SSAs with more states of employment is a high priority for the Philippine government in anticipation of the impending retirement of overseas Filipino workers who started working abroad more than 40 years ago and the steady flow of retirees that is expected to follow as a result of the exponential growth in the number of migrant workers over the years."

Good practices

International SSAs that can extend the necessary social protection to migrant workers are recognized as good practices. It is included in the 2006 ILO Multilateral Framework on Labour Migration, which is composed of fifteen broad principles, derived from existing international conventions and labour standards. Reflecting the principles contained in Conventions No.118 and 157, Guideline 9.9 recommends: "Entering into bilateral, regional or multilateral agreements to provide social security coverage and benefits, as well as portability of social security entitlements." The bilateral agreement between Chile and the USA (2001) is included as a good practice example.

Regional economic associations have also made efforts to ensure that nationals of member states can maintain social security benefits in order to promote internal labour mobility. The European Union has the most extensive SSAs in place to guarantee portability of social security entitlements to EU nationals (EEC Regulation 1408/71). This was extended to include third country nationals who have resided for at least five years and who move within the EU (Council Regulation 895/2003). Additionally, the EU signed association agreements with Algeria, Morocco and Tunisia which contain provisions on the portability of social security benefits for their nationals who live and work in the EU. In the Americas the Caribbean Community (CARICOM) Reciprocal Agreement on Social Security of 1997 aimed to harmonise the social security schemes of its thirteen member states in order to protect the entitlement of workers to long-term social security benefits when they move from one contracting State to the other. Another agreement is found between the MERCOSUR countries of Brazil, Argentina, Paraguay and Uruguay, who established administrative coordination to facilitate the processing of pension benefits. However, a study on these agreements found that the number of beneficiaries is very small; the agreements cover merely two percent and 27 percent of their emigrants, respectively (Forteza, 2008). Possible reasons are insufficient information among potential claimants, the fact that the agreement applies only when workers have not completed the vesting periods in any of the involved countries, and the different age requirements and periods of contributions to access the benefits in member states. Finally, a far-reaching agreement on the portability of pensions, the Ibero-American Multilateral Convention on Social Security, was signed in 2007 by Spain, Portugal, and 12 Latin American countries. However, for its effective entry into force the state parties must sign its implementing agreement, which has been done by only seven of the countries. Attempts at regional social security agreements are less developed in Africa and in the Asia Pacific region, although the ILO has had programs in these regions to promote intra-regional social security coverage of migrant workers (*see* ILO Bangkok, 2008; McGillivray, 2010).

Policy recommendations

- Social security agreements must be promoted as a means of facilitating circular migration. The Annex of the Maintenance of Social Security Rights Recommendation, 1983 (No. 167) provides a model agreement for the coordination of bilateral or multilateral social security instruments. If this is not possible then sending countries must make efforts to make their social security administration more compatible with those of receiving countries.
- In the event that it is not possible to negotiate a social security agreement, social security provisions should be incorporated in temporary and circular labour migration programmes whenever possible. The portability of social security benefits should be included in programmes that recruit healthcare workers from developing countries.
- The development of regionally specific model provisions for bilateral social security agreements can help countries adopt regional social security standards for migrants. Such regional harmonisation of procedures will overcome difficulties in signing bilateral and multilateral agreements (*see* ILO, 2008).
- Countries of employment should be encouraged to provide unilateral equality of treatment between nationals and non-nationals as regards social security coverage as well as the payment of benefits abroad. Countries of origin can provide a basic level of protection to their nationals working abroad through voluntary insurance.

Suggestions for further research

- While there is good knowledge about the legal framework of bilateral social security agreements there is little information and empirical analysis of their actual functioning (benefits covered, coordination mechanism and admin procedures for benefits, etc.) This is necessary to assess the impact and determine which migrant workers can actually access these rights.
- There is much less knowledge about social security legislation and access to social services in middle-income countries, including the portability and exportability of benefits for their migrant workers. Research focused on middle and low-income countries would provide valuable policy advice for protecting their migrant workers.
- The gender dimension is also often lacking in social security legislation and arrangements. Gender analyses should be included in the preparation and in monitoring the impact of social security arrangements in order to identify and respond to the specific needs of women, including potential difficulties women may face in the bureaucratic processes of securing their rights. Such attention is important due to the gender-based sectoral and occupational segregation of migrant workers and the different social protection needs of migrant women and men throughout their life-cycle, notably health coverage, and difficulties faced by women to claim their rights (*see* Truong et al. 2013).

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ECONOMIC AND FINANCIAL COSTS

CIRCULAR MIGRATION OF HEALTH PROFESSIONALS

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International Labour Organization

POLICY BRIEF 5

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Abstract: This policy brief examines the costs involved with the circular migration of health care professionals, that is, doctors and nurses who work abroad and return home temporarily or move on to another country. Such circular migration can allow migrants to earn higher wages and enjoy better working conditions abroad than they would have at home. Costs can be macro or micro. Migrant-receiving countries can benefit from migrant health care workers and avoid draining health care talent permanently from migrant-sending countries if migrants return and work in health-care occupations. However, health-care jobs tend to be permanent rather than seasonal, and many migrant health care workers rest before going abroad again or retire upon return rather than work for lower wages and under worse working conditions. Micro- or individual-level migration costs include education costs and payments to recruiters for jobs, transportation, and other items necessary to go abroad. Even if migrants do not make payments explicitly, they can pay abroad if they receive lower wages and fewer benefits than comparable workers or have inferior working conditions.

