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Framework for Sri Lanka's health workers' mobility adopting fair and ethical recruitment practices

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Foreword

The health care sector presents significant opportunities for decent work for migrant workers and has the potential to generate economic growth for countries across the world. Ensuring decent work for healthcare workers enables them to provide high quality health care. Over the past years, the need for skilled healthcare workers has increased in wealthy countries, fuelled by a global shortage of healthcare professionals. As such, a human resource crisis in the health sector has emerged.

Sri Lanka does not have a comprehensive policy on Health Workers mobility. In 2009, Ministry of Foreign Employment promotion and welfare developed a National Labour Migration Policy that does not give enough reference to the Migration of Health workers. The out migration of Sri Lankan health care workers is becoming an increasing trend.

The Centre for Poverty Analysis (CEPA) was commissioned by the ILO Country Office for Sri Lanka and the Maldives to develop a strategic framework on the overseas migration of health care workers from Sri Lanka, adopting fair and ethical recruitment practices. The study was funded by the Government of China through the World Health Organization (WHO) that partnered with the ILO.

The framework or way forward as outlined in this report would be very relevant to various stakeholders, particularly those in the health sector work force management, which includes the Ministry of Health, the Sri Lanka Bureau of Foreign Employment (SLBFE) and other actors who are working on migration. Additionally, this report also brings some insights on labour migration governance, the regulatory framework, and coordination efforts that are of relevance to Sri Lanka achieving several Sustainable Development Goals (SDGs) commitments by 2030.

The ILO Country Office for Sri Lanka and the Maldives thanks the Ministry of Labour and Foreign Employment for helping to coordinate the data gathering through the Department of Census and Statistics; the Ministry of Health for the timely support and technical guidance; and all respondents and key informants who supported data gathering in country. My thanks also to my ILO colleagues in Colombo and in Geneva for their coordination and technical guidance throughout this process. The ILO also appreciates the work of Ms Chandima Arambepola and her team that resulted in this study.

Simrin Singh

Director,

ILO Country Office for Sri Lanka and the Maldives

Executive summary

Health workers' often invisible roles have received greater attention as a result of the global spread of the COVID-19 pandemic. However, concerns regarding migrant health workers' access to social protection and employment benefits as frontline workers in particular, predate the pandemic as the World Health Organization (WHO) and the International Labour Organization (ILO) have sought means to protect the rights of these skilled workers.

In the case of Sri Lanka, the migration of health workers, brings to sharp relief the convergence of two systems – migration for work processes that are regulated by the Government of Sri Lanka as well as the largely publicly funded health and education systems from which trained/skilled workers seek to exit. Balancing an individual's right to migrate against meeting the demands for a skilled health workforce in-country therefore, requires a fine balance of managing this highly skilled human resource.

In this context and as part of the long-term support provided to the Ministry of Health (MoH) by the WHO and the ILO to develop a health worker overseas migration strategy, this study sought to understand two key dynamics: how does recruitment of health workers occur in the context of Sri Lanka? and secondly, what personal and professional concerns underpin the decision-making process of migrant health workers? Using the ILO's General Principles and Operational Guidelines on Fair Recruitment (2019) as well as the decent work indicators and WHO's Global Code of Practice (2010) this research sought to answer these under-studied area of migration studies in Sri Lanka.

Framework for analysis

As an exploratory study, the research adopted a largely qualitative approach to data collection. This entailed conducting 28 interviews with migrant workers (i.e., aspiring, returned and in-service), two (02) focus group discussions with medical undergraduates and trainee nurses, six (06) interviews with Licensed Foreign Employment Agencies (LFEAs) specialising in the migration of health workers, 11 interviews with key stakeholders in the health sector including public and private educational institutions, regulatory bodies and trade unions among others. In addition, secondary data was analysed to examine key characteristics of the current health workforce as well as to understand the demand for workers from three key migration corridors for health workers.

The following sub-sections highlight the key workforce dynamics, the decent work deficits that shape health workers' decision to migrate from Sri Lanka as well as the recruitment processes in operation to facilitate the migration of workers.

Workforce dynamics in the health Sector in Sri Lanka

With over 155,000 workers, the health sector is largely dominated by women (64% vs 36% male), mostly in the 25-34 year age cohort. The feminisation of the sector can be attributed to the nature of the jobs (i.e., nursing, caregiving) as well as young women's increased presence in tertiary education (i.e., paramedical and medical etc). The workforce is relatively well-educated with 9 out of 10 physicians possessing advanced education; a majority of the health care assistants (59%) and 8 out of 10 nurses and midwives possess an intermediate level of education. Notably, it is men who have received an advanced level of education possibly due to high skilled professions such as physicians being mostly male and skilled professions such as nursing and care work being held by female workers – jobs where entry qualifications do not require a degree. A small yet significant percentage of the workforce is on casual and temporary contracts (10% male;

16% female). While labour shortages persist for some categories of work, according to the MoH projections, filling these shortages is on track; reaching saturation points however, differ based on the type of profession (i.e. medical officers vs nurses). These factors however, can also contribute towards the decisions made by health workers to search for work overseas.

Decent work deficits and intentions to migrate

The reasons underpinning a decision to migrate is complex. In general, health workers had access to employment opportunities and derived benefits from working in a sector that is largely regulated by the GoSL. These include a strong coverage of labour laws as well as social protection schemes. But the casualisation of work of the minor staff and caregivers who remain outside of any regulatory framework, suggests that not all workers are treated nor recognised as equal.

The workers also report high levels of job satisfaction, stemming mostly from the sector's patient outreach. But there remain serious concerns about whether the work of the non-medical officers is adequately recognised. In general, the income earned was considered inadequate, by all types of workers. While the GoSL offers both financial and non-financial benefits especially to Medical Officers including an opportunity to 'moonlight' in the private sector, these were considered far from adequate to meet the social expectations placed on the workers. A similar sentiment was expressed by the non-medical officers, especially as the economic conditions in Sri Lanka have deteriorated rapidly.

A major concern, however, is the lack of decent working hours. Even though work-shifts, on-call days and maximum and minimum duration of work hours are stipulated by law, workers tend to work much longer hours especially where labour shortages are acute, such as in nursing. The lower-skilled workers also tend to clock in overtime as a means to supplement their basic wages – an important financial coping strategy to compensate for inadequate wages.

When combined, these factors lead to concerns about how to maintain a healthy work-life balance. Many of the migrant workers employed overseas pointed to dedicated leisure time which allows them to spend time with their children and pursue hobbies. Notably, the flexibility in working hours offered was cited as a key strength of some overseas health systems which allowed both men and women to balance their childcare responsibilities with work commitments. Concerns about children's education, the lack of childcare in Sri Lanka also act as strong factors shaping the decision to migrate, especially as a family.

In addition to these concerns, the health sector is viewed as a hierarchical institutional structure that privileges the medical officers over all other careers. This forms the basis for unequal treatment in employment, especially in terms of placing certain categories outside of administrative roles, limiting their career paths and the space to practice their profession to the fullest. This is further exacerbated by limited opportunities for career progression, cross-learning and overseas training opportunities for non-medical officers. Tied to this is also a sense that only Medical Officers are allowed to determine and lead patient care. Working in tandem, these factors de-motivate non-medical officers, resulting in them being less productive at work and thereby re-enforcing the notion that they are not competent enough to carry out the tasks assigned to them.

A general sense of disillusionment regarding trade union representation was also evident among the workers. However, the power and influence wielded by those representing the Medical Officers was cited as a major obstacle in ensuring that other worker categories received due recognition from the GoSL. This was seen to further compromise collective action and bargaining as the Trade Unions adopt an interest-based approach.

A major consideration for health systems is to ensure that returning migrant workers' skills are recognised and utilised to help improve patientcare. In Sri Lanka, the absence of an institutional framework to recognise the skills acquired and the lack of appropriate settings to apply these skills remains unaddressed. Similarly, the transfer system in place and its perceived lack of

transparency and favouritism were viewed as detrimental to keeping the workforce in Sri Lanka. These structural as well as personal factors thus coalesce in shaping the decision to migrate either temporarily or permanently from the health sector in Sri Lanka.

Fair and ethical recruitment practices in the migration of health workers

To access work overseas, different modalities are currently being used by workers. The most common include employer-employee (i.e. for employment in the United Kingdom, Singapore or Oman) and, agent to agent, evident in the recruitment of caregivers and nursing assistants. The government-government (G2G) is the least utilised. To date, the caregiver programme with Israel and the more recent approval secured for trained nurses to be sent to the National Health Service (NHS) constitute some examples of the G2G modality.

To migrate however, workers must first meet the necessary qualifications stipulated by the destination country or the prospective employer. Securing these could incur high costs for medical officers in particular. But such costs are seen as an investment especially when it enables the migrant health worker access to semi- or permanent residence status in the destination country.

Similarly, securing work can also be costly. Only some exceptions were noted where the "employer pays" model is adopted. The costs of recruitment vary based on the level of skills, the profession and in some instances, by the demand for particular professions in the labour market as well as the recruitment modality. Among workers, lower-skilled workers such as caregivers were found to incur very high costs, varying between 2.5-2.8 million Sri Lanka Rupees to secure highly desirable work opportunities in destinations such as Israel.

There is also differential access to information about job opportunities overseas, depending on the recruitment modality as well as the destination country and the type of work. The rising popularity of social media platforms to gain access to information is seen as risky by LFEA representatives as these proliferate misinformation regarding access to highly sought-after labour markets in countries like Romania and Poland. Workers also seek out information about the destination country, the job prospects, the minimum standards of living and working conditions and wages from their peers. Notably, accessing information from Sri Lankan institutions on certifying one's qualifications and the process to seek and secure administrative leave etc., was perceived by respondents to be frustratingly slow, with most of the information either not available or out of date.

Migrant workers have little negotiation power to determine their wages as wage-setting is placed within the ambit of the employer. Since the wages are much higher in comparison to Sri Lanka, migrant workers are prepared to even pay high recruitment fees to secure employment contracts. None of the workers in-service or those who had returned, cited any outstanding issues in relation to the violation of their rights as migrant workers. But LFEAs can set conditions and enforce a bond on the migrant workers to ensure that they do not leave the prospective employer prematurely. Signing such bonds can be detrimental to the workers, as this can bind the migrant worker to an abusive employer with little recourse to leave.

Development of a mobility framework to facilitate the migration of health workers

These findings point to the decent work deficits that health workers in Sri Lanka experience and how these factors can thus, shape the decision to migrate. To balance the needs of the health sector in Sri Lanka with the individual aspirations of health workers to migrate thus, requires a framework that responds to these gaps while also ensuring that migrant health workers do not experience exploitation and abuse in the recruitment process. To this end, this report proposes a

framework that could be considered for adoption in order to facilitate policies and strategies for fair migration and return of health workers in Sri Lanka.

Regulatory framework to ensure fair and ethical recruitment

While a separate regulatory framework to facilitate the migration of health workers is not required, it is proposed that minimum standards in recruitment are enforced using the existing instruments. This also includes the universal application of the "employer pays" model as well as the strengthening of the key recruitment modalities that reduce exploitation or acute labour shortages. Furthermore, a means to ensure that the LFEAs adhere to these stipulated conditions, ensuring wider access to information on job vacancies as well as the continued imposition of the Family Background Report on female migrant workers must be addressed.

Protection of migrant worker rights

In relation to the protection of migrant worker rights, the framework must comprehensively address the issue of ensuring that migrant workers' rights are protected regardless of their registration status with the GoSL. Furthermore, the implementation of a grievance handling mechanism anchored within the Sri Lanka Bureau of Foreign Employment's Conciliation division as well as the strengthening of mechanisms to reduce the experience of forced labour conditions must be instituted.

Reintegration of returning health workforce

In terms of reintegration of returning health workers, a systematic process to recognise the acquired skills as well as the recognition of any new qualifications and or accreditations acquired while overseas must be instituted. This will ensure that Sri Lanka's own systems remain robust and adaptable to the changes taking place within global health systems. In addition, a process to encourage the participation of "permanent settled" health professionals to engage with the health sector in Sri Lanka as well as to encourage knowledge and resource-sharing must be streamlined via the professional associations established in Sri Lanka.

Improving retention by responding to decent work deficits.

Adequate responses to retain the existing workforce include providing equality of opportunities for all workers via clear career progression, limiting or reducing the casualisation of work, addressing acute shortages in specific professional categories via public-private partnerships and investments, the extension of non-pecuniary incentive schemes that offset the low wages and equitable access to educational facilities to both men and women.

Data collection, monitoring and analysis

The use of a common denominator to define a health worker, as well as the streamlining of disparate datasets from the private and public health sectors, the maintenance and sharing of databases on migrant workers and maintenance of database of health professionals in the diaspora/diaspora groups must be strengthened.

Coordination mechanism

Finally, an institutional level mechanism to improve coordination among multiple stakeholders must be set up, especially since the entities regulating migration and the health sector presently work in-silos. Similarly, partnerships with private TVET institutions must be strengthened especially to provide standardised trainings to caregivers and other health worker categories that require upskilling.

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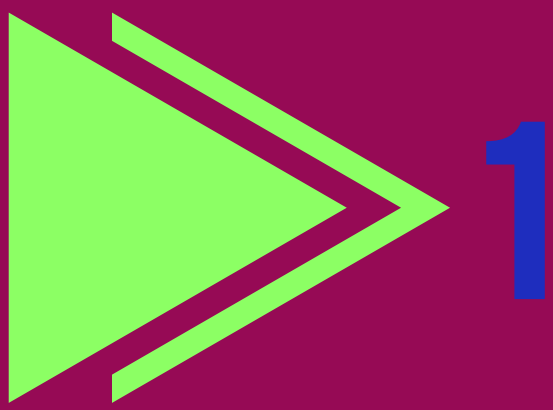
List of abbreviations

AHPRA	Australian Health Practitioner Regulation Agency
AMC	Australian Medical Council
CEPA	The Centre for Poverty Analysis
COD	Country of Destination
COO	Country of Origin
COVID-19	Novel Coronavirus
FBR	Family Background Report
FGD	Focus Group Discussion
FTE	Full-time Equivalent
G2G	Government to Government
GCC	Gulf Cooperation Council
GoSL	Government of Sri Lanka
HCHS	Hospital and Community Health Service
IADEX	Interagency Data Exchange
IELTS	International English Language Testing System
ILO	International Labour Organization
ISCO	International Standard Classification of Occupations
KPI	Key Person Interview
LDS	Labour Demand Survey
LFEA	Licensed Foreign Employment Agencies
LFS	Labour Force Survey
MOH	Ministry of Health
MoU	Memorandum of Understanding
NHS	National Health Services
OECD	Organization for Economic Co-Operation and Development
SLBFE	Sri Lanka Bureau of Foreign Employment
UGC	University Grants Commission
UK	United Kingdom
USD	United States Dollar
WHO	World Health Organization



1 Introduction

As a policy stance, the Government of Sri Lanka (GoSL) has committed itself to the promotion of skilled migration. Key to the success of such a strategy is the ability to respond to the demand for skilled labour for overseas labour markets. However, unless the necessary training and recruitment infrastructures are built, such promotion of skilled migration can also have a deleterious impact on the local labour market, as opportunities overseas can be attractive with the promise of higher incomes, a more stable work-life balance and the prospects of permanent settlement. This study addresses the potential for brain drain in such a critical sector - health - where the GoSL has invested heavily in order to ensure that Sri Lanka maintains progressive health indicators on par with the Global North.

The investments in a publicly financed health sector, accounting for 95 percent of inpatient care and 50 percent of outpatient care (Oxford Business Group, 2016) of the total accessible health services in Sri Lanka, has been beneficial to Sri Lanka in the long run. Management of the highly skilled human resources of the sector however, does not happen in a vacuum. While successive governments may offer multiple benefits – either pecuniary or non-financial - the appeal of working overseas and of permanent migration must be considered from a merging of individual aspirations as well as macro-level determinants.

Examining the individual and structural level factors that shape decisions of health workers' migration trajectories is of importance at present. Migrant health workers sit at the intersection of two strained groups, both within the context of the COVID-19 pandemic and beyond it. The health profession is characterised by physically and psychologically demanding tasks. The migrant worker experience is often characterised by discrimination and exploitation. In tandem, this combination translates to the experience of migrant health workers being rooted in challenge.

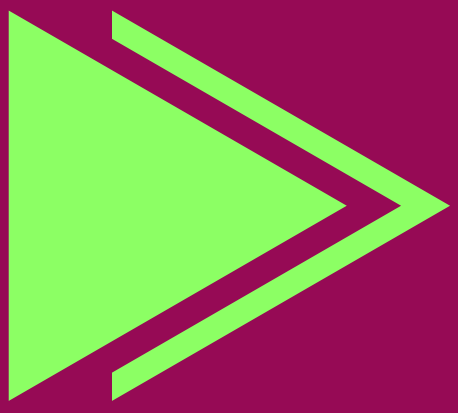
Despite this often-difficult shared experience of migrant health workers, between 2000 and 2010 the number of migrant nurses and doctors that immigrated to Organization for Economic Cooperation and Development (OECD) countries from countries with severe shortages in the health workforce increased by 80 per cent (Schilgen, Nienhaus, Handtke et al., 2017). There is a steady and rising trend of "brain drain," or the emigration of health personnel out of vulnerable countries. Sub-Saharan African countries as well as small island states are most affected by this issue. Countries in Europe, North America and the Gulf Cooperation are the most popular destinations as their need for a larger health workforce increase (Connell and Stilwell, 2006).

The demand for health sector workers has received an impetus from the responses to the COVID-19 pandemic. Health systems in the Global North and elsewhere (i.e. Gulf Cooperation Council countries) may be better positioned to offer lucrative financial packages that appeal to skilled workers in the Global South. But upskilling or recognition of skills is a challenge that workers have to first respond to in the pre-departure phase. In such a context, countries like Sri Lanka must seriously consider how best to balance the needs of the local health system against making the best use of the opportunities presented via migration.

Furthermore, as the health workforce faces unprecedented levels of migration, affected countries must find innovative ways to bring back the trained, health workforce. By engaging with existing recruitment modalities, the experiences of migrant health workers, and various return channels, a better understanding can be established as to why health workers migrate and what can be done to restore the health workforce in the affected countries.

These considerations were central to the conceptualisation of this study. Foregrounded in the World Health Organization (WHO) and the International Labour Organization's (ILO) longer-term aim to support the Ministry of Health (MOH) to develop a health worker overseas migration strategy, this study sought to understand two key dynamics: how does recruitment of health workers occur in the context of Sri Lanka? and secondly, what personal and professional concerns underpin the decision-making process of migrant health workers? Using the ILO's General Principles and Operational Guidelines on Fair Recruitment (2019) as well as the decent work indicators (ILO, 2013) and WHO's Global Code of Practice (2010) this research seeks to throw light on this under-studied area of migration studies in Sri Lanka.

The sections of the report are organised thus: Chapter two details the methodological approach adopted by the research team in consultation with the ILO-Sri Lanka office. This details the reasons to opt for a largely qualitative study, the challenges in reaching out to migrant workers and the limitations in terms of access to data and to migrant workers and the particular timing of the study. Chapter 3 provides an overview of Sri Lanka's health sector, providing the background to the next chapter (Chapter 4) which examines the reasons underpinning migration examined using the decent work framework. In the subsequent chapter, the recruitment modalities are explained, especially in light of the changes noted in terms of the costs and access to certain corridors on the basis of skills. The final chapter lays out the main findings and proposes a framework that offers a blueprint for the fair and ethical recruitment of health workers from Sri Lanka and the possibility to balance the demand for health workers in Sri Lanka whilst responding to the demand for health workers from competing labour markets, overseas.



2 Methodological approach

This chapter details the aims, research questions and the conceptual parameters adopted to conduct this largely qualitative study. A breakdown of interviews conducted as well as some of the challenges encountered are considered in light of the remote data collection mode adopted.

The aim of this research was two-fold.

1. Elaborate on the existing desk review by incorporating views from various stakeholders, including the ILO's tripartite constituents with specific focus on circular migration, fair recruitment, return and reintegration and regulatory frameworks.
2. Develop a framework that would contribute to a strategy for overseas migration of health workers that supports fair and ethical recruitment practices within the primary objective of ensuring the adequate meeting of requirements for the delivery of health within Sri Lanka.

2.1. Conceptual parameters

Health professionals are generally understood or viewed through a narrow definition to comprise mainly the medical officers, nursing categories and the technical cadre (i.e. paramedics in the case of Sri Lanka). There are inherent risks to such a narrow definition, as a larger population of the health sector is then sidelined in policy frameworks.

To provide some clarity, CEPA applied the existing International Standard Classification of Occupations (ISCO) – 08 definition of health workers. This is widely used at national censuses as well as globally, to estimate the number of health workers. The definition also captures traditional occupations such as medical practitioners and nurses, as well as personal care workers and home-based care workers[1]. This broader definition is used in other ILO reports as well (International Labour Office, 2017) and therefore, is a benchmark that is applicable to Sri Lanka as well.

For the purposes of this study, migration is defined as processes that enable/facilitate workers to secure work overseas. This would support the development of a framework in line with the existing National Labour Migration Policy and the sub-policy and action plan for return and reintegration.

2.2. Framework for analysis

The research was largely informed by the ILO's General Principles and Operational Guidelines for Fair Recruitment (2019). These guidelines clearly set out the commitments of the stakeholders involved in migration – the countries of origin (COO), countries of destination (COD), prospective employer, employee and the Licensed Foreign Employment Agencies (LFEAs). It provided a key framework for this study to examine how fair and ethical recruitment processes and practices must be ensured. Similarly, references have been made to the WHO's Global Code of Practice on the International Recruitment of Health Personnel (2010) as this pertains to health workers. However, as both documents contain common elements, these were used as a benchmark to analyse the data collected.

1 Department of Census and Statistics (n.d.). Labour force survey. Retrieved from http://www.statistics.gov.lk/LabourForce/StaticalInformation/IntenationalStandardClassificationOccupation-ISCO-88

A sustainable labour lens was adopted to examine the working and living conditions of health workers. The idea of sustainable labour stems from the argument that aiming to achieve living and working conditions that encourage an extended working life will eliminate factors which hinder workers from staying in or entering the labour market. To this end, the research is framed on the ILO's decent work indicators (ILO, 2013) as these provide a globally applicable standard to examine and compare working and living conditions across multiple national contexts and more importantly, capture the economic as well as the social dynamics at play. This allows decent work deficits to be considered as a possible gap requiring more sustained focus in order to retain the workforce and reduce attrition.

2.2.1. Research questions and data collection tools

As an exploratory study, the research adopted a largely qualitative approach to data collection. In addition to the collection of primary data, the research team undertook an analysis of secondary data to inform the rapid assessment as well as provide information necessary for the contextualization of the study. These were informed by the research questions developed in response to the Terms of Reference issued by the ILO:

1. What specific reasons underpin health workers' preference to secure work overseas as opposed to Sri Lanka's public health sector?
2. What recruitment modalities are on offer and how are they adopted/adapted by aspiring migrant health workers to secure work overseas?
3. How do their work experiences match against those in Sri Lanka and how do such experiences shape their future trajectories and decision-making?
4. Which competing labour markets target health workers from Sri Lanka?
5. How does the migration outflow of health workers impact Sri Lanka's health sector?

These seemingly disparate yet interconnected research questions were explored using multiple tools.

Desk Review

To ground the study and to ensure continuity from Phase I, the research team undertook a desk review to strengthen the existing report produced under the same project. The desk review focused on a). Sri Lanka's existing policy framework in relation to migration for work b). the existing recruitment modalities commonly used by selected countries to facilitate health worker migration; c). experiences of migration including potential for decent work/risks of forced labour among health workers and finally, d). return channels that enable health workers to re-enter local health sector (to identify best practices).

Rapid Assessment

Using available and accessible data, an assessment was carried out to inform the demand and supply of health workers from Sri Lanka. The data sources included the Labour Demand Survey (LDS), the WHO's Health Labour Market analysis, and data from the Sri Lanka Bureau of Foreign Employment (SLBFE) and the Ministry of Health. The overview of the health sector's workforce was informed by the data provided by the ILO-OECD-WHO Working for Health Programme calculated on the most recent Labour Force Survey (LFS) data for Sri Lanka[2]. The assessment provides an overview of the domestic health labour market as well as an exploration of three common corridors (United Kingdom, Australia and Oman) for the migration of Sri Lankan health workers. This information was married into the report to supplement research findings.

2 This publication is forthcoming.

Key Person Interviews

A total of 11 Key Person Interviews (KPIs) were concluded (Table 1). The stakeholders were identified based on the central role they play in terms of health workers and/or their migration, and the relevance to the research questions examined in this study.

Table 1: Breakdown of KPIs Conducted

Type of Organization	Male	Female	Total
Public sector regulatory body	3	-	3
Public sector educational institute	1	1	2
Trade union	3	0	3
Private sector training institution	1	1	2
Private sector hospital chain	1	0	1
	9	**2**	**11**

Semi-structured Interviews

A total of 28 interviews were conducted with migrant workers and 06 with LFEA representatives. (Table 2). Three pre-identified categories of health workers -aspiring, in-service and returned - were interviewed. Aspiring migrant workers are health workers who have indicated – formally or informally – their intention to secure work overseas. These included workers who have sought assistance from LFEAs, those preparing for qualifying examinations/or are in the process of acquiring the necessary technical skills to enable them to migrate. Returned migrant workers refer to health workers who have returned in the past five years after working in another country in a similar capacity. These included workers who have re-joined the public sector, have left the public health sector and are working in the private sector or have moved to a different sector. In-service migrant workers are professionals who are presently engaged in employment with an overseas employer. Most in-service migrant workers were of the high-skilled categories, especially medical officers and some categories of nurses and radiologists and pharmacists. It must be noted that these categories are artificial as some returned workers are considering re-migrating and in-service workers' decisions remain in flux.

Facilitating migration of health workers is a specialized area among the LFEAs. Hence, the SLBFE's database on available job vacancies was used as a search engine to identify LFEAs which had job openings for health workers.

Table 2: Breakdown of Semi-Structured Interviews Conducted

Type of Organization	Male	Female	Total
LFEA representatives	5	1	6
Aspiring migrant workers	-	7	7
Returned migrant workers	3	1	4
In-service migrant workers	8	9	17
	16	**18**	**34**

Focus Group Discussions

Two focus group discussions (FGDs) were conducted via Zoom technology with two identified groups (Table 3). The groups consisted of medical undergraduates completing their degree from a public university in Sri Lanka and a group of trainee nurses from the College of Nursing. For the

latter, access was granted by the College of Nursing. As part of the future workforce, these youth groups were able to discuss their perceptions about decent work in the sector in Sri Lanka, the reasons that could potentially push them to consider migration and the measures they propose that could retain the workforce in Sri Lanka.

Table 3: Breakdown of FGDs Conducted

Type of Organization	Male	Female	Total
Medical undergraduates	2	4	6
Trainee nurses	1	5	6
	3	**9**	**12**

2.3. Data Cleaning and Analysis

All data was cleaned and analysed using the appropriate software. As a general principle, CEPA does not audio-record phone conversations or virtual interviews as this tends to raise fears of audio-records being exploited/misused. In a few instances, (e.g., the FGDs), the discussions were audio-recorded but only after gaining the approval from all participants.

The interview notes form the primary data. These were cleaned (i.e., double-checked for accuracy, gaps) and thereafter, anonymised. The data cleaning process happened simultaneously. All identifiable markers or any reference that may be construed sensitive, were redacted. A master document was maintained by the research team to track the progress of the interviews completed.

2.4. Limitations

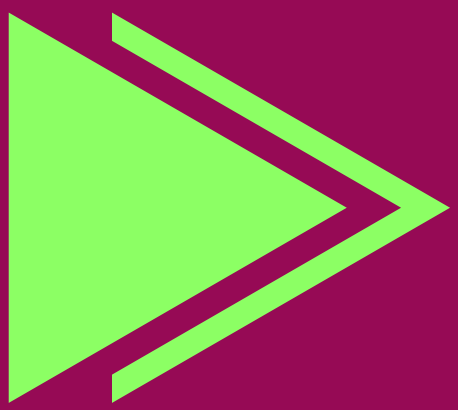
Data was collected during the latter part of 2021. Given the current context in Sri Lanka, CEPA adopted a remote data collection mode. Almost all interviews were conducted over the phone or via WhatsApp messenger application. Only three stakeholder interviews, including the interview with the MOH, entailed in-person interactions. The limitations explained below were context-based rather than any serious consideration on the conceptualization of the study.

i. Timing of the study: The timing of the study was not ideal on two accounts: health workers were under pressure as a result of the ongoing pandemic hence, engaging in this research was not a priority. Key stakeholders especially within the MOH were hard to reach, despite using multiple official channels to request inputs to the study. Secondly, Sri Lanka's current economic conditions has resulted in the creation of a panic to leave Sri Lanka, at any cost. This was a common theme underlying the study. It offers a unique lens to examine a possible exodus but also may over-report the aspirations to leave.

ii. Connectivity issues: Participation in the FGDs was sometimes interrupted because of the loss of the internet connections. As both youth groups are presently studying, CEPA reimbursed the cost of internet charges after the FGD was concluded. For KPIs and semi-structured interviews, all efforts were made to ensure that interviews were conducted over the phone.

iii. The consultation: The research team was unable to organise the proposed consultation with identified members of the diaspora due to time constraints. However, the intentions of conducting the consultation (i.e. exploring how the transfer of skills, capacities and knowledge gained can be optimised to benefit Sri Lanka), were achieved through KPIs and semi-structured interviews with in-service workers.

iv. Generalisability of results: Although qualitative research and stakeholder engagement reveals a wealth of information and helps to better understand current issues, identify needs and supports the implementation of meaningful actions, the results are not generalisable. Yet they provide a sound starting point to further explore how future policies need to be shaped to address the concerns and issues faced by (migrant) health worker



3 Overview of the health sector in Sri Lanka

As a public good provided to all Sri Lankans, the health sector is primarily anchored by the Government of Sri Lanka. This has led to a majority of the workers being employed by the State as opposed to the private sector. Hence, this overview of the workforce provides some background to key characteristics identifiable among the workers. While not exhaustive, this foregrounds the decent work deficits and the intentions to migrate that may stem from the nature of the sector itself.

3.1. Workforce dynamics in the health sector in Sri Lanka

The overall number of persons employed in human health and social work activities[1] has increased from 2016 to 2019, with a decline in persons employed in 2020 (Table 4). This may be due to the job loss or a tendency to leave health sector jobs during the pandemic. However, the change in the overall numbers could also be organic. For instance, the retirement of workers. The data provided is not sufficiently conclusive to prove that the sole reason for the fluctuation in employed numbers is the "COVID effect". The shortage of skilled labour in some sub-sectors such as nursing was highlighted as a challenge by migrant health workers and the MOH; an acute shortage of skilled labour was pointed out as a common challenge affecting Sri Lanka's private health sector in the interviews held with private TVET institutions as well as the administrator of a private hospital. The impact of the pandemic and multiple local and national level lockdowns may have further heightened these shortages.

Table 4:Currently employed persons in health and social work activities 2016- 2020

2016	2017	2018	2019	2020
141,836	149,272	142,861	169,232	156,424

Source: Labour Force Survey 2020, Department of Census and Statistics

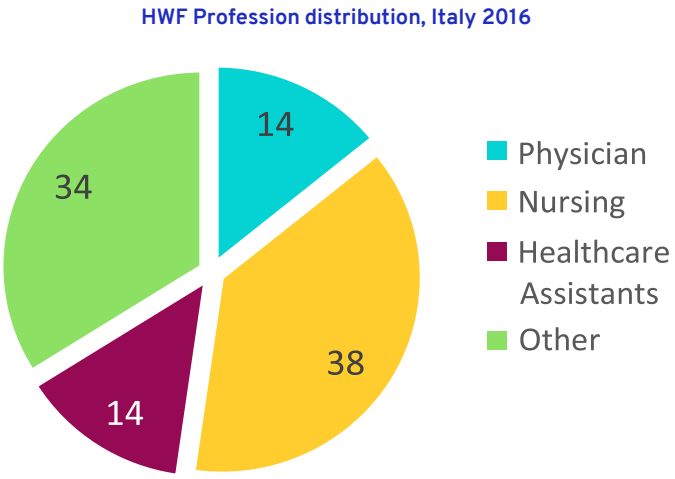
In terms of gender distribution within the overall health workforce, females make up the majority (64%) as opposed to males (36%). A possible reason for this is the gendered nature of jobs related to nursing and caregiving. According to the Health Labour Market Analysis (2018), most nurses in Sri Lanka are female. This is because in training institutes registered under the MOH, each intake is required to have 95 percent of female students, with the perception that nursing requires a caring nature above all. This perception has resulted in a scarcity of male nurses, whose absence is most prominently felt in psychiatric wards and wards with predominantly male patients (KPI, Nursing College representative, female, 9 December 2021).. Notably, since 2000, more than half the medical students enrolled are female and around 70 percent of students enrolled in paramedical education are also female (University Grants Commission, 2021) thus driving up the feminisation of the health sector. This in turn, poses new questions for the public and private sectors in terms of being gender-responsive.

The gender breakdown of the workforce is also reflected in the proportion of female-led professions in the sector. For example, nurses make up the majority at 38 percent (Figure 1). Both health care assistants and physicians make up only 14 percent of the total workforce. This

1 Activities include a wide range, starting from health care provided by trained medical professionals in hospitals and other facilities, over residential care activities that still involve a degree of health care activities to social work activities without any involvement of health care professionals.

trend is important to note, especially in terms of the perceptions among non-physician worker categories regarding the role of the MOH and the hierarchical nature of incentives offered to different professional categories.

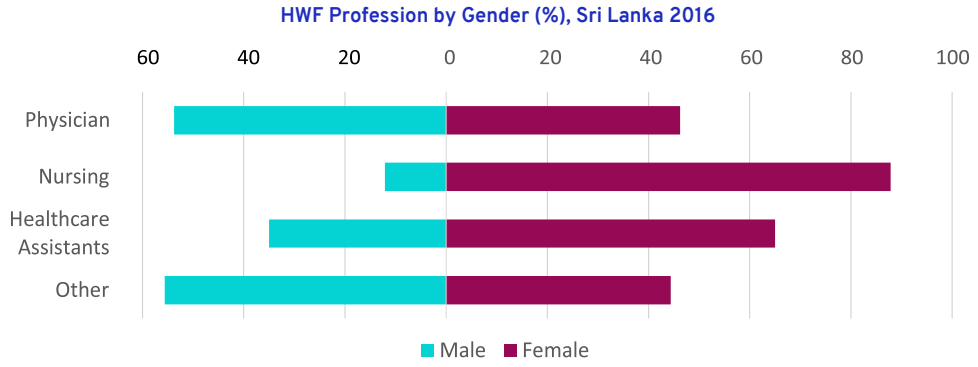
Figure 1: Health Workforce Distribution by Profession (2016)



Source: Global Interagency data exchange project, ILO-OECD-WHO Working for Health Programme (forthcoming)

The gendered nature of professions is further highlighted in Figure 2. Clearly, women have a strong footing in each profession. In addition to nursing, healthcare assistants are also largely female. Once again, this speaks to the feminisation of health work in the country, as healthcare assistants mostly take on the role of providing direct personal care to patients and assist with daily activities of patients admitted to hospitals, clinics and residential nursing care facilities.

Figure 2: Health Workforce Distribution by Gender (2016)

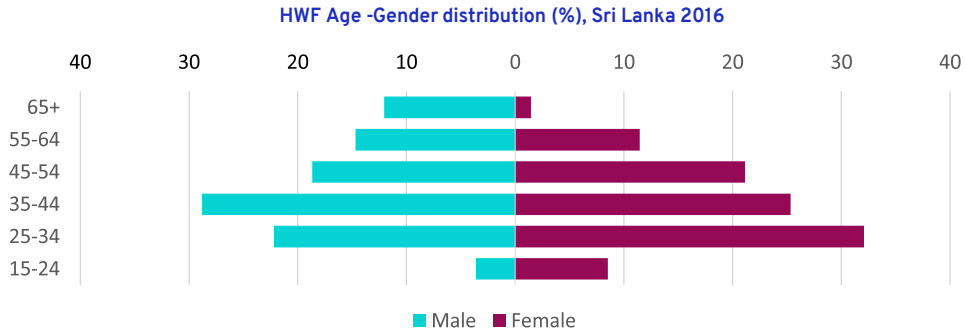


Source: Global Interagency data exchange project, ILO-OECD-WHO Working for Health Programme (forthcoming)

In terms of age, 25-34 year-old females make up the majority of health workers, followed by males aged 35-44 years. The decrease in number of females in the latter age group could be attributed to many factors. In a 2016 study, it was recognised that while the health sector is dominated by women, the lack of career progression for women due to the absence of a standard career path and/or the maternal and unpaid care responsibilities, along with the "double jeopardy" phenomenon[2] may act as deterrents pushing women away from the sector (ILO, 2016). However, this could also be reflective of the changing gender dynamics in the sector as younger cohorts become more female dominant. Hence, these trends may change further, to favour women in the next few decades.

2 Quoting Wickremasinghe and Jayathilaka (2006), the ILO (2016) notes that a double 'jeopardy' refers to women workers not being considered for promotion even where they had the required experience and educational qualifications due to a perceived lack of certain personality traits considered desirable and secondly, that a capable and efficient woman worker would not be promoted as it was difficult to replace her with someone as capable in that position.