Health Labor Markets

All labor markets have three fundamental functions: recruitment or matching workers with jobs; remuneration or offering wages and benefits to induce workers to work' and retention or keeping workers satisfied so their productivity rises over time. These three labor market Rs are the keys to having workers in productive employment that generates rising incomes over time.

There is a vast literature on each of the three labor market fundamentals, and recruitment or, more specifically, worker-paid migration costs, are of major concern in international labor migration. Matching workers with jobs is a challenge because of information asymmetries, meaning that one party to a transaction has more information than another. Employers with vacant jobs typically know more about the requirements of the jobs they are offering, while workers seeking jobs know more about their abilities. This asymmetry can lead to inefficiencies and exploitation: "when one party to a transaction has more information pertinent to the transaction than does the other party… the better informed party [may] exploit the less-informed party."[1]

[1] Nobel economist George Akerlof used the example of buyers do not know which used cars are good "cherries" and which are bad "lemons." As a result, buyers assume that all used cars are lemons and reduce the price they will offer for a used car, which helps to ensure that only bad used cars offered for sale (Akerlof, 1970). Solutions to information asymmetries in the used car market include independent evaluators of used cars and car sellers to offering quality guarantees. In health care, information asymmetries make it difficult for patients to evaluate the quality of health care providers, prompting governments to establish standards and issue licenses to health care professionals who satisfy them.

National borders can aggravate information asymmetries in the labor market. Employers and workers may not share a common language or have experience with the same education and training systems, which may lead to different understandings of the skills required or acquired to fill particular jobs, as with doctor or nurse. One government intervention to overcome such asymmetries is standardization of education and training standards and/or the automatic recognition of certificates and licensing of workers who satisfy these standards.

Countries at similar levels of economic development sometimes develop Mutual Recognition Agreements (MRAs), so that a person recognized as a nurse in one country is also recognized as a nurse in another. However, even where MRAs have been signed and migration is encouraged, as within the European Union, the mobility of professionals can be limited by language differences and the reluctance of health care professionals with jobs in one country to move to another. States and provinces inside many countries, including Canada and the US, do not necessarily recognize the credentials of professionals earned outside the state or province, requiring even citizens who earned their credential outside the place they want to work to pass the destination area's exams in order to be licensed.

Even if MRAs allow professionals to have their credentials recognized quickly in another country, recruitment of health care workers over national borders can be difficult. Employers often recruit new graduates from local universities, and may ask current workers to refer friends and relatives to fill vacant jobs. If current

workers include migrants, such network recruiting can overcome information asymmetries and bring more migrants into a particular workplace. If current workers include few migrants, employers may ask private recruiters in other countries to find workers for them, and workers can contact recruiters to seek jobs.

Private and for-profit recruiters are paid for their services by employers, workers, or both. When the demand for a particular type of workers exceeds supply, employers generally pay recruiters to find workers, including migrants. However, when the supply of workers exceeds the demand for them, workers often pay recruitment costs. Demand tends to exceed supply for highly skilled workers, but supply often exceeds demand for low skilled workers. The "unfairness" of low-skilled workers paying up to a third of what they will earn abroad in recruitment costs, while employers pay the recruitment costs of higher earning professionals such as doctors and nurses, is a major migration issue (Martin, 2013)

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Health Care Monopsony

The health care industry is large and labor intensive, absorbing 10 to 15 percent of GDP in many industrial countries. Labor is 80 percent or more of the total cost of providing child and elderly care. Demand for health care is increasing rapidly, reflecting population aging and affluence. Governments often finance a significant share of health care costs directly or via tax preferences, giving the health care institutions that depend on government funds incentives to hold down health care costs. One way to hold down health care costs is to recruit health care workers in poorer countries (Webster, 2013).

Health care is different from many other industries. Like education but unlike recreational services, health care is often considered a basic human right, prompting many governments to intervene in ways that affect the demand for health care services. For example, if limited government funding restricts the availability of hospitals and other health care facilities, or results in high charges to patients, there will be less demand for health care services. Governments also influence the supply of health care professionals by subsidizing education and training systems and establishing criteria for licensing.

Shortages in health care often have different meanings than they do in other labor markets. Shortages of health care workers are often framed in terms of minimum doctor-to-population and nurse-to-patient ratios.[2] When there are too few providers relative to the population or the number of patients, there is deemed to be a "shortage." For example, the World Health Organization (WHO) ranks countries by the number of skilled health professionals per 10,000 residents, noting that 100 countries had fewer than 35 skilled health professionals per 10,000 residents in 2012. WHO projected a shortage of over seven million skilled health professionals, and a near doubling of this shortage to 13 million by 2035.

The normal response to shortages in markets for goods and services is rising prices and in labor markets rising wages. More expensive goods and workers have the effect of reducing demand and increasing supply. Such "normal" labor market adjustments are more difficult in health care because:

- demand may not reflect the cost of the services being provided if patients do not pay the (full) costs of the services they obtain and
- supply may respond to higher wages only with a lag because of time required to train and certify health care workers.

In many health care systems, patients waiting for services have replaced the more usual role of prices in bringing supply and demand into balance.