Figure 3: Health Workforce Distribution by Age and Gender (2016)



Source: Global Interagency data exchange project, ILO-OECD-WHO Working for Health Programme

To report on the levels of education attained, the Global Interagency data exchange project classified the LFS data using the International Standard Classification of Education (ISCED) versions 11 and 97. For the analysis, both versions were combined to produce four categories: "less than basic", "basic", "intermediate" and "advanced" (Table 5). The analysis shown here therefore, makes no attempt to classify the quality of the education received, nor whether it was competency-based.

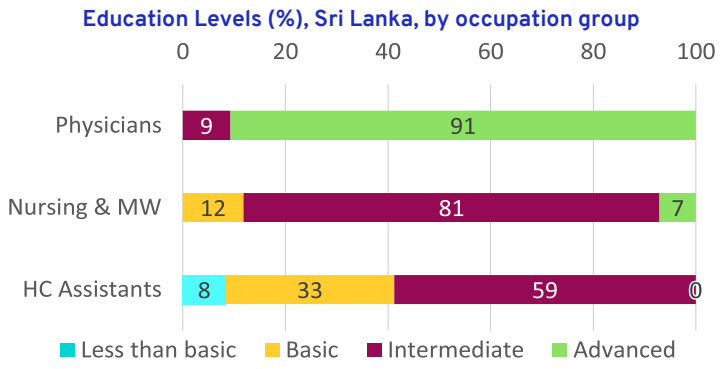
Table 5: Education Categories

Education aggregate	ISCED 11 Category	ISCED 97 Category
Less than basic	No schooling 0. Early childhood education	No schooling 0. Pre-primary
Basic	1. Primary education 2. Lower secondary education	1. Primary education 2. Lower secondary education
Intermediate	3. Upper secondary education 4. Post-secondary non-tertiary	3. Upper secondary education 4. Post-secondary non tertiary
Advanced	5. Short-cycle tertiary 6. Bachelor's or equivalent 7. Master's or equivalent 8. Doctoral or equivalent	5. First stage tertiary 6. Second stage tertiary

Source: Global Interagency data exchange project, ILO-OECD-WHO Working for Health Programme (forthcoming)

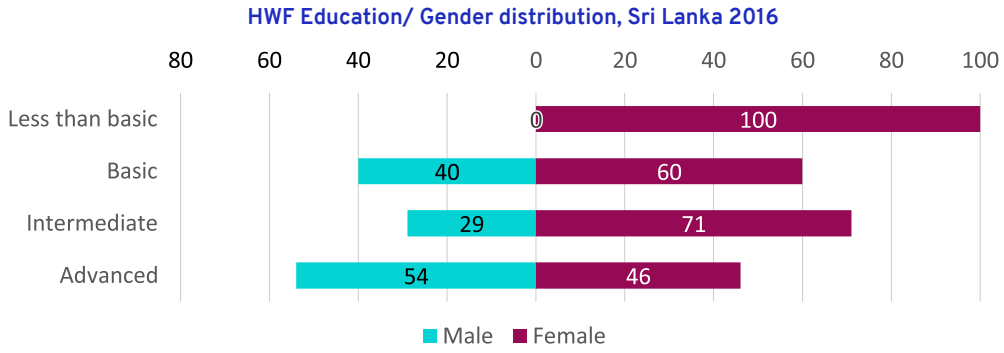
Thus, in terms of education, the following snapshots were observed.

Figure 4: Health Workforce Distribution by Education Level and Profession (2016)



Source: Global Interagency data exchange project, ILO-OECD-WHO Working for Health Programme (forthcoming)

Figure 5: Health Workforce Distribution by Education Level and Gender (2016)

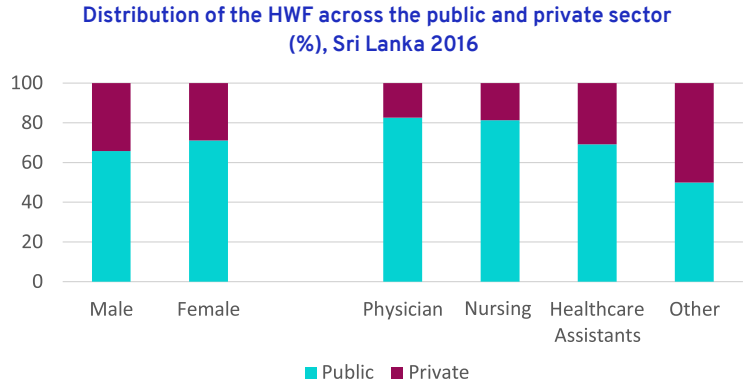


Source: Global Interagency data exchange project, ILO-OE CD-WHO Working for Health Programme (forthcoming)

The data suggest that 9 out of 10 physicians possess an advanced education whereas 8 out of 10 nurses and midwives have intermediate education with 7% having advanced and 12% having basic education. The majority of health care assistants (59%) have an intermediate level of education, with one third having at least basic education and 8% less than a basic level of education. Notably, although a majority of the health workforce is female, it is mostly males who had received advanced level education (Figure 5). This may be due to high skilled professions such as physicians being mostly male and skilled professions such as nursing and care work being held by female workers – jobs where entry qualifications do not require a degree. However, the introduction of degree-awarding institutions for allied health sciences may shift this balance towards a more educated health workforce. The earliest available University Grants Commission (UGC) data shows that there was a total intake of 686 students[3] in 2011 for an undergraduate degree in allied health sciences (240 male, 446 female) (UGC, 2011)[4]. By 2020, this had increased to 2,174 students (1242 male, 932 female) (UGC, 2020).

As in most countries, Sri Lanka also has a "mixed health system", consisting of both public and private sector health services. Figure 6 shows that the majority of health workers are employed in the public sector. This emphasises the predominant role of the GoSL as the primary employer.

Figure 6: Health Workforce Distribution by Sector (2016)



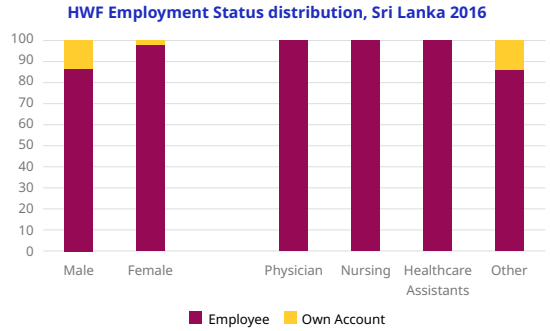
Source: Global Interagency data exchange project, ILO-OECD-WHO Working for Health Programme (forthcoming)

In terms of the conditions of employment, Figures 7, 8 and 9 illustrate the employment status, contract distribution and the part-time/full time divide. It is important to note that a small yet significant proportion are on casual and temporary contracts. According to the data calculated through the IADEX project, 10 percent of male workers and 16 percent of female workers are on temporary contracts (see figure 8 below). This could be reflective of a growing trend in the public sector to rely on sub-contracting or casual work arrangements especially for the lower-

3 240 male, 446 female
4 Retrieved from https://www.ugc.ac.lk/downloads/statistics/stat_2011/chapter%203.pdf

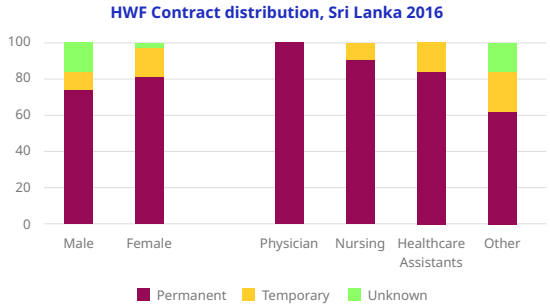
skilled categories of workers.[5] While a similar status could be present in the private sector, the casualisation of employment could not be confirmed via the interviews conducted.

Figure 7: Health Workforce Distribution by Employment Status (2016)[6] [7]



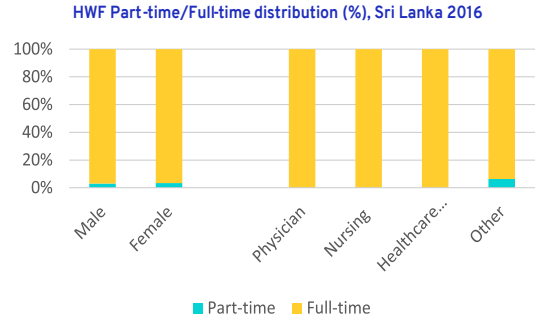
Source: Global Interagency data exchange project, ILO-OECD-WHO Working for Health Programme (forthcoming)

Figure 8: Health Workforce Distribution by Nature of Contract (2016)[8] [9] [10]



Source: Global Interagency data exchange project, ILO-OECD-WHO Working for Health Programme (forthcoming)

Figure 9: Health Workforce Distribution by Employment Basis (2016)



Source: Global Interagency data exchange project, ILO-OECD-WHO Working for Health Programme (forthcoming)

A limitation of the data analysed is the non-consideration of dual practice for which legal provisions have been provided in Sri Lanka. Since the Dual Practice Act of 1977, public sector medical officers have been engaged in private practice after working hours. The implications of this are not well studied. However, sample studies show that 40–60 percent of doctors, 70 percent of dental surgeons and 90 percent of specialists employed in the public sector are engaged in

5 Interview with Trade Union Representative, 20 November, 2021
6 Employees are all those workers who hold paid employment jobs, which are those where the incumbents hold employment contracts, which give them a basic remuneration not directly dependent upon the revenue of the unit for which they work. Source: International Labour Organization (2021b)
7 Own-account worker: Workers who, working on their own account or with one or more partners, are self-employed and have not engaged on a continuous basis any employees to work for them. Source: International Labour Organization (2021a).
8 Temporary employment: Temporary employment, whereby workers are engaged only for a specific period of time, includes fixed-term, project- or task-based contracts, as well as seasonal or casual work, including day labour. Source: ILO (2021b)
9 Part-time employment: The definition of part time varies by country. In ILOSTAT, the incidence of part-time employment is based on a common definition of fewer than 35 actual weekly hours worked. Source: ILO, 2021b
10 Full-time employment: The definition of full time varies by country. In ILOSTAT, the incidence of full-time employment is based on a common definition of 35 or more actual weekly hours worked. Source: ILO, 2021b.

private practice after hospital working hours (Rajapaksa De Silva, Abeykoon and Somatunga et al, 2021). This is largely attributed to the inadequate pay in the public sector employment as well as a means of responding to the shortages of professionals in the private health systems.

3.2. Labour shortages in the sector

The operations of the health sector rely on a workforce that possess a set of skills and knowledge that is specialised but also constantly evolving. Public investments in the improvement of the sector are informed by the need for a healthy population. But the training of skilled professionals requires a major public investment on the part of the GoSL. Despite these investments into the training and retention of workers, workforce shortages are still prevalent. The Annual Health Bulletin of the MOH highlights the numbers of key health personnel and rate per 100,000 population (Table 6).

Table 6: Key Health Personnel and Rate per 100,000 Persons

	Medical Officers[11]	Dental Surgeons[12]	Registered/ Assistant Medical Officers[13]	Nurses	Public Health Nursing Sisters[14]	Public Health Inspectors	Public Health Midwives	Hospital Midwives
2015	87	6.4	4.5	202.3	1.4	7.7	28.8	13.2
2016	89.5	6.8	4.2	200.7	1.3	8	29.5	11.2
2017	92.3	6.9	3.8	212.1	1.5	8	26.8	11.6
2018	91.0	7.2	3.6	212.4	1.4	7.8	26.8	12.4
2019	93.5	7.2	3.4	214.8	1.5	7.7	26.2	12.1

Source: Annual Health Bulletin – Ministry of Health

The increase in rate per 100,000 population is not considerable, especially for dental surgeons and public health midwives. But analysis of decades-long data has indicated a steady increase year-on-year of the cadre, that has resulted in bridging some of these gaps (Rajapaksa De Silva, Abeykoon and Somatunga et al, 2021). Moreo ver, the population per medical officer, as of 2019, is approximately 1070 persons, which is marginally above the WHO recommended ratio[15]. According to the MOH projections, filling these shortages of the different categories of professions is on track; reaching saturation points however, differ based on the type of profession (i.e. medical officers vs nurses)[16].

A point raised in multiple KPIs was the severe under-funding of the public sector training institutes especially for nursing and for allied health sciences, both of which conduct degree and diploma programmes. For instance, since the College of Nursing is tied to the adjacent teaching hospital, resources are oftentimes split disproportionately between the two institutions (KPI, Nursing college representative, male, 24th November 2021). On the other hand, private sector institutes cited no such deficit but the high fee structures can deter youth from considering taking up these opportunities. The status quo begs the question whether more private-public partnerships to improve the teaching and training of allied health services in Sri Lanka is necessary to not only address the domestic shortage of nurses but also to increase capacities and infrastructure within the existing state-operated institutions.

Overall however, this also raises the question of whether Sri Lanka's public sector can indeed afford to lose its skilled workers to migration overseas. A comparison of Sri Lanka against leading COD for health workers point to the possible strains the migration of trained health workers can place on the domestic market.

11 All medical officers in curative, administrative and preventive services including specialists and interns.
12 Includes regional and consultant dental surgeons.
13 Excludes Supervising Public Health Inspectors
14 According to the Annual Report (2019) of the Family Health Bureau, a Public Health Nursing Sister (PHNS) is responsible for supervising public health midwives belonging to the MOH.
15 World Health Organization. Global Health Workforce Statistics . Retrieved from https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=LK
16 Interview with a senior administrator of the MOH, 28th January, 2022

Table 7 Number of medical staff per 1,000 persons

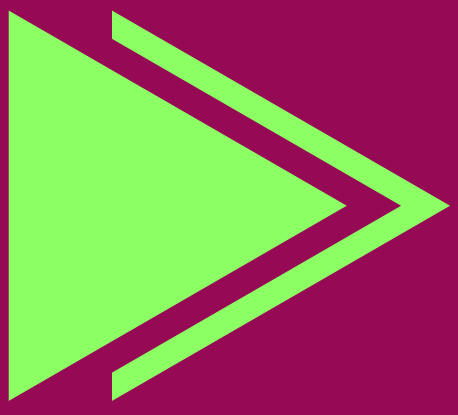
	2016		2017		2018	
	Physicians	Nurses and Midwives	Physicians	Nurses and Midwives	Physicians	Nurses and Midwives
Australia	3.6	12.4	3.7	12.5	-	-
Japan	2.4	12	-	-	-	12.1
Oman	1.9	4.4	1.9	4.3	2	4.2
United Kingdom	2.7	8.3	2.8	8.2	2.8	8.2
United States	2.6	-	2.6	14.6	-	-
Sri Lanka	0.9	2	0.9	2	1	2.2

Source: World Health Organization's Global Health Workforce Statistics

In comparison to these main CODs, Sri Lanka is just below the WHO's recommended number of medical staff per 1,000 people[17]. Furthermore, Sri Lanka has almost reached the minimum density threshold set by the WHO (34.5 skilled health workers per 10,000 population) with 33 health professionals per 10,000 population (Rajapaksa, De Silva, Abeykoon, Somatunga et al, 2021). This increment however, has been driven mostly by Medical Officers, nurses and dental surgeons, rather than other health worker categories (Rajapaksa, De Silva, Abeykoon, Somatunga et al, 2021), yet again highlighting the implications of certain sub-sectors that are resource-poor. But this estimate also falls short when compared against the WHO's newer Sustainable Development Goals threshold of 4.45 skilled personnel per 1000 population (WHO, 2016). As indicated previously, while the MOH works towards bridging these shortages by gradually increasing the number of those trained, there continues to be demand from these CODs for migrant labour to maintain their above-average standards. Such migrant labour tends to derive from countries like Sri Lanka which heavily invest to maintain minimum standards of health.

Considering that public investments are channeled towards the training of health workers in Sri Lanka –medicine remains the costliest degree programme offered by the public university system (Gunaruwan, Samarasekera and Gamage, 2016) - a valid question to raise is who ultimately benefits from these long-term investments. Reducing the negative impact on origin countries has already been raised by both the ILO (2019) and the WHO (2010) in their respective policy guidelines to ensure that the origin countries' labour markets are not severely affected by such an exodus of workers. These reasons make it imperative that a COO like Sri Lanka work towards balancing the demand for trained workforce in the domestic market against the benefits that could be reaped through the migration of health workers overseas. To do so however, a clearer idea of what factors shape the decisions of such migrant workers require more in-depth understanding.

17 World Health Organization. Global Health Workforce Statistics. Retrieved from https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=LK



4 Decent Work Deficits and the Intention to Migrate

This chapter discusses the overall experience of migrant workers overseas as well as the decent work deficits in Sri Lanka that may shape their decision to migrate. It is important to note these deficits in order to draw up a comprehensive framework which benefits domestic and migrant workers alike.

4.1. Migrant workers' experiences of decent work – an overview

Multiple studies indicate that there are generally economic, institutional, and social factors that both "push" and "pull" individuals to migrate (Castro-Palaganas, Spitzer, Kabamalan, et al, 2017; Oda, Tsujita and Rajan, 2018). Underfunding of the health system, underemployment, social costs and concerns about security are some of the common characteristics noted. Reasons that make working overseas appealing for health workers include opportunities for career advancement, the ability to practice to full scope, a better quality of life, increased earning, and professional growth and enhancement (Castro-Palaganas et al., 2017; de Silva Samarasekara, Rodrigo et al, 2014).

There also exists a gap between perceived benefits and the actual work experiences of these migrant health workers. Described as the "U-Curve theory" (Tu and Ehiobuche, 2011), some argue that migrants begin their first year of migration with feelings of excitement, often followed by a period of frustration due to the challenge of coping with the new culture, norms, and language in daily life. Adaptation is therefore gradual but will eventually lead to a sense of calm and belonging within their new environment. Despite feeling settled, many studies show that migrants suffer from increased levels of anxiety, stress, and depression the longer they live in their host country (Schilgen, Nienhaus, Handtke et al., 2017). An analysis of migrant and minority nurses reported the presence of job stress, burnout, job dissatisfaction, discrimination, racism, lack of employment opportunities, poor career progression, poor learning environments, unknown norms and behavioural patterns, and limited setting-specific knowledge (Schilgen, Nienhaus, Handtke et al., 2017) as some of the major setbacks experienced. Another study looking into migrant nurses in Norway found that differences in language were the main stressor as it impedes team collaboration as well as a working nurse-client relationship (Nortvedt, Lohne and Dahl, 2019).

Equally important to note is that health workers employed in their own countries also encounter issues in terms of working conditions, living conditions, wages and inadequate representation. However, existing literature on migrant health workers point to how similar conditions can become further exacerbated as such workers also are placed at the intersection of immigration laws and regulations and therefore, may not have access to the same regulations and labour laws that protect the destination country's domestic labour force. Hence, migrant health workers' ability to demand higher wages, decent work conditions and access to representation can be undermined by their status as temporary migrants in the countries of destination.

Such work experiences however are further compounded in the context of the COVID-19 pandemic. A study from Israel found that migrant care workers reported higher levels of mental health risk during the COVID-19 lockdown. These elevated levels of mental distress were attributed to harassment, discrimination and the burden of feeling responsible for their employer's home and safety while simultaneously worrying about the health and safety of their family "at home" (Attal, Lurie and Neumark, 2020). Similar findings were noted in Singapore where burnout – defined as emotional exhaustion, depersonalisation, and feelings of reduced personal accomplishment

- was experienced at high levels by every level of the health workforce during the pandemic. However, ethnicity and education levels were significantly associated with different experiences of burnout (Tan, Kanneganti, Lim, Tan, Chua et al, 2020).

A key concern in migrant health worker literature is the influence of gender. Thirty years ago, medical officers were the main migrant group, but migrant nurses have now become more numerous. Due to systematic disadvantage and sex discrimination, medical officers are more likely to be male and the nurses female. The shift in the main migrant group has resulted in international migration assuming a gendered structure (Connell and Stilwell, 2006). This has garnered less conversation despite multiple studies having shown that gender has an impact on the levels of stress, anxiety and burnout among migrant health workers. One study explicitly states that in relation to anxiety and depression, gendered differences are documented across cultures. Explanations of this difference point to sexist discrimination and variations in sense of duty of care. Women who experience frequent sexism exhibit greater numbers of depressive symptoms. Some studies indicate that sex discrimination can account for almost half of the variance in depressive symptoms.

In addition to sex discrimination, due to existing gendered expectations within many cultures, women are placed at greater personal risk due to a higher moral obligation to care (Attal, Lurie, and Neumark, 2020). Sex discrimination and moral obligation to care can interact with an often higher likelihood of work-family role conflict which has shown to lead to long work hours and increased fears for the health and safety of loved ones (Tan, Kanneganti, Lim, Tan, Chua et al, 2020). Within the context of migrant health workers, depression resulting from gendered differences compounds with the already difficult and depression-inducing conditions of being a migrant health worker. It has also been noted that these difficulties associated with female migrant health workers are only heightened in the context of the pandemic (Tan, Kanneganti, Lim, Tan and Chua et al, 2020).

Despite its importance, there are indications that migrant health workers do not always return to their home countries. A study in Botswana argue that "social" reasons are fundamental in explaining why workers return. These include homesickness, family and having accomplished economic and/or professional goals. This study, in corroboration with other studies, suggest that often barring individuals from fulfilling their desire to return is the presence of political instability, high crime rates and the shame of not achieving their migration goals (Motlhatlhedi and Nkomazana, 2018).

Another serious consideration is complications and difficulties with reintegration. Very few studies tackle this concern in-depth. In the case of Botswana, the ease with which an individual can reintegrate into the Botswana health system depends on whether they were joining the private or public health sector. Those entering the private health sector often had jobs lined up for them whereas those who chose to work in the public health system faced greater difficulty in re-entering the sector – a finding that was confirmed in a few instances in Sri Lanka, where young Medical Officers struggled to re-enter the public sector as they had fallen foul of its administrative regulations. Subsequently, there is a call to increase connectedness with one's home country, advocate for institutions to facilitate links between migrants and source country institutions and increase the presence of professional and personal development opportunities to increase migrants' desire to return (Motlhatlhedi, Nkomazana, 2018).

These findings offer some perspective to how migrant health workers' decisions to migrate and return are shaped and how their work and lived experiences may be further shaped by their intersecting identities. Grounded on these findings, the next sections in this chapter, focus on the main findings from this research with specific attention being paid to factors influencing the migration decision, perceptions or lived experiences of working conditions overseas and in Sri Lanka and the possibilities of return.

4.2. Intentions to migrate

Despite the identification of factors that underpin migration decisions, among health workers in Sri Lanka, no single reason was found to define the decision to migrate. While some outliers exist, in general, a complex set of reasons that cut across personal, professional and external factors shape the migration decision-making process. While there are some common characteristics, these can vary in importance on the basis of the skills

level and the professional recognition accorded to the workers. These are discussed in detail below using the decent work indicators, pointing to institutional, macro as well as individual level reasons stemming from work experiences in Sri Lanka's public health sector.

4.2.1. Employment opportunities, adequate earnings and productive work

Given that the health cadre in Sri Lanka is mostly concentrated in the public sector, health workers are able to find employment opportunities in the sector quite comfortably. Medical officers and nurses graduating from state-operated universities and nursing colleges may experience delays in securing an appointment, however, this does not dissuade young professionals to opt out of the sector. As indicated previously, for professions such as nursing, there remains a shortage of trained professionals and therefore, the young graduates are generally assured of a job. Instead, confirming evidence from the literature, a key factor determining decisions to migrate, especially where long-term migration is concerned, is inadequate earnings.

All respondents pointed to the capacity to earn higher incomes in the COD as opposed to in Sri Lanka. This is confirmed by multiple sources of evidence; an analysis of the WHO member countries' available data on public expenditure on health in 2013 confirm the ability of high and upper middle-income countries to compensate their health workers at a much higher rate than the lower middle income and low-income countries (Hernandez-Pena, Poullier and Mosseveld, 2013).

As the interviewed stakeholders and the workers point out, the earning capacity within the sector is limited. The currently enforced salary scales are based on the Public Administration Circular Number 06/2006 – a universally applicable regulation that sets up a common structure for the public sector. However, as has been pointed out by almost all respondents at different skills level, the composition of the salary – when broken down – does not reflect the level of commitment demanded by the sector nor the qualifications and time and resources they have committed towards becoming skilled professionals.

Successive governments have sought to allay some of these concerns by offering non-pecuniary benefits including quotas for admission of children to national-level schools, duty-free permits to import a vehicle of choice and research grants etc. Since most of these benefits are targeted at medical officers, these have led to dissatisfaction among the majority of the health workforce. However, migrant workers who seek work overseas, uses one of these benefits in planning their overseas work stints. Both nurses, paramedical professionals and medical officers apply for no-pay leave which is granted up to a maximum of five years. This enables them to plan their work stints in a more organised manner. Interestingly, this option is also used by workers who wish to migrate permanently, as it guarantees the option of re-entry into the health sector should their migration pathways become less tenable.

Notably, medical officers are keenly aware of being among the highest paid professionals in the public sector. However, concerns were also raised about the pressures to maintain social expectations – to build a house, to send children to good schools and to be seen playing a significantly larger role within their own communities by making higher financial contributions. Hence, the question of earning an adequate income is inextricably linked to the social status attributed to 'doctors' in Sri Lankan society in particular.

> *Even though as doctors we get a higher salary compared to other professionals, our expenses are also high. Since we are both [husband and wife] working, we need a servant, need two vehicles, otherwise we cannot do on call and people also expect a lot from us. Even for charity work, they expect more contribution from us, as we are doctors (Returned migrant worker – doctor, male, 15 November 2021)*

Medical officers therefore, are not immune to the demands to live up to social expectations and the pressures to 'perform' a specific role in their community.

Inadequate earnings were cited as a major concern among other categories as well. Placed within lower professional tiers and lacking the necessary academic qualifications at the degree level, nurses and para-medical professionals were found to struggle, at times, to meet their expenses. Their experiences are further complicated when they are stationed in commutable, but rather long distances from their home. Given the nature of their work (i.e. shift basis), the lack of a well-developed transport infrastructure makes it imperative that such workers have access to a private vehicle. These are viewed as additional costs.

Until a recent shift in policy, as a general rule, public sector employees were mostly disallowed from assuming work in another sub-sector as this would be a conflict of interest. As discussed earlier, health workers were the exception: they had been allowed the option to "moonlight" in the private sector for decades and thus, earn an additional, higher income.

The introduction of this exception was instituted partly as a means to support the emergent private sector which continues to suffer from acute labour shortages (the reasons why health workers prefer to join and continue to work in the public as opposed to the private sector are discussed in the next section). By allowing health workers to thus work in parallel health systems, the Government has provided somewhat of a free reign as maximum ceilings on payable fees are not strictly adhered to nor regulated.

> *If you look at Sri Lankan labour law, it restricts us working in 2 organizations simultaneously. But what happens in the health sector is, mainly because of the skill shortage, if you are a government employee, during your time, you can practice in any of the private hospitals. This is the only industry which has an arrangement like that. There is no contract or anything. If I am a government nurse, in my off hours, I can decide which private hospital I am going to work today and practice. So, the government understood that there is a major shortage [in the private sector] and made arrangements for this. But there is no Act or anything. If you look at private hospitals, they depend heavily on locum because of this reason (Senior administrative officer - private hospital chain, male, 03 December 2021)*

As with many other benefits, those benefiting the most from this exception is the medical officers; many of the male respondents maintained their own private practice or worked in a private-sector hospital. Another group who straddle the state and private sectors are the paramedical professionals such as radiographers, pharmacists and physiotherapists.

Workers also benefit from being paid overtime for additional hours of work. Even though ceilings have been placed on the total number of hours each category of worker can seek compensation for,

workers tend to use this option in order to supplement their income as well.

The question of inadequate earnings however become further exacerbated when the macro-level economic conditions are in a rapid decline. As indicated previously, data collection coincided with a sharp decline in economic growth in Sri Lanka, with inflation high and the cost-of-living indicators pointing to the importance of a stable and adequate income to meet basic needs. This was consistently brought up as an issue, as the workers struggle to juggle the increasing

expenses against, what they all experience to be, lower than average incomes for employment at a high-risk, high demanding sector. Medical officers in particular tend to compare their incomes against the earning capacity of their (non-medical) friends and former schoolmates working in the private sector.

Even though inadequate incomes were cited as a strong reason, there is near-universal agreement among the respondents that working in Sri Lanka's health sector renders higher job satisfaction. This was strongly evident among workers who have made a transition to a more permanent basis in other countries and was earning a much higher income. Interestingly, this is despite or because of the high volume of patients, the sector is able to treat on a daily basis. A strong sense of being able to help people from lower socio-economic backgrounds and being able to 'do good' was cited as a key strength in being employed in Sri Lanka. This is also despite the common acknowledgement that the public sector operates on limited resources which may further exacerbate the pressures placed on the health cadre to function in difficult working environments. Ironically, the limited resources and the high volume of patients being treated can yield a higher sense of job satisfaction.

> *I always say that in Sri Lanka, we practice humanitarian medicine because it really is, when you look at it from the outset. We treat about 400 patients a day, at times each of us sees over 100 patients a day in the OPD [Outpatient Department] perhaps and we carry out 14-hour shifts. And there is this tendency I think that we are not necessarily looking at only the sickness but at times, it is about something more, offering advice on general life, their lifestyles, behaviour patterns. It is more than medicine in some instances, I feel we are also helping them out, in a sense (In-service worker, Australia, male, 29 October 2021).*

The high degree of job satisfaction could also be because working in the sector requires very specific skills and knowledge. This leads to productive labour as there is limited opportunities for under-employment or brain waste. But as has been noted elsewhere, the workers' perception of whether their work is valued by the employer differs widely, especially among the lower skilled categories of workers including nurses and paramedical cadres.

4.2.2. Stability, security of work and social security

As a leading employer, Sri Lanka's public sector offers relatively strong coverage in terms of access to social protection schemes – from which health workers also benefit. The wages and pensions schemes in place constitute a major expenditure of the GoSL's revenue, accounting on average, for about 45 per cent of government revenue (Central Bank of Sri Lanka, 2019). Employees can further contribute towards a widows' widowers' and orphans pension fund as well as make use of access to low-interest credit facilities and access to leave – the latter of primary importance to ensure a return to the sector for migrant workers. Attrition rates within the public sector therefore, is quite low, compared to the private sector. Despite relatively lower wages offered by the public sector, the long-term stability and financial security offered by the public sector and the perceived social status linked to being a government official have made it a far more appealing and attractive employer as opposed to the private sector.

For women, the public sector also offers more benefits in terms of extended maternity leave, more equal pay compared to the private sector and the opportunity to rise up the career ladder on the basis of one's qualifications and tenure – reasons that potentially result in women queuing for the limited opportunities available in the public sector (Solotaroff, Joseph, and Kuriakose, 2017). This degree of stability and the social security offered makes the health sector jobs highly sought-after. The recent extension of the retirement age to 63 years for all medical officers (Ministry of Health Nutrition and Indigenous Medicine, 2021) and the added benefits that are offered to the health sector help ensure that health workers do not give up these permanent positions.

But the same level of protections and benefits are not available to all health sector workers. Minor staff in general are side-lined and the increasing casualisation of work for the lower-skilled work categories have been cited as a troubling development. Similarly, those occupying the lowest rung of the sector are the caregivers who tend to be positioned within the private sector which is yet to be regulated. Outside of the formal setup and lacking recognition, their access to social protection is not well known.

4.2.3. Decent working time

Job satisfaction and the degree of security offered alone however cannot offset the pressures of working in the sector. As has been noted previously, globally, the health sector places demands on workers' time. While the COVID-19 pandemic has imposed unprecedented amounts of pressure on the health workers, during less intensive periods, in-service migrant workers pointed out that adequate rest times and work shifts are instituted in order to support these professionals and limit burnout. In Sri Lanka too, work shifts, on-call days and a minimum and maximum duration of work hours are drawn from the Establishments Code (Ministry of Public Administration, Home Affairs, Provincial Council and Local Governments, n.d.) and from the subsequent circulars issued by the Ministry of Health (Society for Health Research and Innovation, n.d). However, in comparison to the rest of the civil administration, the health sector, as an essential service, must work around the clock and thus, tend to work much longer hours than other sub-sectors in the government. This is further compounded when labour shortages continue to persist.

The workers tend to clock in overtime as a means to supplement their basic wages which in turn, is also regulated by the relevant government circulars issued in this regard and can vary on the basis of the category of worker[1]. This is considered an important financial coping strategy, especially among the lower skilled categories of workers.

However, a key factor driving burnout is the existing labour shortages in some sub-categories of the cadre. For example, shortages among trained nurses force young nurses to clock very long hours. Where labour shortages are acute, especially in hospitals that are outside of the main cities, some workers are compelled to work regardless of financial compensation.

> *Even if we don't want to do overtime, we have no option but to work. How can we when there are not enough nurses? The wards can't function, the doctors can't do our jobs, nobody else can. So we have to work whether we like it or not. Sometimes, taking leave to sit for exams or just a day off is difficult to negotiate and no, not all those hours can be considered as OT [overtime] because we work beyond the stipulated ceilings (Aspiring migrant worker, nurse, female, 26 November 2021).*
>
> *There are acute shortages in some hospitals among minor staff. I won't deny that they use OT as a way to compensate their very meagre earnings but the level of stress is extremely high among these people because whether they want to or not, some are forced to work very long hours…I'm not surprised that people scold these attendants and say they are not kind and nice. How can we expect them to be, when they have been working two shifts or more without any proper break or rest? (Trade union representative, male, 27 November 2021).*

Evidence from Peru suggests that health workers who experience higher levels of burnout, have a higher likelihood to migrate (Anduaga-Beramendi, Beas, Maticorena-Quevedo and Mayta-Tristán, 2019). The easing of such undue pressure and maintenance of decent working hours was a key difference noted by in-service migrant workers. Few of the workers had experienced burnout once they had assumed work responsibilities overseas. There were clear indications that the number of work hours must be strictly adhered to and that rest days were strictly monitored. The recognition that health workers must have clear rest hours as longer working hours reduces their attention to detail was cited as a reason for such strict adherence.

1 For example, General Circular No. 01-11-2020 stipulates the extension of overtime payments and other allowances to specific categories in the health sector.

> *But in UK, as there are a few doctors per unit, you have a break between on-calls. Here in the UK, there is a circular stating the amount of work a junior doctor should cover. Nobody can make them work more than that. Here they give priority to patient safety, so, if the doctor is exhausted, it affects patient safety, that's the law. In Sri Lanka also, working hours are similar to UK, but I do not know if there are standards and whether they follow these standards (In-service, doctor – United Kingdom, female, 10 November 2021)*
>
> *Well, we are on call although our work times are from 8.30 to 5 PM. The Lab accepts specimen till 8.30 PM and over weekends, we have to be on-call for any emergencies. But I mean this is nothing compared to what I did back in Sri Lanka where it was ten times more work than what I do here. I mean I didn't complain though because there was that satisfaction that came with working, so I have no complaints in that regard (In-service – consultant, Australia, female, 12 November 2021)*

The income inadequacy can also have a cascading impact on the pressures the workers place on themselves. For example, medical officers as well as other categories of health workers maintain very long hours if they also engage in a private practice. These hours generally begin before the start of their official working hours at 8.30 AM and extend the day's work hours by at least another 4-5 hours in the evening. The general 36 to 40-hour week thus becomes extended to at least 60 hours or more per work week.

Migrant workers on the other hand, have the choice to work a few longer hours or forego additional work time, altogether. For example, in countries like Romania, Singapore and Israel, caregivers are allowed to work on a freelance basis on their rest day but the respondents choose not to, because they are adequately compensated for the 40-50 hours of work they record each week.

4.2.4. Combining work, family and personal life

The pressures placed on the workers as a result of long working hours and inadequate income, leads to serious concerns about the possibility to maintain a healthy work-life balance. This has been raised as a major concern among nurses in Sri Lanka (Dayananda and Samarakoon, 2019).

A key finding of this study has been the inversion of long-held perceptions that working in the labour market in a developed country makes work-life balance far more challenging. Most of the respondents - those who have returned as well as those in-service - cited the ability to spend time with children and family in general, once they had migrated overseas.

> *We did not have issues in the income as my husband did private practice. But it was also another reason for coming abroad. Because he had to work late. So, we did not have time to spend together, or visit our parents or go on trips with friends. But we did not have a choice, because earning is also necessary. Honestly I feel like, it is only now that we are here, we are able to enjoy something resembling a family life [laughs] (In-service, physiotherapist, female, 31 October 2021)*
>
> *Doctors are paid well [overseas]. If we want to earn a little more, there is something similar to private practice there. It is really flexible though; each doctor can book a certain time period on certain days and you get paid hourly. We can do that outside of work. In Sri Lanka, doing private practice is really hard, you work from 4pm to 10pm or so. So, in UK, it provides more work life balance (Aspiring migrant worker, female, 15 November 2021)*

Taking up hobbies, the opportunity to pursue further studies or travel were some of the options for which rest time was allocated. The workers were also able to negotiate their time and return to Sri Lanka to visit family and friends - at times annually - or for those working in Singapore or the GCC, twice or several times each year.