Dealing with health care worker shortages via migration requires an understanding of monopsony power in local health care labor markets (Sullivan, 1989). A monopsony employer is one with a positively sloped supply of labor curve, meaning that the employer must raise wages to attract more workers and also raise wages for current workers. Suppose 100 nurses are being paid $20 an hour or $40,000 each for 2,000 hours a year, or a total of $4 million. If a wage increase of $1 an hour is required to recruit 10 more nurses, the marginal cost of the additional nurses is $600,000 million, since 110 nurses earning $21 an hour or $42,000 a year each cost $4.6 million.

Monopsony explains why health care providers often try to separate current workers from new hires so they can expand employment without raising wages for current workers (Sullivan, 1989). If the provider

[2] For example, California approved a law mandating nurse-to-patient ratios in state hospitals effective in 2004, becoming the first state to do so (www.cdph.ca.gov/services/DPOPP/regs/Pages/N2PRegulations.aspx). The American Nursing Association is campaigning for more such laws (www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-StaffingPlansRatios)

could pay $42,000 only to the 10 additional nurses, they would earn $420,000, and the total wage bill would rise by $420,000 rather than $600,000. Monopsony power explains why some health care providers hire traveling nurses at higher-than-current wages or pay recruitment fees for migrant health care professionals, thereby expanding supply along a "new" supply curve and leaving the regular salary structure unchanged.

By creating two labor supply curves, one for "regular" nurses and another for travelers or migrants, monopsony employers save on overall labor costs, since they are paying higher wages only to selected groups of employees. Traveling nurses and especially migrants often have inelastic supply curves, meaning that they must satisfy the employer in order to keep their jobs. This makes them more willing to fill less-desirable jobs with unsocial hours and in remote locations. A monopsony hospital can save money by hiring migrants even if it must pay their recruitment costs.

Migration Costs and Circular Migration

Circular migration involves periods of employment in two countries, with most scenarios involving migrants switching between employment in lower and higher wage countries (Hugo, 2003).[3] If migrants rotate between jobs in two countries, they incur at least travel and perhaps visa, work permit and similar costs to move between countries, and perhaps also extra housing costs.

There are several circular migration scenarios, each with different cost implications. Consider first a newly graduated health care worker who obtains a two- or three-year contract to work abroad that is not renewed, either because the migrant or the employer elected not to renew it. In this case, migrants may incur recruitment and travel costs and leave the sending country without ever working there, which may complicate efforts to find a job at home upon return. If the returned migrant does health care work at home, there can be individual and social benefits from the experience abroad. However, if the returned migrant does not work in health care at home, individual and public investments in health-care education may be lost. Working in health care abroad but not at home can benefit individuals and foreign countries, but perhaps not the home country.

A second scenario could involve a health care worker already employed in a health care job in one country who works in a similar job abroad. In this case, the migrant may incur travel and other costs to work abroad, the sending country may lose an experienced worker, and the receiving country may gain from the entrance of an experienced worker. If health care workers circulate between countries and fill health-care jobs in both, they can contribute to the health care systems of both, especially if they transmit knowledge of techniques that improve health outcomes. At a minimum, just as with innovation in IT, having employee teams comprised of diverse individuals can spur innovation and efficiency by bringing new perspectives to bear on problems. When workers are employed in health care in both countries, circular migration can benefit migrants and health care systems in both countries.

A third scenario involves health care workers leaving one country to work in another and returning before going abroad again to do health care work. This appears to be the case in some poorer countries that send health care workers to richer ones, as with Caribbean island health care workers employed in Britain, Canada, or the US. The reasoning of many workers seems to be that they prefer to work for higher wages abroad and rest or retire at home, so they are "lost" to the local health care system. In this scenario, the major benefit to the migrant-sending country is remittances.

These scenarios of having a first job abroad and returning, circulating between health care jobs, and working abroad and not working at home, have different implications for migrants and sending and receiving countries. The individual costs of such migration can also vary. The first job abroad may result in recruitment costs, but circulation should reduce recruitment costs if migrants move between known employers. The work abroad and rest and retire at home scenario suggests minimal recurring recruitment costs if migrants return to their old jobs abroad. Migrants may also incur social costs due to separation from family and friends, a cost that may be mitigated by working with colleagues from the same country. These costs are likely to vary significantly from one migrant to another and between migration corridors.

Country effects are also likely to vary. Migrant-receiving countries are likely to benefit in each of the scenarios, but sending countries may not benefit as much in the first and third.

[3] Migrants could move between countries even if there were few significant wage differences in order to learn or experience different techniques or experience another culture and labor market.

Good Practices

The major concern with moving health care workers from poorer to richer countries involves fears that richer countries are "draining" workers from poorer countries, making it harder for them to provide basic health care services that are human rights. Many of the good practices cited in the literature involve agreements between governments that promise not to leave shortages of health care workers in poorer countries (Siyam and Dal Poz, 2014).

Many government-to-government agreements regulating the recruitment of health care workers involve former colonial powers whose health care systems persist in former colonies, expediting recruitment. A notable effort to recruit health care workers in Britain's former African colonies after 1997, when the British government sought to reduce waiting times for health care services, led to demands from some governments in former British colonies for compensation. Instead, the British National Health Service agreed not to recruit health care workers in countries with acute shortages, although this agreement did not apply to private hospitals and other providers.

Recruiting health care workers in poorer countries to work in richer ones could generate win-win-win outcomes for individuals and health care systems in both sending and receiving areas if workers did health care work in both countries and returned periodically with remittances and new ideas to improve care and productivity in both health care systems. Turning this ideal model into normal practice can be difficult. There are many proposals and pilot projects that lay out plans for circulating health-care workers, but few that move large numbers of workers and persist over time.