> *My friends who are still working in the hospitals in Sri Lanka, they joke saying that I get to see my parents more often than they do, because they are posted in outstation posts and rarely get time off to see their parents (In-service – doctor, Singapore, male, 16 November 2021).*
>
> *I visit Sri Lanka, every 8 weeks. So, I do not feel like I am missing time with my family too, even my family does not feel that way because I get to visit them quite often (In-service, medical logistician, Mali, 11 December 2021).*

For migrant workers this was also an important way to maintain a healthy work-life balance as leave could be planned in advance and a longer break could be taken to visit Sri Lanka. An inter-connected determinant shaping the decision-making of health professionals is family commitments. Workers at times return prematurely or opt out from staying for a longer period with the overseas employer because of caregiving responsibilities. This was commonly cited as a reason by both men and women. While the presence of siblings in Sri Lanka can moderate out the pressures placed on these workers to a large extent, at times, the intention to stay on overseas or return and rejoin the sector are mostly informed by ageing parents. This also points to the emphasis workers place on meeting family obligations and the need to be close to parents to ensure their wellbeing.

In contrast to Sri Lanka, working overseas also comes with the added benefit of being able to migrate as a family. Among migrant workers securing work for short-term stints (i.e. 2-5 years in duration), the decision to take the family abroad is made on the basis of the presence of school-aged children, the potential disruptions to their schooling and the quality of education offered in the COD. However, it is not uncommon for male migrant workers at all skills levels to leave their families behind even when the opportunity to migrate as a family is offered.

For female workers who migrate, some of the health systems overseas offer flexibility which allows for childcare to be prioritised. Importantly, the number of working hours is thereafter increased or re-negotiated so that a smoother transition to full-time work can be secured.

> *In the UK, working fulltime includes 37.5 hours per week. I work for 32 hours. When my kids were in primary school, I worked from 9 to 3.30. Then when kids started secondary school, I increased my working hours. Here, we get to work flexible hours as they give priority for childcare. In Sri Lanka, [there is] no flexibility like that. If there were some flexibilities like that, many people will find it easy to work (In-service, paramedical professional, female, 15 November 2021).*

A key concern driving health workers' decision to migrate is children's education and the objective to ensure a financially more stable future for them.

> *[The] main reason is our children's future, we kind of had our time but what can our children do here in this country? And when you think of the salary also, it is barely enough to manage everything. I have two kids; one is in grade 3 and the youngest is still in preschool. We are really unsure about the country's future and how it will affect our children. So, I planned to go to Oman (Aspiring migrant worker – Medical officer, male, 29 November 2021).*

As mentioned earlier, access to top-tier government-run schools have been enabled for medical officers, through a quota system – another privilege afforded only to the medical professionals in the health sector. However, these allocations are limited and competition is high. There were clear instances where medical officers had struggled to secure admission to "good" schools for their children. In the absence of a quota system, fears were also raised by other groups of workers of the inability to access public schools at all and the possibility that fee-paying private schools would be the alternative option.

Access to schools is further complicated by the quality of the education offered in local schools. Concerns that children are overwhelmed by the Sri Lankan examination-driven education system and the inability to offer support because of the parents' busy schedules further heighten fears about the children's futures. These workers also echo emerging concerns about accessing tertiary education through the private sector and the rising costs of securing a degree, either locally or by studying overseas.

> *...had we been in Sri Lanka, would we have been able to afford the lives our children have now? I mean could we have been able to afford to send them abroad to study? These would have been just dreams because cost wise, we cannot even imagine spending so much for the kids as international students. Not on our income levels in Sri Lanka (In-service, former doctor retraining in Canada, female, 28 October 2021).*

For workers in Sri Lanka's health sector, in the face of having to balance work and family lives, they increasingly rely on elderly parents or where affordable, on domestic workers for childcare. Where both spouses are working in the health sector, the demands placed on the family were considered too high.

> *Luckily for me, my husband is not in the medical profession. ...I know of a family where one parent is posted in Kalpitiya and the other is in Tangalle in the deep south. And the kids, guess who is looking after the kids? They are with the servants and the grandparents in Colombo because that is where they school. If you work in a faraway place, it is not convenient at all. It is not like you can travel back and forth and then manage the kids and the household all alone as well (In-service, consultant in the UK, female, 28 October 2021).*
>
> *My idea is not to get married to a doctor. The reason for that is being busy; as a doctor I will definitely be busy. So, if my partner is also a doctor, we will not have a family life. When I saw doctors also, I kind of felt that. So, I always thought that I would not marry a doctor (Respondent 1, male, Focus group discussion, medical undergraduates, 02 December 2021)*

Work-life balance thus forms a core factor that health workers take into consideration. It is not surprising therefore, that multiple layers of eldercare and childcare concerns as well as the future of children's education coalesce. In the face of limited space allowed to maintain a satisfactory and healthy work-life balance, these professionals thus seek out comparatively higher standards of living that also promote flexibility, regardless of the demands the sector places on all health workers.

4.2.5. Equal opportunity and treatment in employment

> *There is [an] obvious hierarchy in our health system. More recognition is given to the doctors. That is alright but then other health professionals also should receive similar recognition accordingly. That should be started from the top level to the bottom. If the ministry is giving that recognition to the nurses, then automatically others will also do the same (Key stakeholder – nurses, female, 09 December 2021)*

The public health sector was commonly cited as embodying an institutional structure that is hierarchical and as one that privileges the medical officers over all other careers in the health sector. This forms the basis for unequal treatment in employment, especially in terms of placing certain categories outside of administrative roles, limiting their career paths and the space to practice their profession to the fullest.

Chief among these shortcomings is the presence of medical officers in administration, resulting in the marginalisation of all other professions in administrative and therefore, decision-making roles. The frustrations for many of the non-medical professions thus stems from the inability

of the medical officers/administrators to fully grasp the needs of the other professions. As has been pointed out, paramedical streams and the nursing streams are led by medical officers as opposed to senior professionals in the respective professions. The lack of recognition within the policymaking entity – i.e. the Ministry of Health – and regulatory entities such as the Sri Lanka Medical Council are viewed as detrimental to the career progression and due recognition being accorded to non-medical professions in the public sector.

> *A friend of mine left the government and joined [name of leading private hospital chain]. He started off at a usual technician level in the laboratory but the hospital realised his potential and before long, he was heading their expanding laboratory section. He would never have been able to achieve this in the government because there is no room for him to be promoted to such a high rank! (In-service migrant worker, male, United Kingdom, 29 November 2021)*

Hence, this concern is also seen as specific to the public sector. However, lack of access or being denied an opportunity to contribute in a meaningful manner to the development of policies and strategies that determine the work experiences of these non-medical careers is considered a serious misgiving by those who have migrated overseas. These frustrations are a clear indicator pushing workers to consider permanently exiting the sector in search of better opportunities overseas.

The public health sector also operates within a structure that offers limited opportunities to expand knowledge, cross-learning and career progression and changing careers (Rajapaksa De Silva, Abeykoon, Somatunga, Sathasivam, Perera et al. 2021). The rigidity is set at the time of admission to training programmes. For example, prospective nurses must possess Advanced Level qualifications in the Sciences stream to be eligible to train as a nurse. This already sidelines youth who may have an interest in pursuing a career in nursing. Since the three-year Diploma leads to the offer of employment opportunities in the public sector and registration and recognition as trained nurses, seeking to acquire similar qualifications outside of the training Colleges while possible, may not result in any progressive career advancements. Similarly, gender discrimination can also sideline youth.

> *No one has recommended to increase the recruitment of 5% of male students, up to 15% or so. In Sri Lanka, men are willing to join nursing, not like in other countries and they are needed especially in specialist care wards like for psychiatry. There is a demand. And I do not think a science background is essential to produce a good nurse. We can give the necessary science knowledge to a student and turn him into a really good nurse (Returned migrant worker – nurse, male, 09 December 2021)*

The hierarchy in place that accords the highest work status to medical officers also culminates in other professions receiving only limited opportunities to enhance their knowledge and skills. Frustrations were voiced by those who had left the sector or were planning to do so, about the lack of opportunities available to expand their knowledge and skills.

> *...if we go abroad, there are a lot of courses we can follow and become geriatric nurses, anaesthetic nurses, oncology nurses etc. But in Sri Lanka, we do not have these opportunities yet. There are a lot of well-educated nurses in our sector. But they have gained that knowledge on their own, there is not much support from the government side. Even during lecturers, our tutors inform us that we have to improve our qualifications on our own [as] there is not much support in the system for that (Respondent 1, focus group discussion – trainee nurses, 02 December 2021)*

It was also stressed that while medical officers can earn a specialisation and specific skills training during their learning period, most nurses gain the knowledge equivalent to that of a "general nurse", and any additional specialisation would come in the form of "on the job training" (KPI,

Nursing college representative, female, 9th December 2021). The effect of this is two-fold; it demotivates nurses from pursuing formal specialisation, and it creates a notion that nursing and other allied health services are not as significant as a medical officer's service provision, further intensifying the rift between them.

> *For some of our subjects like Pharmacology, doctors conduct lectures and sometimes they tell us that it is not necessary for us to study that area or gain knowledge that much. It shows that they do not value our profession a lot. But actually, if we follow the degree and become more knowledgeable, it benefits the patients (Respondent 5, female, focus group discussion – trainee nurses, 02 December 2021)*

These frustrations also stem from the recognition that health workers need to upskill and be aware of new technologies. Partly aware of the changing dynamics in the global health systems and partly informed by an individual desire to further their own knowledge, the perceived lack of support to conduct and/or participate in trainings related to one's profession was seen as detrimental.

The clear career pathways enabled for medical officers are viewed therefore, as a privilege afforded to a minority in the public health sector. While a national Continuing Professional Development (CPD) Certificate has been so far introduced to medical officers, the system has only been as yet piloted for other workers (Rajapaksa et al, 2021). But as has been pointed out by Medical Officers employed in overseas health systems, the emphasis placed on further learning is far greater than in Sri Lanka.

> *Here they are more focused on our professional development. When we renew our registration each year, we have to take points for emergency management. And it is compulsory for all the professions. There are programmes for that in the hospital itself. And they allocate 8000 dollars [Australia] for everyone each year for professional development. I can claim it for whatever the trainings I complete. Those are really good. And as I am a trainee doctor yet, they spare one hour every week for a lecture for me to attend to. Another hour is allocated for me to present a case study and all (In-service – doctor in Australia, female, 20 November 2021)*

In Sri Lanka however, even when workers pursue educational or professional qualifications on their own, there was a lack of recognition of these skills from the employer. A common sentiment expressed by the worker categories other than medical officers was that despite maintaining a long tenure and specialising in particular sub-sectors within their professions, their designation remains unchanged. This lack of recognition, despite being intangible, is a serious issue for these professionals as they feel their work is undervalued and not offered due recognition.

> *We only have efficiency bar exams and other than that, none of our qualifications are considered for promotions or anything. Our seniority is the only thing considered; how long I have worked in the filed since 1997. So, in a way gaining all those qualifications serves no purpose, because at the end only seniority matters; how long we have worked in this field, nothing else (In-service worker, radiographer in the UK, male, 31 October 2021).*

Further complicating this process is the uneven access to overseas training opportunities to upskill. The clear pathway identified for medical officers to become consultants is lacking in the case of other professions. A reasonable question is thus raised by workers who have transitioned to work in competing global markets: why does Sri Lanka's health sector not offer similar opportunities for non-medical officer categories? The lack of opportunities for career progression therefore, drive some of these professionals abroad to other health systems where they have been able to expand their skills and thereby, climb the career ladder.

Tied to the lack of opportunities and recognition is also a sense that only Medical Officers are allowed to determine and lead patient care. The notion of a multi-disciplinary approach to patient care where each professional provides technical inputs and advice on patient care and treatment, was found to be gravely lacking in the case of Sri Lanka. The experiences overseas where the basis for patient care is built upon this approach, thus, offers a stark contrast to the experiences in Sri Lanka.

> *It is super specialised. There are so many professions and sub-specialties that respond to every aspect of patient care. There are social care workers, there are dieticians who will look into specific aspects of the wellbeing of the patient and in all honesty, the doctor's job is then more or less about giving medical advice. You don't go to assume those other jobs because there are specialised people to offer that kind of advice (In-service, doctor, Australia, 29 October 2021)*
>
> *In Sri Lanka .... there is a hierarchy. Doctors do not like anyone else passing them with knowledge and skills. Then doctors and nurses do not like it when paramedics come in. But in the UK, no issues like that, and everyone respects other professionals. We can always share our opinions and even the consultants respect that. So, it is really satisfying and easy to work here (In-service, paramedical professional in UK, female, 15 November 2021)*

These further fuels the underlying tensions with medical officers and contributes to a sense of their work being undervalued within the health sector – a fact confirmed in research conducted among Sri Lankan nurses (Aluwihare-Samaranayake, Ogilvie, Cummings, and Gellatly, 2017). While not all experiences are rife with such tensions, the perceived stagnation in the absence of a clear career pathway and the limited ability to practice their skills to the full capacity, make these workers more likely to be less productive at work, thus re-enforcing the notion that they are not competent enough to carry out the tasks assigned to them. In contrast, those employed overseas are able to perform at a high level because such opportunities are enabled through the health systems; as many of these workers pointed out, the quality of the health provided thus improves as the professional cadres are incentivised to absorb new knowledge and acquire the necessary skills.

Another key concern was the lack of space to consider a change in career pathways within the health sector. While opportunities are limited to all professions, the ability for medical officers to straddle or shift towards academia or administration and/or policymaking was considered an exception. This was evident when speaking to medical undergraduates and trainee nurses: the former group pointed to possible avenues for diversification especially where practicing medicine was not a chosen career path whereas, the nurses have very few options /alternatives presented to them.

The multiple career pathways offered in other countries becomes a strong incentive for workers to consider migration on a permanent basis. While medical officers tend to pursue medicine, a few instances where they had retrained for other careers in health were also found. Similar evidence was observed among paramedical professions who, as migrant workers, have been able to upskill, acquire new qualifications and knowledge and assume positions in policy decision-making or move towards academia.

Migration therefore offers multiple options for dissatisfied health professionals. This could be either through employment in a similar capacity but with potential for career progression, complemented with opportunities to acquire new knowledge and skills or secondly, the opportunity to retrain in a new career in health altogether as due credit is provided for the years of experience and basic qualifications they have acquired in Sri Lanka.

Evidence points to the value that workers in general place on dignity of labour. Thus, the challenge for the public health sector lies in striking a sensitive balance in reallocating funding and re-distributing senior management/administrative positions to be more inclusive.

The privileging of certain professional groups to the detriment of others within the sector is also grounded in social recognition granted to professions such as medical officers. Medical officers and specialist medical officers who were working overseas, pointed to the lack of accountability and transparency within Sri Lanka's sector as a major concern. The lack of accountability regarding diagnoses and treatments prescribed, respondents argued, result in minimum standards not being observed in patientcare. As one medical officer succinctly pointed out:

> *Like I said, the sector [in Sri Lanka] is good. But if you ask me which health sector or system is better, let's say where I would want my parents to receive health care for example, I would say undoubtedly Singapore. Like I said before, patient care is at the maximum because it is the right attitude and the service, right? (In-service – medical officer, Singapore, male, 16 November 2021).*

This lack of accountability also then has a knock-on effect as performance-based assessments are not used in the sector. Rather, promotions are based on paper qualifications. This was seen to de-incentivise medical officers from acquiring new knowledge and skills and enhancing patientcare. Hence, stagnation at certain "grades" are viewed as demotivating for medical officers who lack incentives to pursue further knowledge.

An overall impact of these shortcomings is the question of what awaits the workers on their return from working overseas. While overseas employment opportunities are viewed as highly beneficial by migrant workers, the lack of opportunities and space to practice these skills or apply the new knowledge gained frustrates these workers. With the exception of specialist medical officers, all other professions (including medical officers) felt sidelined and under-utilised on their return. This is partly because of the lack of modern technology in Sri Lanka which prevents these returning migrant workers from contributing in a meaningful manner.

On the other hand, it is the lack of an institutional framework to recognise these acquired skills and a process to enable these returning workers to apply them in the appropriate settings. Since many of those who return to Sri Lanka's public health sector would have taken advantage of the 5-year no-pay leave option, they accept that financial incentives or a career promotion would not be a practical expectation. However, given the existing labour shortages in both the public and private sectors and the need to ensure that migration of workers indeed benefits the wellbeing of patients in Sri Lanka, the introduction of a process to share new knowledge and space to practice them, will benefit the health system as a whole.

> *What is really problematic in Sri Lanka is the red tape and the bureaucracy. I don't know how we are gearing up to meet the needs of our public when there is so much red tape like this. How can change happen if there are all these regulations that are so old and make no sense? (Returnee – medical officer, private sector, male, 17 November 2021)*

Another key concern that specifically impacts medical officers was the Ministry-instituted transfer system. Deployment of trained medical officers is determined by a national ranking system and is thus, merit-based. However, the MOH has also instituted a system whereby the officers can seek a transfer within a 4-5 year period, on the basis of seniority (Rajapaksa, de Silva, Abeykoon, Somatunga et al, 2021). As some of the medical undergraduates and young Medical Officers pointed out, a higher-ranked officer can opt to join his/her partner whose national rank and therefore, placement is lower, but not vice versa. Hence, the system is in general considered equitable. But many of the in-service and aspiring migrant workers as well as returned workers remarked on the lack of transparency as a major issue and attributed this to the system becoming open to exploitation and favouritism.

Young medical officers are prepared to assume jobs in sub-urban or remote locations during the initial periods; the high intensity work schedules stipulated during the internship period in particular, are considered part and parcel of the job and are generally viewed as a good

learning experience. However, access to good schools, basic public services and not being within commutable distance of the permanent residence, add pressure on medical officers who return from foreign trainings. This becomes further exacerbated when both partners are in the medical profession. While the transfer system is equipped to allow for couples to choose a single destination and thus, has some flexibility, the longer-term sustainability of serving in these remote locations then becomes cast against family obligations related to children's education and elder and childcare commitments. The implications for women in particular require a more in-depth examination as they may be compelled to set aside their professional aspirations to prioritise their family's wellbeing. But the fact that some professionals are able to influence the transfer system was cited as a serious challenge leading medical officers to consider migrating overseas.

Ironically, in migrating overseas, these professionals are not necessarily based in urban settings or hospitals with higher capacities. The deciding factor is access to good schools and the ability to maintain a good standard of living regardless of the distance to the nearest city. Hence, factors such as the transfer system in operation is not necessarily faulty but the general lack of regional development and the inequitable access to basic services in non-urban settings in Sri Lanka, reduces the ability of these professionals to maintain an acceptable standard of living.

4.2.6. Social dialogue, employers' and workers' representation

The pervading "us" versus "them" perception existing between medical officers and other professions is also evident in worker representation. The public health sector has multiple trade unions and associations[2] that further reflects the division of labour and hierarchy present in the workforce. While collective actions are taken by these respective unions, either individually or as a cluster, union actions are seen as a powerful tool to effect changes that benefit one group over the other.

Both medical officers who are working overseas as well as non-medical officers cite the powerful ways in which the Medical Officers' Unions have prevented the other professions in the health sector from gaining recognition and a foothold in the public health sector. A common example cited by both groups is the union actions adopted to prevent the institutionalising of degree programmes for nursing and other paramedical professions. Such actions were commonly viewed as sacrificing patientcare and the effectiveness of the health system to safeguard the privileges enjoyed by medical officers who constitute only a minority of the health system. Disillusionment with worker representation was thus, a common sentiment expressed.

While the power to influence such changes to national policy is exercised by only a few of the leading unions, there is also dissatisfaction with these same unions for becoming highly politicised and failing to represent the needs of their members. On the other hand, union actions can be stymied where the lack of members and the nature of their role within the health sector affect the impact:

> *GMOA[3] caused most of our problems, that's the true story. As I know, it is they who do not allow us to have a salary scale too. Because everyone in the ministry is a doctor. We had a union but it was not powerful because there aren't many physiotherapists in Sri Lanka. And since physiotherapy is something that has a long-term effect, people do not understand the importance of it. So, even our strikes are not that influential (In-service, physiotherapist, Canada, female, 31 October 2021).*

This also points to the further segmentation of the health workers on the basis of sub-categories such as physiotherapists or minor staff. As one Trade Union representative pointed out, collective

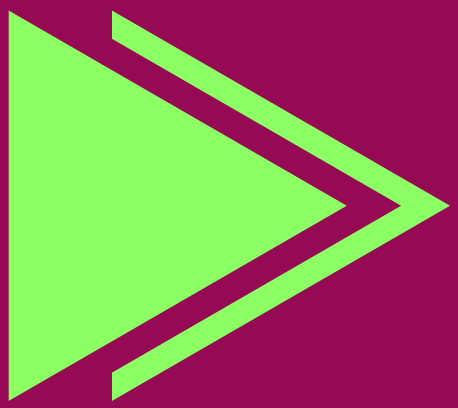
2 The most powerful among these – in in terms of capacity to influence decision-making at a political level - is the Government Medical Officers Association; Other unions representing different health worker categories include the Government Nursing Officers' Association, Sri Lanka Federation for Health Professionals and the Public Services United Nurses Union. In addition, professional associations also operate which focus more on professional growth of their respective categories and include such entities as the Sri Lanka Medical Association and varying specialist Associations including the Sri Lanka College of Cardiology, the College of Surgeons etc.

3 Government Medical Officers Association

action is further weakened when interest-based unions are formed in order to fight for job security for these smaller groups. This further dilutes the ability to advocate on a common agenda of needs as intra-group and inter-group competition is heightened.

Among migrant workers, trade union representation is not considered as important as it was in Sri Lanka. This is despite the fact of weaker job security. However, there is a strong perception that working conditions and commitments by the employer are held in good stead and that in the case of unfair treatment, avenues are open for these workers to pursue redress. Hence, transparency and accountability in terms of human resource management was considered part and parcel of the overseas health systems. Furthermore, the existence of anti-discriminatory laws to protect workers, a redress mechanism to lodge complaints was viewed as important measures that create a good working environment for workers overseas.

In conclusion, gaps in access to decent work and the perceived lack of dignity of labour are powerful reasons underpinning the migration decisions of health professionals. The fact that most of the concerns raised require structural level changes is important to note. But the permeation of socially ascribed status to some jobs in the health sector has resulted in the marginalisation of non-medical officer cadres. The differential treatment in terms of capacity to negotiate, career progression, access to non-pecuniary benefits therefore, further weakens the public sector's ability to retain their trained workforce. As indicated by many of the respondents, these conditions become further compounded when the existing economic conditions deteriorate and the long-term stability of the country, rather than the stability of their own profession, comes into question.



5 Demand for Sri Lankan Workers and Recruitment Modalities

This chapter in particular focuses on the recruitment modalities available to and utilised by health workers who wish to migrate. Given the GoSL's policy position to encourage skilled migration, a key issue highlighted is how recruitment processes including the cost are determined by external factors as well as the individual choices of the aspiring migrant workers. As indicated previously, collected data was analysed and the major findings are presented using the ILO's General principles and operational guidelines for fair recruitment as a framework (2019). Where applicable, reference to the WHO's Code of Practice is also made.

5.1. Migration of health workers from Sri Lanka

As an individual choice, migration for work cannot be prevented. However, a key aspect in translating the idea of migration for work to a reality is shaped by the demand for labour from elsewhere. Estimating the number of health workers who migrate through regular channels is difficult. As pointed out by the SLBFE, most migrant workers prefer to use informal channels to secure work and higher skilled workers may forego registering with the SLBFE in the pre-departure stage. Despite the inability to respond to the open job orders in the past few years, demand for Sri Lankan workers continue to be stable.

Table 8: Number of Vacancies Received and Number of Recruitments 2017 - 2019 (SLBFE)

	2017		2018		2019	
Job	No. of Vacancies received	No. of Recruitments	No. of Vacancies received	No. of Recruitments	No. of Vacancies received	No. of Recruitments
Doctor	5	0	485	0	420	0
Nurse – House[1] - Female	2576	18	3210	29	4533	19
Nurse - Male	420	0	70	10	2	1
Nurse - Female	25	0	195	11	305	0
Assistant Healthcare (Nursing home)	100	0	0	0	150	2
Caregivers (Nursing home)	60	0	165	0	128	3
Pharmacist	25	0	40	0	50	0
Nurse – General Duty	70	1	840	0	3061	5

Source: SLBFE Annual Statistics of Foreign Employment

1 Provides one-on-one patient care outside of the hospital setting (i.e. disabled, critically ill, recovering from a surgery etc.).

The nursing sector presents a rising opportunity for Sri Lanka which has been aptly recognised by private educational institutions. However, there are certain points of concern. Firstly, the preference for degree-holding nurses over nurses with a diploma, has acted as an obstacle when securing work overseas. While there are some private educational institutes which have been permitted by the University Grants Commission to award nursing degrees, uptake is stymied by the high cost and for the public sector nurses, by the lack of adequate time to commit to completing a degree programme, while working. There is also a higher likelihood of students choosing the public nursing schools as those selected receive a student allowance and a placement within the public health sector is guaranteed.

On the other hand, there is also a significant demand for nurses within the domestic health sector as well. According to the Labour Demand Survey of 2017 (Department of Census and Statistics, 2017), nursing professionals are ranked among the top occupations that are in high demand in Sri Lanka and is the only health related profession to be included in the list. Nursing and childcare workers were also ranked among the top ten professions with the most number of vacancies in the formal service sector and also appeared in the list of professions with vacancies that are hardest to fill.

Similarly, the demand for skilled caregivers from overseas labour markets is also on the rise. The challenge remains in streamlining skills acquisition and ensuring that aspiring caregivers receive adequate language competency to carry out their tasks. Key person interviews confirm that the Association for Licensed Foreign Employment Agencies (ALFEA) is presently seeking partnerships with private educational institutions to rollout short-term programmes custom-made to meet the minimum requirements for caregivers.

5.2. An Exploration of Common Corridors

The demand for health workers also originate from particular countries and specific contexts. In the course of data collection, it was apparent that countries such as Australia and the United Kingdom are yet again becoming popular destinations for Medical Officers and nurses, especially those with a view to settle down permanently with their families. In contrast, countries like Singapore and Oman and Israel continue to seek out health workers from Sri Lanka for multiple categories. The dynamics of these potential labour markets are thus examined to provide some context regarding emerging and/or further entrenchment of existing corridors for health workers.

5.2.1. United Kingdom

In the United Kingdom, immigrants make up approximately 14 percent of the employed population but are much more strongly represented in the health workforce, making up more than a third of medical practitioners, pharmacists, and dental practitioners, and over one fifth of nurses[2]. According to the Health Labour Market Analysis (2018), when the annual stock of foreign-trained Sri Lankan medical officers in five English-speaking OECD countries is considered, the UK and Australia are the largest recipients of Sri Lankan medical officers.

In terms of shortages, the ongoing pandemic has pronounced the need for skilled health workers in the UK (Ungoed-Thomas, 2021). In fact, according to the Office for National Statistics (2020), "Human health and social work activities" is now the largest sector and accounts for almost one-third of all vacancies in the UK. In a study conducted by The Health Foundation (2021), a UK based think tank, the nursing sector was identified as facing a significant strain with over 35,000 nursing posts remaining vacant as of February 2021. The study also forecasted that by 2029, England will face a shortfall of 108,000 nurses.

For Sri Lankans however, a clear pathway is not prominent in this corridor. According to the Nursing and Midwifery Council in the UK, only 83 nurses of Sri Lankan nationality were practicing

2 Retrieved from https://www.who.int/hrh/migration/14075_MigrationofHealth_Workers.pdf

in the UK in 2017. It was assumed that others might be working as unregistered nurses or as informal carers (WHO, 2018). A more recent analysis of the nationalities of individuals employed by the NHS indicated that Sri Lanka ranks 11th among hospital doctors but overall, has approximately 1500 workers employed by the NHS in England (Baker, 2021). The UK's points-based immigration system for employers can also act as an obstacle for hiring migrant workers. While the points-based system favours skilled workers, lower-skilled and unskilled workers face significant obstacles when securing work.

5.2.2. Australia

Similar to the UK, while nurses and midwives (334,000) far outnumber the medical practitioners (98,400) and allied health professionals (133,400), Australia is forecasted to face a shortage of over 100,000 nurses by 2025 (Harrington and Jolly, n.d.). Furthermore, in terms of care for the aged, in 2010, the Department of Health and Ageing estimated that the aged care workforce would need to increase between two and three times before 2050, in order to provide care to the growing number of aged care residents (Harrington and Jolly, n.d.). Hence, a shortage of personal and institutional care workers is also expected, presenting a potential opportunity for Sri Lanka.

Sri Lankan professionals have a long-standing history of seeking employment in Australia. A considerable number of Sri Lankan medical officers has secured employment in Australia. In a study conducted in Sri Lanka (De Silva, Liyanage, De Silva, Jayawardana et al, 2013) among all trainees who left Sri Lanka for postgraduate training through the Post Graduate Institute of Medicine, University of Colombo, from April 1980 to June 2009, 11 percent have not returned or have left the country without completing the specified bond period. The majority (53 percent) had migrated to Australia. This is confirmed by a study conducted by Hawthorne (2017) for the WHO, where Sri Lanka was ranked number eight in the top ten source countries for migrant health professionals seeking temporary employment in Australia.

The pathway to becoming a registered health practitioner in Australia is straightforward. International medical graduates applying for general registration need to pass the Australian Medical Council (AMC) examinations, which consists of a multiple choice examination and a clinical examination. While the AMC provides several pathways for registration by the Australian Health Practitioner Regulation Agency (AHPRA), this is the "standard pathway". In a recent study conducted (Yeomans, Sewell, Pigou and Macintyre, 2021), among the top ten residence countries of candidates, Sri Lanka ranked third in the MCQ examination and second in the clinical examination component. However, according to the WHO's Health Labour Market Analysis (2018), a decrease in the flow of Sri Lankan trained medical officers registering to practice medicine in Australia is noted, resulting in only a few being successful at the examination. This may be due to the decrease in the success rate of Sri Lankans passing the clinical component.

5.2.3. Oman

Oman is highly dependent on foreign workers, with most non-Omani health workers seeking employment in the private sector. Sri Lanka has been a source market for Oman in terms of workers for many years. In fact, recent discussions were held by the State Minister of Regional Cooperation with the Minister of Commerce, Industry and Investment Promotion of Oman to enhance bilateral economic ties, which includes exploring the prospect of employing Sri Lankan skilled workers in the health sector in Oman (State Ministry of Regional Cooperation, July 2021). The steady demand for health professionals from Sri Lanka was confirmed in the interviews with returned and aspiring migrant workers who confirmed the presence of medical officers in Oman and the present drive by Oman to recruit up to 100 medical officers through an open interview process. With the prospects of earning much higher wages and the ability to migrate with family members, GCC countries such as Oman can therefore, offer lucrative short-term opportunities to health workers from Sri Lanka.

5.3. Existing regulatory frameworks for migration of workers

Only a few studies have focused on recruitment modalities and the general operations of recruitment agencies in relation to health workers. Of concern is that recruitment agencies exist beyond codes of practice and regulating legislation (Connell and Stilwell, 2006). Subsequently, the use of recruitment can lead to undervalued and stigmatised care work (Yeoh and Huang, 2015).

Unethical recruitment is a rising trend that correlates with the rise of health worker emigration. Unethical recruitment practices can result in exploitation, discrimination, an unfavorable workload, and human rights violations. An example of these human rights violations includes contractualisation, a government system that allows a company or an employer to hire a worker for a temporary period without the security of tenure or benefits (Castro-Palaganas et al., 2017) Similar to contractualisation, cases of migrant nurses in the United Kingdom sometimes involve "adaptation periods," a practice by which nurses undertake periods of training or "adaptation" with the promise of subsequently being paid on a higher nursing pay scale. These periods of training are only meant to last between three and six months but often are drawn out and result in nurses being exploited by overwork and excessive accommodation costs (Connell and Stilwell, 2006).

This system is not unique to the United Kingdom: a study examining the migration of Indian nurses explains two systems that result in similar human rights violations - the bond system and the internship system. The former involves private health facilities financing students' tuition fees "during nurse education in exchange for their commitment to work for that institution for a certain period following graduation" (Oda, Tsujita and Rajan, 2018). Although beneficial for underprivileged students, some hospitals force nurses to hand over their original nursing licenses until they are able to pay a large sum for their right to leave. The internship system involves nurses committing to one year of clinical internship at a private hospital in order to work as a full-staff nurse. It has been reported that these low-paid internships can extend beyond one year and even result in some nurses having to pay to complete their internship period (Oda, Tsujita and Rajan, 2018).

Similarly, a study in Israel found that one major form of recruitment for migrant care workers is the promise of accommodation. Although this form of recruitment is intended to aid in migrant care workers integrating and settling into their new communities, this model often results in employers illegally assigning care workers to rooms within their own assisted-living facilities and nursing homes (Attal, Lurie and Neumark, 2020). Such exploitative situations become further entrenched when workers are bound to employers for immigration status. Governments in the COD can also limit immigration via rigid regulations that forbids the migrants from being accompanied by their dependents and disallowing pathways to permanent residency or citizenship (Yeoh and Huang, 2015).

Due to the lack of regulations and conversation surrounding the recruitment of migrant health workers, there are efforts to centre more ethical forms of recruitment. Ethical international recruitment can and has been defined in many ways. An approach that has been utilised is letters of intent. These letters, although not formal or enforceable, are exchanged between two countries in an effort to discourage unethical forms of recruitment (Connell and Stilwell, 2006). Ultimately, the importance of countries focusing on self-sufficiency, or the importance of producing an adequate national health workforce without the reliance on migration has been stressed. This lofty goal involves improved economic performance, a stable political situation, and a peaceful working environment but ultimately will take a lot of work beyond just the health sector to achieve (Connell and Stilwell, 2006).

A common definition establishes that ethical international recruitment "aims to prevent adverse effects on health systems of the source countries and to protect the rights of the individuals" (Connell and Stilwell, 2006).

While not specifically addressing the health sector, the ILO's General Principles and operational guidelines for fair recruitment and definition of recruitment fees and related costs (ILO, 2019) is a key instrument setting out some of these basic guidelines to be followed by the origin and destination country, the recruitment agent as well as the employer. Similarly, the WHO's Global Code of Practice (2010) specifically encourages employers not to recruit workers from vulnerable countries. For instance, the NHS in the UK draws from the WHO Health Workforce Support and Safeguards List, 2020 (WHO, 2020) that encourages employers not to recruit from vulnerable countries. The most updated list includes countries such as Afghanistan, the Republic of Yemen and South Sudan as well as Nepal, Liberia and Gabon but this code does not apply to private practices nor prevents individuals from applying independently (NHS Employers, 2022). In terms of establishing bi-lateral agreements, the ILO has also developed the Guidance on Bilateral Labour agreements, to ensure that minimum standards are maintained by both parties to the agreement (UN Network on Migration, 2022)

5.4. Regulatory framework governing migration from Sri Lanka

Given the relatively long history of Sri Lanka as an origin country, a regulatory framework has been built to facilitate the migration of workers. The Sri Lanka Bureau of Foreign Employment acts as the regulatory entity to the policymaking arm of the State Ministry of Foreign Employment Promotions and Market Diversification. The SLBFE's role is largely determined by the SLBFE Act No. 1985, which clearly stipulates the roles and responsibilities of the SLBFE and the LFEAs. While the SLBFE's role has helped streamline the facilitation of migration for work, not all its decisions have been held in good stead (International Labour Organization, 2019b).

A key element in relation to recruitment is the question of who bears the cost of migration. Despite the SLBFE Act prohibiting the charging of costs from the migrant, subsequent amendments extended legal provisions to the LFEAs to charge costs from the migrant worker. As the ILO (2020a) has pointed out, the most recent circular issued in August 2019 has set out maximum chargeable amounts. These include expenses related to advertisement, communication, courier as well as multiple taxes. Furthermore, they

> *"...are allowed to charge an amount equal to one month's salary for migrants heading to the Middle East or South Asia, while those heading to Europe and other countries can be charged a maximum equal to two months' salary. Visa endorsement and air tickets can be charged to the migrant as per the actual expense incurred" (p.5).*

A key decision made in 2013 has been equally controversial as this successfully sought to curb women's migration overseas. Studies have pointed to the discriminatory nature of the imposition of the Family Background Report which prevents women with children under the age of five years from migrating overseas for work (ILO, 2018)[3]. Similarly, concerns have been raised about the composition of the Board of Directors of the SLBFE which unfairly favours the LFEAs over the rights of the workers (Helvetas Intercooperation, 2017). More recent advocacy efforts have focused on how best to promote the "employer pays" model among the LFEAs; while the SLBFE has declared this as a way forward, the applicability and practicalities of operationalising this model has been questioned. The SLBFE's role has also come into criticism in terms of responding to the needs of migrant workers during the COVID-19 pandemic – the prevention of migrant workers from returning home, the repatriation of stranded migrant workers and the underlying policy stance that the SLBFE would only support those who had registered with it in the pre-departure phase – have contributed to an erosion of trust.

3 Since this report was concluded, the GoSL eased the FBR regulation to allow women with children between 3-5 years to migrate and also relaxed restrictions placed on the age of the female migrant worker.

5.4.1. Recruitment modalities available to workers

As explained by ILO (2020a), Sri Lanka adopts several types of modalities to facilitate the migration of workers. These include Government to Government (G2G) agreements, employer to employee, employer to agency and finally, agent to agent. Chief among these is the G2G process that has enabled the migration of lower skilled workers to countries in Southeast Asia such as South Korea and caregivers to countries like Israel. In the case of health workers, all these modalities are in operation but at varying degrees.

Employer to employee

As discussed previously, the reasons underpinning a decision to migrate is complex. The use of this modality to secure work is mostly present among higher skilled workers such as paramedical professionals (i.e. radiologists) and the medical officers. While most of the jobs applied to, was in Australia and the United Kingdom, workers also directly applied to vacancies advertised by the Ministry of Health in Oman and the Ministry of Health in Singapore.