Recommendations and Research

The major policy recommendation is to better understand the nature of health-care labor shortages and the role of international migration in alleviating and aggravating them. If health-care shortages are defined as a desired ratio of health-care workers to population and without reference to ability or willingness to pay, these ratios can highlight shortages but not lay out a path to reduce them.

Second, too little is known about the work experiences of migrant health care professionals in sending countries. Were they employed before departure? What did they do after a period of employment abroad? Tracking the health-care employment of migrant professionals is required to know if periods of employment in health care at home and abroad are the norm or the exception.

Third, policymakers should remember that there are no solutions to complex problems, only trade offs between competing goods. Circular migration is a very appealing solution to "shortage" of health care workers in aging industrial countries and the quest of many health care workers in poorer countries to seek higher wages and more opportunities abroad. The question is whether circularity is a "natural" behavior of migrants or a behavior that can be induced only by policy intervention, either subsidies or regulations, raising questions about how such interventions affect migrant freedoms and migration's benefits and costs.

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BRAIN DRAIN,
BRAIN GAIN OR BRAIN SHARE?
Policy brief series edited by Graziano Battistella

CIRCULAR MIGRATION
OF HEALTH PROFESSIONALS

International Labour Organization

POLICY BRIEF 6

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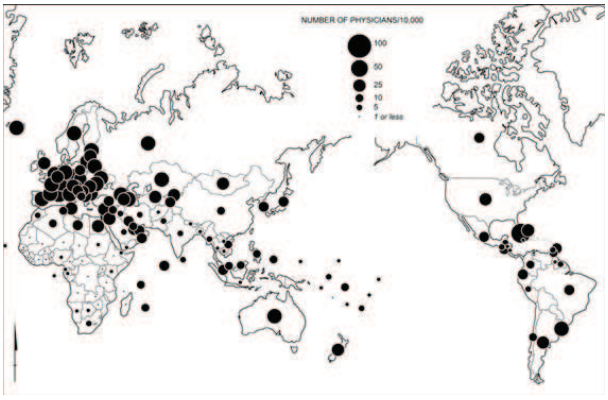
Abstract: The rapidly increasing demand for health care professionals associated with ageing in High Income nations is producing a net migration loss of these workers from Low Income nations who also are experiencing an increase in demand for health care. An alternative to the resulting dichotomisation of brain drain and brain gain is presented by circular migration. The existence of such mobility is demonstrated with respect to Australia and the potential for its expansion and extension is discussed. Circular migration offers the opportunity of brain sharing of health professionals but there are a number of disadvantages which need to be considered and addressed by policy. A number of policy recommendations are outlined along with suggestions for future research.

Beyond the Brain Drain-Brain Gain dychotomy

The world has 8.6 million physicians, 1.3 million dentists, 17 million nurses and midwives and 1.2 million pharmaceutical workers. There are two key dimensions of this global workforce. Firstly, demand for professional health workers is increasing exponentially due to continued rapid population growth in developing countries and population aging in the developed countries. Secondly, they are unevenly distributed between developing and developed countries. Figure 1 demonstrates this stark imbalance by depicting the number of physicians per 10,000 residents by country. The lack of doctors in Africa and much of Asia is striking. Despite this imbalance there is a net outflow of doctors and nurses from Low Income to High Income nations. An example is Australia where the proportion of Australia's doctors and nurses who were overseas-born is currently 53.1 percent and 34 percent, respectively. Moreover the share of overseas-born doctors and nurses has increased significantly with each population census (Hugo, forthcoming).

This dichotomisation of a 'brain drain' of health professionals from the countries who most need them and a 'brain gain' in countries that already have high levels of accessibility to health services is part of the new internationalisation of labour markets and associated expansion of labour-related skilled migration. The current reflection on circular migration involving the migrant being engaged in both origin and destination or returning to the Low Income homeland after a sojourn in a High Income nation opens up the potential for an alternative to the dichotomy – a win-win pattern of brain sharing or brain circulation.

Figure 1: Physicians per 10,000 people, 2003-12*



Note:* Data refer to the most recent year available during the period specified.
Source: UNDP, 2014

Brain Drain of Medical Professionals

A 'brain drain' involving a net loss of skilled persons from less developed nations and a net gain in the more developed countries of the OECD was recognised as long ago as the 1960s (Adams, 1968). More recent analyses (e.g. Carrington and Detragiache, 1998; Dumont and Lemaitre, 2005; Dumont, Spielvogel and Widmaier, 2010) have confirmed that emigration rates in Asian and African countries are higher for skilled groups and that some experience a significant brain drain. A comprehensive analysis by the OECD (Dumont, Spielvogel and Widmaier, 2010: 26) used data from more than 200 sending nations and 89 receiving nations and calculated emigration rates of highly qualified persons (with a university education) for non-OECD nations. Overall some 4.3 percent of all Asia-born persons with a university qualification live outside of their country of birth, which is lower than

that for Africa (10.6 percent), Europe (7.8 percent), Latin America (8.8) and Oceania (7.2).

For Asian countries, highly skilled emigration rates vary considerably: the rates are quite low in large nations like China (2 percent), India (2.9), Indonesia (2.9), Japan (1.0), Pakistan (4.3) and Bangladesh (4.5); the highest rates were in smaller nations like Seychelles (40.6 percent), Brunei (19.7), Hong Kong (16.9), Macao (16.7) and Maldives (11.9); and rates were substantial for some medium sized Asian nations which have become known as important origin countries for skilled migrants, such as the Philippines (15 percent), Vietnam (18.4), Sri Lanka (28.8), Cambodia (43.7) and Laos (10.9).

It should be noted that the loss of even small numbers of the most skilled, most educated and most entrepreneurial can be a significant constraint on development. This is especially true, for example, in the case of the net loss of doctors, nurses and other health professionals from several Asian and African countries. For example, the presence of close to 19,000 doctors trained in Sub-Saharan Africa in OECD nations could seriously undermine the delivery of health services, especially efforts to promote infant, child and maternal survival in the home region (ECA, 2006:6-7) or to fight HIV Aids or epidemic diseases such as Ebola.

It has been argued that these effects can be offset by: (1) the influx of skilled workers from another country such as Canadian doctors moving to the US, being replaced by South Africans who also in turn are replaced by Cubans (Farrant et al., 2006, 11); (2) the influx of remittances and other engagement of the skilled workers in diaspora; and (3) increased investment and participation in the education system to train medical professionals because of the prospect of migration. Such investments in training have positive spin-offs for the home country, not just create a new pool of potential skilled emigrants (Stark, 2003). In the case of health professionals there would seem to be compelling evidence, such as that presented for Africa above, that their outflow is a constraint on improving the health of communities in origin countries.

Brain Gain: The Australia Case

Like other OECD countries, Australian immigration policies are highly selective of the skilled, well educated and young, and it has been the beneficiary of net immigration gains of skilled medical personnel. Moreover, this selectivity has increased substantially over the last two decades (Hugo, forthcoming), driven by an increasing proportion of permanent settlement places being allocated to the skilled migration scheme, a skill-oriented temporary migration programme, and a very active student migration programme which includes the opportunity to remain in Australia when they complete their studies.

There has been an increase in the tempo of migration of medical personnel from Asia and the Pacific to Australia. Many go to rural and remote areas in Australia where there is an overall shortage of medical personnel (Australian Institute of Health and Welfare, 2003). This has led to a debate within Australia about the ethics of such movement and raising such issues as:

- Developing a code of conduct for ethical recruitment;
- The possible reimbursement of the sending country for costs incurred in training of personnel;
- The need for more training of health workers in Australia;
- Selectively limiting proactive recruitment of skilled health professionals;
- Better supporting health care training systems in less developed countries; and
- Encouraging the return of these doctors after they complete a period in Australia (Reid, 2002; Scott et al., 2004).

Banning recruitment of health workers from poor countries by Australia or any other High Income nation would have little benefit to such countries since potential migrants will simply seek an alternative destination. There are, however, other policy options. Receiving countries could make an investment in training/education in the Low Income countries of origin of skilled migrants in recognition of the costs invested in the development of the human capital of migrants. However, there could be serious implementation challenges for such policy. Moreover, while to some extent this policy could be interpreted as only producing future skilled migrant doctors for High Income countries, it is apparent that there are also beneficial spin-offs for the origin. Moreover, it recognises that destination nations have a responsibility to meet the development costs of human capital paid for by origin nations. Investments in such training could be 'tied aid' in the sense that it is targeted to particular areas of education/training in particular origin nations. Another strategy in a more ethical approach to recruitment of health professionals by High Income countries is to facilitate circular migration of those professionals between their home country and the destination, but this has hardly been effective.

Brain Circulation: The Circular Migration Option

Circular migration refers to repeated migration experiences between an origin and destination involving more than one migration and return. Effectively it involves migrants sharing work, family and other aspects of their lives between two locations. Circular migration occurs on a substantial scale, both within and between countries, and often involves movement from a peripheral location (rural area, Low Income country) to a core area (city, High Income country). There is considerable variation in the frequency of movement

and the time spent at the destination but the defining feature is that the mover spends significant periods of time at both origin and destination and 'lives' in both.

The concept of circular migration and policy considerations can be applied to situations where the main permanent place of domicile is the origin country and a number of moves are made to the destination. However from a development impact it is also important for migrants who have made their major place of domicile in the destination country. Encouraging their regular circulation (both virtually and actually) to the origin also can be an important policy initiative to facilitate development in the origin.

It has been argued that contemporary circular migration is an integral element in globalisation (Agunias and Newland, 2007). However, due to data limitations, most nations are unable to detect the extent to which migrant medical personnel in North countries are circulating back to their homelands in South nations; this is an important barrier to the development of policy.

Existing studies, albeit based on inadequate data (Findlay, 2001; Finn, 2001; Farrant et al., 2006), suggest that the scale of brain circulation is limited. Australia is the exception, since it collects data on all movements into and out of the country. Over the 1993-2013 period there has been a massive increase in the number of doctors and nurses moving to Australia on a permanent or long term (temporarily but for more than one year) basis. The numbers from Sub-Saharan Africa also increased, but much less dramatically, and it has declined from a peak in 2008-09. However, it is also notable that there is significant emigration from Australia of doctors and nurses born in Asia and Sub-Saharan Africa. Australian data, thus, indicate that there is a significant counterflow.