What is unique in these instances is the recognition of the qualifications of the medical health professionals. A decision to apply therefore, hinges on the workers meeting the minimum qualifications stipulated by the prospective employer. While these can change over time, the medical officers in particular, are well aware of the need to meet these minimum requirements. This requires investigating the requirements and planning in advance to complete examinations that are offered by the respective Medical Councils.

There have been some notable exceptions. For example, until recently, the graduates of the University of Colombo's Faculty of Medicine could practice in Singapore as its Medical Council recognised the University's MBBS qualification. While this recognition has now been removed[4], it allowed Singapore's MoH to directly recruit young graduates and offer them opportunities to both intern and work within their health system.

> *They [Singapore MoH] invited us to the interviews and said that if we are selected, we could work as a House Officer but it would be on the basis that we first get our degree. So, we all went for the interviews. Myself and my roommates. There were about five of us I think. I mean, we had nothing to lose and they had actually replied [to email inquiries], which we didn't even expect. We had the interview and when the final results came we were asked to share the results sheet certified. And that is how it happened (In-service Medical Officer, Singapore, male, 16 November 2021).*

The same process has been adopted by trained nurses and radiologists to access work in the National Health Services of the UK.

> *The thing with UK was that our diploma is recognized in UK, so I could directly get the registration done. Because until 1975, our course had been conducted under the supervision of the society of radiographers, London. So ... when I applied online, I received direct registration. The content of the course we follow in Sri Lanka and the course they have here are quite the same (In-service worker - radiographer, United Kingdom, male, 31 October 2021).*

For nurses wishing to migrate to the UK for work, ample information is available online through the respective websites. The workers are also incentivised as the costs of resettling in the UK, including the visa costs, are reimbursed once the worker successfully migrates and assumes the new position with the employer.

4 In the course of data collection, multiple stakeholders and in-service migrant workers pointed out that as a destination country's education system produces an adequate and steady number of medical professionals, such schemes are removed

Interestingly, countries in the GCC such as the Ministry of Health of the Kingdom of Oman also work through the same system. The MOH or potential employers such as the Department of Defence advertise these vacant positions. However, there is also a tendency for these employers to work with a LFEA (employer-agent) model in order to facilitate the process of securing Medical Officers.

The respondents interviewed pointed to the ease with which information was accessed via websites and the streamlined process of applying for available jobs while still in Sri Lanka. The employer-employee modality therefore functions in a manner that effectively removes the role of an intermediary. However, utilising this option hinges on the workers taking the necessary pre-application steps of ensuring that their qualifications are on par of what is required by the potential employer.

Agent to Agent

The agent-to-agent model is mostly prevalent in the recruitment of lower-skilled categories. Nursing assistants or aides, as well as caregivers are thus recruited by the LFEA representatives in Sri Lanka who supply such workers to the agency in the COD. In the case of Singapore, trained nurses employed in the public sector in Sri Lanka, are sent to work as nursing aides or assistants by several LFEAs that specialise in the recruitment of health workers. Where medical officers can upgrade their qualifications by facing the relevant examinations, nurses working in Sri Lanka's public health sector opt to work in a lower-skilled category of work for higher wages in Singapore. They forego the opportunity to upgrade their qualifications, as the tenure of stay is limited to two (02) years or 27 months. Such nurses have the option of either working in a hospital or within a nursing care home facility for the stipulated period. In such instances, the cost of recruitment, stipulated leave and the choice of the workplace are all determined by the respective LFEAs.

> *For Singapore, they recruit our government registered nurses as assistant nurses. They look for the certificate issued by the Ministry of Health. But to become a nurse in Singapore, you have to do the exams there. Like I said, we can send our nurses as assistant nurses only. Basic salary is 850 USD, with food and accommodation provided. They have to work 8 hours. Contract is for two (2) years. It's my agent who looks for nursing homes and hospitals. Good English knowledge is necessary (LFEA representative specialising in nursing, female, 03 November 2021)*

The migration of caregivers to Israel and elsewhere in the GCC is also largely facilitated in a similar fashion. While working and living conditions are already stipulated, the cost of recruitment in such instances are generally passed on to the worker, rather than being absorbed by the agent in the COD or the potential employer.

Government to Government agreements

The G2G agreements are the least utilised in the case of health workers. The ILO (2020a) notes that a pilot programme was established between Israel and GoSL to facilitate the migration of 50 caregivers. The detailed description of this pilot programme initiated in 2016 points to the transparency of the process including the basic costs that would have to be borne by the potential employees and the power of the Population Authority of Israel (PIBA) to determine "randomly" which workers are selected from a screened pool of 100 applicants (SLBFE, 2016). In February 2020, a Memorandum of Understanding (MoU) was signed between the Government of Israel and Sri Lanka for the "Temporary employment of Sri Lankan workers in specific labour market sectors in Israel". As indicated by the GoSL, the aim is:

> *...to ensure a legal, fair and transparent recruitment process for Sri Lankans to work in Israel as Caregivers. The agreement will require both countries to work together to improve the process of selection, recruitment, placement, arrival and employment of Sri Lankan Caregivers as well as their return to Sri Lanka after the temporary employment and to promote the protection of the labour rights of Sri Lankan Caregivers in Israel. Through this agreement, more job opportunities will be available for Sri Lankans to work as Caregivers in Israel at a drastically reduced initial cost (Sri Lanka Embassy in Israel, 2020).*

Regardless of this commitment however, the information derived from aspiring caregivers to Israel and the LFEAs point to high recruitment costs that must be borne by the migrant worker.

Importantly, the demand for health workers from countries such as the UK is apparently being taken up as a potential avenue to establish a government-government agreement. Information gathered during the course of two KPIs pointed to the GoSL exploring the establishment of an MoU with the NHS-UK to facilitate the migration of nurses[5]. Since this is in the preliminary stages and requires the approval of the Cabinet of Ministers, the introduction of such a scheme would inevitably have far-reaching effects on the nursing cadre in Sri Lanka. How far such a process would displace the opportunities nurses are currently tapping into by adopting the employer-employee modality will need to be observed.

5.5. Mutual recognition of skills

A key aspect underscored in the ethical recruitment guidelines is the due recognition of skills and qualifications by the respective governments and/or the employers. However, as has been already pointed out, within the health sector, there is uneven recognition as health systems in competing labour markets tend to prefer its own systems of qualifications rather than the universal application of a standardised skills recognition.

The onus of meeting these differential requirements falls on the aspiring migrant worker, regardless of their level of skills. Medical officers in general, must first pass the qualifying examinations held by the respective Medical Councils. While considered highly competitive, preparation for such examinations require both time and financial resources. Among those interviewed, Medical Officers tend to plan two-three years in advance at times to meet these basic requirements. Many tend to study while they are stationed in outstation locations, as examinations are paper-based as well as in the form of a viva. Furthermore, the Medical Officers may also need to travel overseas – sometimes to neighbouring India as the examinations are not offered in Sri Lanka, and at times to the COD in order to meet some of these requirements.

The investment in terms of money and time is generally informed by the aspirations of the migrant worker. Medical Officers who wish to migrate to countries like Australia, the UK and Canada, make these investments with a view of a long-term future and plans to permanently settle in these countries.

A similar trend was noted among paramedical professionals including therapists and radiologists. A major shortcoming is the lack of the basic qualification of a bachelor's degree. Hence, additional qualifications must be first secured to meet the minimum qualification standards. The nursing cadre in contrast, is responding to this "gap" in their educational qualifications. Evidence from interviews with the FGDs points to how nurses seek out to "top-up" their qualifications by enrolling in the limited number of UGC-approved degree programmes on offer in Sri Lanka[6]. The fact that nurses are investing financially in degree programmes on offer by private educational institutions point to the importance they have placed on academic qualifications. The FGD conducted among nursing students also indicated the encouragement and advice provided by their seniors as well as their instructors to secure this qualification, while being employed in the public health sector. These young students are acutely aware of the importance of the degree providing a clear pathway to migrate to Global North countries.

5 Since then, the GoSL has publicly stated of the intention to sign a MoU but no further details have been forthcoming.
6 This was confirmed by the MOH, private tertiary institutions and nursing colleges.

While the local qualifications lack recognition, the experiences the health professionals have gained by working in Sri Lanka's public health sector are highly valued elsewhere. Both the LFEA representatives and the health workers pointed to the ease with which their work experiences were recognised.

However, the lack of recognition of qualifications has also led to brain waste – a common concern raised in relation to migrant workers (Pires, 2015). As indicated previously, practicing nurses within the public sector in Sri Lanka, work in Singapore as nursing assistants. Instances where qualified para-medical professionals as well as Medical Officers opted to work in lower-skilled categories in the health sector was not uncommon.

> *A lot of the doctors I know who have migrated from Sri Lanka, they are doing all kinds of jobs. There are some, as I told you, who have retrained as nurses, because there is quite a demand for nursing and there are jobs and it is not as expensive or time-consuming as pursuing medicine. There is this person I really know well, who trained as a caregiver and is working in a nursing home (In-service – former medical officer, Canada, female, 28 October 2021)*

These choices are however, yet again shaped by the decision to settle down with family in the destination country. Furthermore, the cost of the examinations, the difficulties in passing these examinations and at times, the lack of an assured employment opportunity regardless of passing the examination and the duration it takes to secure work can also work against such health professionals.

> *Once you pass both AMC [Australia Medical Council] exams, you are in a pool and then you just start applying for jobs. So, from what I hear there is a wait list to do the exams also. About 2-3 years and even after you do the exams, an opportunity must come up so there is more time that you have to wait and see (In-service, medical officer, Australia, male, 29 October 2021)*

An important observation however is that where the qualifications are at least partially recognised or can be certified easily, health workers are able to quickly secure work and make long term commitments in the COD. This was seen mostly in the UK, among the paramedical and nursing professions as well as in Oman, where the Sri Lankan qualifications are recognised. Hence, the turnaround time in terms of securing jobs is drastically reduced where there is mutual recognition of skills and qualifications, thus pointing to the importance of such an application.

5.6. Migration related costs

In the ILO Guidelines, the recruitment fees or related costs "refer to any fees or costs incurred in the recruitment process in order for workers to secure employment or placement, regardless of the manner, timing or location of their imposition or collection" (2019, p. 12). Furthermore, under the Operational Guidelines, it is the government's responsibility to ensure that the costs of recruitment are borne by the employer and not the migrant worker. This includes the prevention of fraudulent charges being incurred, transparency of costs being paid to the labour recruiter by the potential employer and deterring the charging of fees from the prospective migrant workers in the promise of securing work overseas.

As the ILO (2020a) has argued, "[t]he costs borne by private recruitment agents in Sri Lanka vary based on whether the "free recruitment" or "recruitment for fee" approach is adopted" (p. 32). This was found to be the case in another study which considered the recruitment of workers to the hospitality industry in Sri Lanka. In this instance, the study found that highly desirable destinations in Europe led to higher costs being charged, in some instance, leading to rent-

seeking behaviour (ILO, 2020b).

In the case of health workers, the costs incurred are yet again determined by the skills and professional levels of the health workers and in some ways, the demand for particular professions in the competing labour markets and/or the COD. For example, the ability to apply for jobs directly in nursing and the medical profession – where the qualifications are duly recognised – ensures that the costs to the migrant workers is minimal.

Nurses who wish to work in the NHS can have most of their costs borne by the employer. In the pre-departure phase, the migrant worker bears the cost of visa processing and the air tickets but with the understanding that these costs are reimbursed once they have assumed the job. More importantly, the settlement fee provided also helps in covering any other costs that the migrant workers may have had to incur, especially where family members accompanied them.

As noted previously, Medical Officers need to meet the preconditions set by the respective Medical Councils in order to secure employment in some of the Global North countries. Respondents pointed to costs ranging from 500,000 Sri Lanka Rupees (LKR) upwards to a million rupees incurred in meeting these minimum qualifications in the pre-departure phase. These mostly consist of examination fees, air tickets and accommodation for a short period of time when examinations must be taken in foreign countries and for meeting the minimum language requirements by taking the International English Language Testing System (IELTS) examination. The latter is a common standard used to assess language competency among nurses as well.

Where mutual recognition of qualifications is available, the modality will determine who bears the cost of recruitment. For example, in Singapore, the MOH advertised and conducted the interviews in person, and assessed the qualifications of the medical officers. Hence, the costs of recruitment were borne by the employer. In contrast, when the employer-agent modality is adopted in countries like Oman, the Medical Officers have to pay the agent at least a month's wages as a recruitment fee.

> *Anyway, if you are going through an agency, you have to pay one month salary to the agency. Because the agency coordinates everything, and passenger gets visa, job letter and everything via the agency. They take around 1 million. You do not have to pay extra for visa. Everything is covered in that 1 million (Medical Officer, returnee – Oman, male, 15 November 2021)*

However, LFEAs also point to the practice of "employer pays" model being practiced in the recruitment of Medical Officers and nurses.

> *Normally, we do not charge from the passenger[7]. As we are working with the professionals, we get paid by the companies [employer]. For nurses, doctors, it is the same. We always try to get our service charge from the companies. Not like some other agencies. Because that is easy for us. That's good for our applicants too (LFEA representative– 02, Male, 15 November 2021).*

The variations in the practice of sharing or passing the full cost of recruitment on the health professional also then, is determined by the kind of relationship the LFEA has established with the prospective employer or the agent in the COD.

What is troubling and important to note is the high costs incurred by trained caregivers to secure work in Israel. While the SLBFE has stipulated ceilings on such charges, by the LFEAs' accounts, the costs must be borne by the aspiring migrant worker. This can vary between 2.5 – 2.8 million LKR - much higher than what is charged from a medical officer. The reasons cited include the

7 LFEAs in Sri Lanka generally refer to the migrant worker as a passenger

agent in Sri Lanka having to pay the agent in the COD – a factor pointed out in another study and linked to the competitive nature of the business (ILO, 2020a) and more recently, the changes in the exchange rate leading to a higher cost being incurred by the LFEA.

> *Despite of the calculations of the Bureau, passenger is willing to pay the real costs, because they know how much these things costs. For instance, to go to Israel, Bureau's estimated value is 10 lakhs. But we, the agencies, have to pay at least 15 lakhs just for the agent as the commission. When we try to negotiate, they say they will recruit workers from Vietnam, Nepal etc. Recently one agent asked for 1200 USD commission for a passenger ((LFEA representative – 01, Male, 4 November 2021)*

In this context, what is worrying is that LFEAs charge fees from the migrant worker that are significantly higher than the stipulated SLBFE ceilings. As was found among the hospitality sector workers (ILO, 2020b), what makes this process more difficult to regulate is the willingness of the aspiring migrant workers to bear the cost and the concurrent steps taken by the LFEAs to offer low-interest credit facilities or link such workers with banks to secure such loans.

> *Then the bureau says we can collect around 2 lakhs from a nurse and for a healthcare assistant, it is Rs.180,000. Recently, one person called me and asked, it is surprising to see that they can go to Singapore for this amount. Because everyone understands the costs in Singapore. Bureau is acting crazy for real. [but] people [aspiring migrant workers] understand this and they pay our actual costs and go abroad. For the Ministry of Manpower [in Singapore] they have to pay around 2000 US dollars, then the ticket is also there. Considering all this, bureau's calculations are all over the place. Since nurses are educated, they understand that bureau's prices are not realistic and so, they don't fuss (LFEA representative-05, female, 03 November 2021)*

In some cases, the rising cost of facilitating migration has led LFEAs to stop supplying migrant labour to certain countries. Israel was mentioned as a specific country where demand for Sri Lankan caregivers is high but the demand for financial compensation from the LFEA representative in Israel was considered unsustainable by some LFEA representatives in Sri Lanka. While LFEAs are concerned about "passing on" the costs to the migrant worker, as reflected in the quotation above, a considerably large pool of workers is willing to migrate and bear these high costs.

5.7. Transparency and access to information

As noted previously, for the higher skilled categories of workers, information about the basic qualifications and the criteria for consideration of employment are comparably more accessible than for lower-skilled categories of work. Such information access is also most common in the case of Global North countries including in Europe, the United States and Australia. The speed of response from these health systems and institutions leads to quick decision-making on the part of the migrant worker as well.

In contrast, accessing information from Sri Lankan institutions with regard to certifying one's qualifications and the process to seek and secure administrative leave etc., was found to be frustratingly slow, with most of the information either not available or out of date.

In the agent-agent modality, information tends to flow from the LFEA to the prospective employee. In contrast to a previous study where experienced migrant workers also failed to ask basic questions regarding contractual obligations (ILO, 2018b), health workers were found to question the LFEAs more closely regarding the contracts, the wages and the leave stipulated by the employer. Access to such information helps the prospective migrant workers arrive at decisions based on the costs to be incurred and the time required for the process to be finalised.

Interesting to note is that workers are also proactively seeking opportunities to destinations such as Romania – an emerging country of preference which has been highlighted in previous studies as well (ILO, 2020b) but in relation to the hospitality sector. While a few LFEAs have established agent-agent modalities in Romania, the cost of migration remains high.

The emerging importance of social media advertisements as an effective means to reach out to prospective migrant workers must be noted. While LFEAs must operate within the regulations set by the SLBFE, the informal networks and job pages that are now being populated through Facebook in particular is creating discord among the LFEAs and these informal intermediaries

> *Most of the Facebook groups who promote Romania, are not real agencies. They just deceive people. The Sri Lankan embassy was closed for 3 months. So, they had given us permission to send the passports to Vietnam to get it stamped. So, we got 43 visas stamped under that process. One of the most popular pages had published posts asking people not to give passports to agencies, there is no law to get visa stamped like that and all. We personally contacted that page owner and asked not to share false information. So, because of their false information, a lot of people got scared to give us their passports. So, most of these page owners know nothing, they only share false information (LFEA representative – 01, Male, 4 November 2021).*

While some of the Medical Officers pointed to the circulation/sharing of advertisements on recruitment drives to Oman and similar countries via social media, these were verified posts shared among closed groups whereas, the public pages that are promoting job opportunities in highly desirable destinations such as Romania for caregivers can mislead prospective migrant workers. A key issue highlighted by the LFEAs is the inability of the SLBFE to regulate these pages and thereby counter the spread of potential misinformation. The inability to verify the information, the lack of transparency of the process adopted to facilitate migration and increasing expectations based on incomplete information were all cited as shortcomings in such a context.

As noted elsewhere (ILO, 2020b), it is important to note that aspiring migrant workers who are working in the private or public sector in Sri Lanka tend to seek out information about the COD, the job prospects, the minimum standards of living and working conditions and wages from their peers. Colleagues who have returned from working overseas or those who are already employed overseas form a strong pool of resources to verify and at times, triangulate information. In the course of collecting data, in-service migrant workers from different destination countries remarked on the increase in the number of inquiries being made in the past six months as health workers from all skills levels and regardless of gender and age, seek out available options to migrate.