Many of the medical personnel moving to Australia from Asia and Africa are engaged in strangely circular patterns of mobility. However, while these patterns indicate that the south-north permanent migration of health professionals is only a small part of a complex pattern of circular movement linking them also to their origin country, they tell us nothing about the nature, motivation and impact of that movement. Moreover they give little indication of the sorts of policy interventions which would be needed to encourage circular migration of a type which enables health professionals to work effectively, both in their home nation as well as in the destination.

Advantages and Disadvantages of Circular Migration of Health Professionals

The option of circular migration for skilled medical personnel migration to High Income countries can have both advantages and disadvantages for the migrant themselves as well as the countries of origin and destination. Some of these are summarised in Table 1. Much, of course, depends on the migrant themselves and their attitudes, preferences and loyalties. However, the key to whether or not the advantages of circular migration are to be realised depends a great deal on policy and governance in origin, but especially, destination countries. Most destination countries have systems in place which facilitate either permanent and/or temporary settlement programmes available to health professionals. However, they largely do not have systems which enable and encourage circular migration.

To make circular migration work to deliver its full benefits will require significant adaptation to new models, not just of migration and settlement but also in terms of workplace practice, access to education and other services for families of medical personnel and citizenship. It also ideally requires significant cooperation between origin and destination country.

Table 1: Select Advantages and Disadvantages of Circular Migration of Health Professionals

For the Migrant

Advantages

- Retain traditional and family associations
- Able to contribute to health of homeland population
- Can still gain earning and professional advantages of working in High Income country
- Children can gain experience of growing up in both countries
- Create opportunities for family

Disadvantages

- Complexity and costs of moving
- Social cost of separation from family for part of the time
- Difficulties of adjusting to two work contexts
- Disruption of moving

For the Origin

Advantages

- Brain drain human capital loss not as great
- Health workers return with greater skills and enhanced networks
- Contribution to health of the nation
- Enhanced links with destination country

Disadvantages

- Loss of skills for part of the time
- Difficulty of organising health system with personnel only in the country for a limited time
- Governance challenges

For the Destination

Advantages

- Most health worker shortages handled in a flexible way
- Savings in training of health professionals
- Part of a 'development friendly' national migration policy
- Can meet health worker shortages in rural and remote areas
- Enhanced links with origin country

Disadvantages

- Workers not available on a permanent basis
- Complications of organisation health system at destination
- Governance challenges
- Difficulties for immigration policy

Policy Implications and Recommendations

For destination countries like Australia there is a need to investigate the extent to which their migration policies and programmes can be more 'development friendly', i.e. policies that not only meet national labour needs but also have positive effects in origin countries. Facilitating and encouraging circular migration of health personnel drawn from Low Income countries desperately short of health skills should be an important part of this strategy and could include such initiatives as the following:

- Develop a range of immigration options for highly skilled workers such as health personnel from Low Income nations. It should avoid approaching permanent and circular migration as mutually exclusive policy choices. Rather they should aim to develop migration policies and programmes which include a judicious mix of circular and permanent migration channels.
- Reduce circular migration costs by developing policies which encourage and facilitate the maintenance of links with home countries, such as dual citizenship provisions, multiple entry visas, job sharing and portable social welfare benefits. Governments should also pursue policies to minimise the family disruption caused by circular migration by facilitating frequent return or allowing family to accompany migrant workers.
- The siloization of migration policy needs to be reduced and effort has to be made to integrate development assistance and immigration policy. Both immigration and development policies and program,ess should be designed with the goal of maximising the benefits and minimising the negative effects of circular migration on origin countries.
- Facilitate dialogue on skill recognition and skill portability between origin and destination countries.

While the cooperation and indeed direct intervention is required from destination countries, origin countries also need to make appropriate policy and institutional changes to accommodate the circular migration of health personnel. Careful integration into the health system as well as with national and regional development planning is crucial. In addition, reducing the costs of migration and facilitating the engagement and investment of the migrants in their home country is needed.

Recommendations for Future Research

- Undertake a detailed study of the existence of circular migration of health professionals for thepurpose of deriving better policy programs.
- Undertake studies of those medical professionals already engaged in circular migration to examine their motives, difficulties etc.
- Undertake a study to identify the types of policies which are needed in origin and destination countries to facilitate and accommodate circular migration. Not only migration policies but also the adjustment needed in the health situations of both origin and destination.
- Explore whether reducing migration costs helps promote return.

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RETURN AND REINTEGRATION
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CIRCULAR MIGRATION OF HEALTH PROFESSIONALS

POLICY BRIEF 7

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Abstract: Return migration is a notion that has changed noticeably from the times in which migration was considered a one-time journey. The opportunities for frequent movement among integrated economies in a globalized world facilitate different types of return. The temporary and final return of health professionals for reintegration in the country of origin might be desirable for various parties, but will not occur successfully unless countries of origin and destinaion cooperate, appropriate policies are implemented, and migrants are prepared.

The development of the concept of return

From the old days of the great European migration to the Americas, return migration has changed considerably both in terms of dynamics as well as significance. In the days when migrants were going abroad with their whole family, after selling property and leaving their familiar environment, return was considered a myth in the sense that it was an unlikely event. In reality, about one third of the migrants who left Europe for North America before World War I actually returned. In the 1950s, migrants leaving for Northern Europe had a short-term migration project in mind, and return was part of it. However, for a portion of them who established themselves abroad with their family, eventually return became a myth, a move that was intended or desired but never implemented. In contemporary labor migration in Asia, where migration is designed to be temporary, return is embedded in the process and is mandatory. Non-return at the end of the contract is considered a violation of migration norms, transforming the worker in an irregular migrant. Throughout history return has changed from unexpected and to some extent undesired to expected and desired by both countries of origin and destination, but for different types of migrants. In fact, the significance and political valence of return has become differentiated for skilled and unskilled migrants. Countries of origin tend to favor the return of their skilled migrants, whereas destination countries would rather keep them for their skills are valued. The situation is generally the opposite for migrants with lower levels of skills.

Several typologies have been constructed to categorize return. Cerase (1974) considered the return of permanent migrants from the perspective of the impact on the development of the country of origin. King (2000) used different variables to formulate different typologies, an interesting one being the time spent in the country of origin (which results into occasional, seasonal, temporary and permanent return). Battistella (2004) combined time and decision to arrive at a matrix of return which occurs after achievement, completion, incompletion/setback and crisis, to which respectively correspond policies of entrepreneurship, reintegration, re-deployment, and emergency.

Circular migration is contributing additional elements to the complexity of return migration. Within circular migration return can be temporary (when it is followed by further migration) or final (if it does not lead to further migration and involves reintegration in the national labor market or retirement). If there are similarities in the return of migrants from temporary and circular migration, there also is distinctiveness, particularly in the fact that temporary return from circular migration should not be mandatory and it should be motivated by reintegration in the country of origin. While typological distinctions can be drawn from abstract consideration of migration, real distinctions can be harder to determine.

The difficulty to measure return

Many have observed that return is a less studied and more poorly understood stage of the migration process. One fundamental reason for this is the difficulty in obtaining data on return migration. Many countries do not require administrative procedures of returning migrants and therefore do not capture their return; as a result, it is also difficult to establish what type of reinsertion the migrants implement in the home economy and society. When local administrations require registration and cancellation of residence it is possible to arrive at some approximation of internal and international movements, including return, but this is not implemented everywhere or

with a high degree of certainty. Embarkation and disembarkation cards are another source of information, when they are processed. Otherwise, estimates have do be derived from specific research, which focuses more on the reasons for return and the type of reinsertion that migrants pursue, rather than estimating the size of return. Even when some data are available, determinig whether return is temporary or final remains difficult, as it remains difficult to distinguish whether those who return are temporary, circular or permanent migrants.

The return of health professionals

There is a widespread consensus that health professionals who have secured employment in a country of destination and found opportunities for successful integration will tend to remain abroad until the completion of their migration project or until retirement. Whether they return after retirement will depend mostly on family and environmental circumstances.

The return pattern of health professionals during their career is not that different from that of skilled migrants in general. According to de Haas et al. (2014) structural integration in the country of destination is not sufficient to discourage return. Instead, socio-cultural integration has a negative impact on the intention to return while career opportunities and the strength of ties in the country of origin tend to reinforce the intention to return. Some examples of return migration by health professionals fit within those parameters.

Doctors from India returned because of family reasons (caring for parents or concern for the education of children) and to escape from unsatisfactory working and living conditions abroad. The decision to return also coincided with the development of the health care industry in India so that they could use the skills acquired abroad, or with opportunities to become involved with colleagues in entrepreneurial projects (such as the establishment of private clinics) (Haour-Knipe and Davies, 2008, 23; Federation of Indian Chambers of Commerce and Industry - Deloitte Touche Tohmatsu India Pvt Ltd, 2014).

Nurses have a higher probability of returning than doctors. However, even for nurses the same factors apply. Nurses from South Africa have returned from the United Kingdom because their professional and social conditions abroad were not as expected and because migration had left vacancies in the home country's health care structure which could be filled up. It helped that return was advertised by institutions such as Netcare Group, which also provided bonuses, sometimes advanced to allow nurses to buy the return ticket (Haour-Knipe and Davies, 2008, 23).

In a study of 80 Jamaican nurses who had worked in the US and had returned to the country, Brown (1997) discovered that return was motivated by family reasons and usually delayed as it took nurses longer to reach the goals they had set for themselves. Of those who returned, two thirds re-entered the nursing profession, while one third opted out because of the low salaries and working conditions. Circularity among nurses was characterized by three groups: those who returned and had no intention to go abroad again: those who returned because of interests in the country but considered the US as their basis; and the majority, who travelled periodically for employment in the US.

The return of nurses from the Philippines who migrated to the Gulf countries is rather difficult, because opportunities for re-employment in the Philippines seem to be low. Hospitals can count on a large supply of nurses and it is less costly to train such nurses rather than re-hire returning nurses with higher qualifications. With limited possibilities for acceptable local employment, nurses tend to re-migrate toward a western country or tend to circulate among hospitals in the Gulf region. The trend in Saudi Arabia to reduce the time of employment to ten years might increase the circular migration of nurses, but not their return to the Philippines.[1]

Policies to facilitate return

Temporary return for circular migrants is a movement taken if the migrants have the possibility to move again. If leaving the country of destination entails difficulties to return to it, migrants might decide not to return temporarily, thus diminishing the possibilty that countries of origin might benefit from such tremporary return. In this regard, countries of origin and destination should cooperate to ensure that the movement of health professionals is not hindered by administrative burdens. Hugo (2013) recommended, among others, reducing migration costs by allowing for multiple entry visas, the portability of welfare benefits and minimizing family disruption.

Since structural conditions in the country of origin might be a deterrent for the migrants' return, it is suggested that incentives be provided to them. Examining studies about incentives programs conducted in developed countries, Bärnighausen and Bloom (2009, 2) concluded that there were lessons to be learned, like on the financing and promotion of incentives programs, but difficult to apply in less developed countries.

[1] Interview with Lito Soriano, CEO of LBS, a recruiting agency deploying nurses in Saudi Arabia (12 November 2014).

Improving structural conditions in the country of origin remains a priority not only to diminish the necessity to migrate and to increase employment opportunities for the whole population, but also to create investment opportunities, with most favorable conditions for returning migrants. Inserting such provisions in local development plans can facilitate the circulation and return of health professionals.

Preparing for return

In the experience of many migrants, return is not a smooth process. The longer the migration experience, the more difficult the reintegration process might be. In that regard, it is advised that migrants should factor return at the very beginning of the migration project. However, experience says that many circumstances lead the migrants to modify, postpone or abandon the intention to return. Nevertheless, preparedness to return is considered essential at the personal level. Cassarino (2014) has insisted on this notion and explained that preparedness is achieved when migrants have the willingness to return (forced return because of setbacks in the migration experience or because of crisis renders migrants unprepared to return) and the readiness to return. Readiness implies the capacity of the migrants to mobilize tangible and intangible resources needed for return.

For a successful return of health profesionals, preparedness must involve government and private institutions in countries of origin. If reintegration in health care facilities can be difficult in countries with a large reserve of health professionals, alternative initiatives related to health, such as wellness consultancy services, and training programs could broaden employment opportunities.

Return is not the top priority of successfully integrated health professional migrants and will not occur in large scale as hypothesized by the notion of circular migration. On the other hand, migration as a one-time journey is also less common. Providing opportunities will ensure that the gains from the migration experience are not wasted.

Best practices

Diasporas: associations of health workers in diaspora populations can contribute to initiatives in the country of origin. Success is higher if the members of the associations are from the same origin communities, have strong motivations for the development of the country, and have active connections with persons and institutions in the home country. The Balik Turo (Teach-Back) program of the Philippine Nurses Associations of America (PNAA) started in 2006 and consists of visits to the Philippines of teams of nurses who share their clinical expertise and knowledge with their colleagues in the Philippines; in return, the US-based nurses also gain knowledge about the health systems in other settings. Similarly the Haitian American Nurses Association (HANA) carries out missions in Haiti and the Dominican Republic and assists in the training of nurses. The National Association of Nigerian Nurses in North America (NANNNA) assists Nigerian universities with skill shortages by participating as visiting faculty members and contributing to the capacity building of nurses in Nigeria.

TOKTEN: Within the framework of the Transfer of Knowledge Trough Expatriate Nationals (TOKTEN), a UNDP program initiated in 1977, some countries, including China, India, Iran, Lebanon, Mali, Palestine, Pakistan, Rwanda, Sudan and Turkey, have utilized consultants who volunteered to return for a short period of time and provide education related to the health care. The experience was particularly successful because consultants were of the same origin and language, had good motivations in providing support for the development of their country, there were minimum administrative procedures, and costs were lower than hiring professional experts (Haour-Knipe and Davies, 2008).

MIDA: "The International Organization for Migration's (IOM) Migration for Development in Africa (MIDA) initiative makes it possible for African professionals in Europe and North America to return to give short-term assistance and expertise in a number of fields, including health care. The initiative has facilitated the return of health workers and also supported hospital twinning and other diaspora activities in several African countries… The Ghana MIDA Project, for example, has facilitated the transfer of diaspora skills and knowledge to Ghana through periodic, temporary and/or circular return. Over a two-year period, the 20 health workers participating in the project made a total of 25 temporary returns, giving them an opportunity to test the ground and to re-establish contacts in their home country" (Haour-Knipe and Davies, 2008, 31).

Policy recommendations

- Codes of conduct regulating nurse migration should include provisions (even in the form of bilateral agreements) where return is embedded in the process. Countries of destination must participate in the facilitation of return through development of health projects in countries of origin as part of the cooperation for hiring foreign nurses.
- Migration policy measures that can be taken in cooperation among countries include allowing and facilitating the acquisition of dual nationality, ensuring the portability of social security and retirements schemes, reducing time-consuming or laborious bureaucratic requirements.
- Countries should work toward recognizing the equivalence of academic attainments and experience. Concomitantly, programs to hire foreign nurses without professional recognition to maintain them at a lower occupational level and reduce costs should be discouraged and terminated.
- Temporary return is possible if the movement and professional insertion is facilitated. In this regard, the possibility that health professionals might take leaves of absence without losing employment is very relevant, as well as the recognition of skills acquired abroad and at home and the recognition of the value of overseas experience for promotions and salary advances. The contribution of diaspora associations should be strengthened.
- Final return should be adequately prepared. While often coinciding with specific stages in the life cycle, the professional component should not be ignored. Cooperation among associations at origin and destination can be utilized for a less difficult reinsertion in the health care system of the country of origin.

Recommendations for future research

- The traditional gap in return migration data should receive better attention. Where administrative procedures are missing, use data from secondary sources. Ensure that census data reflect the residence of the person prior to a certain date.
- Improve knowledge on return migration by inserting the appropriate question in labor force surveys that most countries conduct periodically. Improve the migration procedures in countries of origin that require them by ensuring that double counting is avoided and that return is captured.
- Conduct specific research on repeat and return migration for a number of countries of origin, measuring the correspondence between migration and return intentions and the variables that best predict circular and return migration.

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