5.8. Setting of wages

The ability to negotiate wages is limited for the health workers, as the employer determines the wages and the package of benefits offered. This is a common occurrence across all skills levels and professions. However, the transparency afforded in terms of information in the pre-departure phase makes it easier for the workers to have a clear idea of the expectations in terms of incomes. For example, interviews with prospective caregivers who consider Israel as a very attractive destination, justified the cost they have to bear, since the wages are much higher (between 300,000-400,000 LKR) than what they could earn in Sri Lanka and the provision of accommodation and food promises the capacity to save the wages in its entirety. This was confirmed by the LFEA representatives who specialise in sending workers to Israel.

Similarly, interviews with Medical officers and nurses as well as Ministry officials and Trade Union representatives pointed out that Medical officers and nurses can earn at times, "ten times" higher than the wages provided in Sri Lanka. Therefore, short-term migration to Oman and Singapore

is considered highly lucrative and desirable because the wages are further compensated by low taxation and access to other pecuniary and non-pecuniary benefits. This also allows in-demand professions such as Medical officers to reject certain CODs as suggested below:

> *At the moment, we don't recruit doctors. We were planning though as Seychelles was looking for doctors. But there are doctors from Russia and Kenya who want to work outside their country. They got the opportunity, not our Sri Lankan doctors. But there are a few Sri Lankan doctors who are working in hotels, as house doctors…Sri Lankan doctors are a little bit demanding too, they are asking more than other doctors from countries like Russia (LFEA representative -04, male, 07 November 2021).*

Wage-setting is therefore, strictly within the purview of the employer in the COD. The powerful role played by the employer has been highlighted in other labour supply chains as well (ILO, 2020b) and is rather worrying in this context, as the COD seeks to respond to its own labour shortages. The access to information regarding wages in Sri Lanka and the relatively higher paying power of the CODs to far outmatch the wages in Sri Lanka, leaves little room for negotiation. As with the cost of migration, the workers do not complain as the wages are considered more than adequate to save and realise any expectations they have set out to achieve.

The wages that are stipulated by the employer also varies by the COD.

> *In Romania, a nurse gets around $600. They get more in Oman. In Oman they pay around $3500 for nurses. One of my friends told me that lately UK had called for nurses and only 18 or 19 nurses were from Sri Lanka, while the rest were from Kerala, India. Actually, Sri Lankan qualified nurses have a demand anywhere in the world (LFEA representative – 03, Male, 02 November 2021).*

For caregivers in countries like Israel, the high recruitment costs, they believe, can be offset within a short period of time and migrant workers anticipate saving upwards of two (2) million rupees from being employed for 24-36 months.

5.9. Protection of rights

A key commitment identified on the part of the destination and origin country is the protection of the rights of the workers. A range of measures including filling any loopholes that allow for contract substitution, the adherence to or negotiation of decent working and living conditions for the workers and the freedom for the migrant worker to choose a different employer and return home safely are included in these responsibilities. With regard to health workers, the general consensus is that protection of the rights of the workers is common as the employment contracts are strictly adhered to: an 8-hour workday or 36-40 hour work week is generally accepted as the norm.

None of the workers cited any outstanding issues in relation to the violation of their rights. The existence of an internal system within the workplace was cited as a means of mediating any work-related issues. While there were some exceptions noted, especially in Singapore, where the adjustments to a new system resulted in young Medical Officers spending more than the stipulated number of hours per day at the workplace, these were considered "teething" issues rather than any enduring, longer-term expectations to work very long hours.

In many of the Gulf countries and Singapore, workers can also extend their stay once the initial two-year period is completed. Unlike with lower-skilled workers in other sectors, the choice to continue with the same employer or choose a new employer is generally left at the discretion of the worker.

> *If they like to extend their stay, they have to inform us 40 days prior to the deadline of their contract. Then through my foreign agent, they can go to another nursing home or stay in the same place. As they go abroad after applying for leave here, if they want to extend the contract, they need to come back to Sri Lanka, arrange things and go back. Almost all the nurses who went to Singapore, came back to Sri Lanka after their 2-year contract (LFEA representative specialising in nursing, female, 03 November 2021).*

What is more worrying however, is the measures that may be adopted by the LFEAs in the pre-departure phase to ensure that the workers remain with the employer:

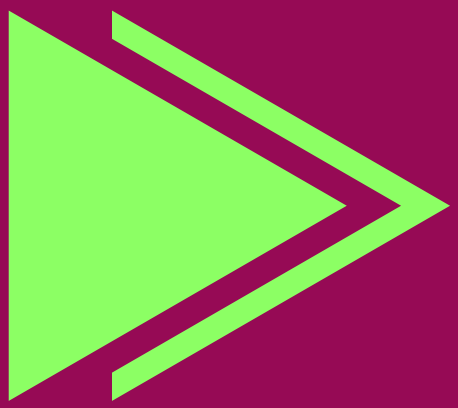
> *Now, Romania does not like to give our people even a visit visa as they try to run away to some other country. Since that is not good for us too, now we ask our clients to sign a bond. If still they disobey, we can take legal action against them, and pay the sponsor. Two guarantors have to sign for the bond. So, people don't try to run away. They stay until they finish the contract (LFEA representative – 03, Male, 02 November 2021).*

While not common, such practices have also arisen as a consequence of countries like Romania becoming more popular as a destination country. The misinformation regarding the ability to cross borders to Europe and the perception that Romania is part of the European Union may be further fuelling the popularity. However, signing of such bonds can be detrimental to the workers, as this binds the workers to the employer resulting in the potential for experiencing forced labour conditions.

Credit facilities are accessed through both formal channels, such as state-owned banks, as well as informal networks. Returnee migrant workers cite the ease with which such debts were settled within a considerably short time period – a sentiment shared by those aspiring to migrate as caregivers as well. However, such decisions are arrived at, in a vacuum of incomplete knowledge, especially regarding the possibility to work for a "good" employer (ILO, 2018). Hence, such high costs borne can make lower-skilled workers vulnerable to exploitation in the COD as they may have few options to leave sub-standard working environments including long working hours, lack of adequate rest hours and inadequate compensation for the long work hours.

It must be noted that the continued imposition of the Family Background Report (FBR) on prospective female workers was cited as a concern in promoting migration among female health sector workers. Instances where LFEAs self-select male workers to reduce the complications of women having to secure the clearance was cited by the LFEA representatives. However, higher skilled female workers including Medical officers were able to circumvent this process of securing a clearance. None reported having to undergo the clearance.

In conclusion, there is much room for improvement if Sri Lanka is to capitalise on the demand for health workers. The adherence to minimum standards in recruitment, the capacity to negotiate working and living conditions and the shift towards where employer bears the cost of recruitment for all skills level must be addressed in a more comprehensive manner. Both the SLBFE and the MOH have specific roles to play in this regard, especially in terms of developing a framework that reduces exploitation and enhances the transfer of knowledge and skills back to Sri Lanka's health sector.



6 Way Forward: A framework for Migration of Health Workers

The preceding Chapters of this report set out the key workforce dynamics among health workers in Sri Lanka, the demand for skilled workers from overseas labour markets and the decent work deficits underlying the migration decisions of prospective and in-service migrant workers as well as the recruitment modalities that facilitate this process. This concluding chapter proposes a framework that could be considered for adoption in order to facilitate policies and strategies for fair migration and return of health workers in Sri Lanka.

The WHO's Code of Practice clearly states that while migration of health workforce is an inevitable process, such migration trends should not undermine the quality of the health services provided in the origin country. This clearly points to the unfavourable nature of negotiating power as wealthier countries are better placed to offer lucrative financial and non-financial incentives to attract suitable candidates from countries that struggle to match the same socio-economic conditions on offer. A similar sentiment is echoed in the ILO's General Principles and Operational Guidelines for Fair Recruitment (2019) for all categories of work, reinforcing the notion of the lack of bargaining power of COOs in the particular context of labour migration. This unequal relationship underscores the importance of developing a framework that enables the mobility of health workers while ensuring that the reasons that propel skilled workers' decisions to migrate are also addressed. Such measures would help ensure that in the long-term, health workers as well as health systems in both destination and origin countries can benefit from the sharing of skills and experiences acquired.

In the case of Sri Lanka, the public sector looms large as the chief employer for health workers. As the analysis indicated, social security and the stability of employment are key aspects that the sector can offer. While wages remain relatively high compared to other public sector jobs – a reflection of the particular skills and lifelong learning that medical professionals need to engage in – there is major concern that the income remains inadequate. However, what is noteworthy is the steps adopted by the GoSL to extend extra benefits to medical officers in particular, in order to offset the burden of inadequate incomes. Hence, overall, higher skilled categories of workers in the health sector are positioned to reap most of these benefits. However, the hierarchical, top-down nature of the administration, the invisibility of lower skilled categories of workers, especially in terms of accessing further training and knowledge enhancement, are seen as key factors that shape migration decisions among non-medical officers. The proposed framework therefore, seeks to respond to these identified decent work deficits while also focusing on fair and ethical recruitment frameworks that would reduce exploitation of all migrant health workers, regardless of their skills level and work experiences.

To this end, the framework aims to support in a comprehensive and sustainable manner, the safe, orderly and regular migration of health workers from Sri Lanka while maintaining an adequate and skilled cadre to meet the demands placed on Sri Lanka's health sector. In doing so, the proposed framework seeks to meet the non-binding yet important conditions set out in the WHO Code of Practice regarding reducing the negative impact on local labour markets. The framework further seeks to ensure that Sri Lanka's certification systems for the different categories of health workers are on par with international standards.. Thirdly, the framework aims to ensure that fair and ethical recruitment of health workers for work overseas is facilitated.

To this end, the framework addresses key aspects to be included in the development of health worker migration policies, in particular: regulatory aspects; protection of health workers' rights; reintegration of returning health workers; addressing decent work deficits and finally, improving processes for robust data collection.

6.1. Regulatory framework to ensure fair and ethical recruitment

The migration of workers for overseas employment is determined by the regulatory framework in place in Sri Lanka. The SLBFE Act No. 1985 and the subsequent amendments will continue to provide the overarching framework for migrant workers in general. The establishment of a different regulatory framework for health workers' migration therefore is not possible nor required. However, some key issues within this framework can be revised to facilitate fair and ethical recruitment for migrant health workers.

6.1.1. Application of minimum standards to recruitment through existing instruments

The ILO's Guidelines on Fair and Ethical recruitment and the WHO's Code of Practice offer the basic parameters to establish fair and ethical recruitment standards in Sri Lanka for health workers. Key principles to be adhered to include ensuring that migration of health workers do not result in Sri Lanka experiencing acute shortages, the application of a "zero cost" model of recruitment for the migrant worker, and the minimum responsibilities of the COD and the employer to ensure the wellbeing of the migrant workers. The latter is of critical importance especially during times of health crises.

6.1.1.1. Universal application of "employer pays" model

The shortages in cadre in health systems overseas is pushing demand for health workers from different regions of the world including the global south. As per the ILO's Ethical and Fair recruitment guidelines (Section B) recruitment costs must be borne by the employer. As a universal rule, job placements for health workers, therefore, must not incur costs for the aspiring migrant worker. A system where such costs are borne by the employer must be established for all sub-categories of worker. The often used "logic" that the cost can be easily recouped as the wages are much higher must not form the basis for the migration of skilled workers.

6.1.1.2. Strengthening of key modalities that reduce exploitation or cause acute labour shortages

Government-Government (G2G) agreements to facilitate migration of health workers – with the exception of sending caregivers to Israel - do not exist as yet. However, the GoSL's consideration of a possible agreement with the United Kingdom may offer a blueprint for how the MOH can play a more decisive role within the recruitment process, especially in the case of public sector workers seeking to migrate overseas. Strong bi-lateral agreements between Sri Lanka and the respective destination country would set minimum standards in terms of wages, other benefits, working conditions, the transparency of the recruitment process including the application of the "employer pays" model and importantly, regulations facilitating a smooth reintegration of returning migrant health workers. These agreements should be developed in line with the Global Guidance on Bilateral Labour Migration Agreements developed under the UN Network on Migration co-chaired by the ILO and IOM (UN Migration, 2022).

6.1.2. Adherence to the stipulated conditions by the LFEAs

As only a few specialised LFEAs are recruiting workers for the health sectors overseas, the differences in practices on the basis of the COD and the type of employer and the category of workers, must be streamlined. The application of a zero-cost model including in agent-agent modality of recruitment, must form the minimum standards if health worker migration is to be promoted. The opening of job orders in the SLBFE may be stipulated on this basis to reduce exploitation and ensure minimum standards are maintained.

6.1.3. Easing of the Family Background Report (FBR) on female migrant workers

The demand for caregivers and trained nurses has a strong gender dimension. Capitalising on this demand however, hinges on easing regulations in place for aspiring female migrant workers in the pre-departure phase. A Cabinet decision arrived in late June 2022 has eased the imposition of the FBR on female migrant workers, allowing for the first time since 2013, for women with children aged two-five years and above to migrate.. The partial lifting of the regulation must also be accompanied by strengthening the a protection framework that enables access to services for left-behind family members.

6.1.4. Access to information on job openings/minimum standards

the provisions of the SLBFE Act prevent LFEAs from advertising in any other platform other than print and electronic media. This has given rise to a large number of powerful social media pages that promote misinformation. Through a concerted and targeted campaign, the SLBFE can reduce the power of these individual pages, especially by maintaining a stronger presence in social media, as well as by easing the necessary legal provisions for LFEAs to maintain a social media presence. Similarly, access to up-to-date information from the SLBFE's own website would help ensure that a comprehensive and transparent repository of information in all three official languages are accessible to prospective migrant workers.

6.2. Protection of migrant worker rights

6.2.1. Protection of migrant workers' rights regardless of registration status

the existing Constitutional provisions ensure the right to free movement of Sri Lankans from and back to Sri Lanka. The existing regulations of the SLBFE however, displaces this right of Sri Lankans to seek assistance/protection from the SLBFE unless they are registered with the SLBFE prior to migrating. The right to seek assistance and protection of the State (either from the SLBFE or the Foreign Affairs Ministry) must not hinge on the workers' ability to pay a fee to the Government. The discriminatory practice further marginalises the lower-skilled workers especially where they have opted to migrate by securing work though the employer-employee modality. Furthermore, the Government has a vested interest in ensuring that health workers return and reintegrate into the national health system which can be undermined by the lack of protection afforded as migrant workers.

6.2.2. Implementation of a grievance handling mechanism

The conciliation division of the SLBFE presently mediates between employer and employee (via the LFEA) with regard to contract violations and potential exploitation/abuse experienced by the

migrant worker. A selected and specialised sub-unit could be set up to mediate on behalf of the health workers as their working environment, working conditions and adherence to international protocols in terms of patient care in health systems abroad will require specialised attention and technical support.

6.2.3. Mechanisms to reduce experience of forced labour conditions

The recently launched Migrant Recruitment Advisor (MRA) platform in Sri Lanka is a first step towards equalizing access to information and the balance of power between employers and migrant workers. Since informal sources and known peers continue to be a main source of information in the pre-departure phase, access to first-hand accounts of working experiences and potentially abusive/exploitative employers can be screened through the wider use of the MRA platform.

6.3. Reintegration of returning health workforce

6.3.1. Skills recognition for the health sector workers

The dynamics of migration point to how the existing health workforce utilises the option of no-pay leave to seek work overseas, for a maximum of five years. While a Recognition of Prior Learning (RPL) process along with a skills passport has been introduced in Sri Lanka, its applicability to the public health sector is questionable. This is mostly because of the need for an internal mechanism within the MOH to first recognise the qualifications and skills that have been acquired overseas. Therefore, a systematic way to recognise the skills and qualifications acquired while overseas must be initiated from within the MOH and its constituent professional bodies. Sub-specialities where workers have acquired new technological innovations, access to specific emerging areas of medicine can only be recognised in Sri Lanka if the local systems remain robust and adaptable to these changes.

6.3.2. Recognition of new qualifications/accreditations

By their own account, Sri Lanka's accreditation standards remain "archaic", resulting in migrant workers' qualifications acquired overseas lacking recognition in Sri Lanka. An overhaul of the existing system is required, especially by investing in and subscribing to an international accreditation body that recognises such skills. The SLMC can lead this process for the health sector with technical input from the professional bodies to ensure that nursing, paramedical and other categories of health professions also have equal access for their qualifications to be recognised.

6.3.3. Mechanisms to encourage participation of 'permanently settled" professionals to engage/contribute to health sector in Sri Lanka

The diaspora, regardless of ethnic identity, lack trust in Sri Lanka's political processes. Contributing towards Sri Lanka's health care system through the MOH and/or through the Foreign Affairs Ministry may not render the best results. Instead, the professional bodies and associations linked to specific skills categories are well-recognised and becomes the preferred method of engaging with Sri Lanka. Whether the respective Trade Unions could also potentially play a role in facilitating engagement of the diaspora in this regard must be explored. However, given the political nature of the Trade Unions in Sri Lanka, the professional associations may offer a more conducive conduit for engagement.

6.3.4. Encouragement of knowledge and resource sharing

Health workers in the diaspora are also keen to engage within a more formalised setting. This includes contributions to the academia, via research grants, partnerships to encourage exchange student programmes and granting of fellowships. While provision is available in the Foreign Affairs Ministry's blueprint to engage with the diaspora, the formalisation of relationships/ partnerships must originate from the health sector itself while the bureaucratic processes to formalise relationships between collaborating universities/medical colleges and/or Professional associations would require technical inputs from the inter-linked national-level ministries.

6.4. Improving retention by responding to decent work deficits

Adequate responses to retain existing workforce are required. These responses will also help ensure that the investments made into the development of a skilled workforce by successive governments, support the Sri Lankan health sector.

6.4.1. Equality of opportunities recognised by clear career progression

An important step is due recognition being accorded to all health workers in the public sector. The importance of retaining medical officers by incentivising them via non-pecuniary measures have had positive results, however this has also led to the side-lining of all other professions within the health sector. A clear career pathway therefore is necessitated where acquisition of qualifications and work experience would allow other categories to also become policymakers and senior administrators.

6.4.2. Limiting/ reducing casualisation of work

Limiting or reducing the casualisation of work arrangements, especially for the lower skilled and poorly educated categories of workers will help create a more conducive working environment for the lower-skilled workers. This in turn, will positively influence the quality of care provided to patients in the health systems.

6.4.3. Addressing acute shortages in specific professional categories via public-private investments

A key issue highlighted by health workers was the long working hours which in turn lead to burnout and stress and the inability to maintain a healthy work-life balance. While the MOH is aware of the acute shortages in professions such as nursing, progress towards addressing these shortages is slow due to the public investments required. The MOH has projected the period required to reach saturation for Medical Officers and Nurses, which in turn would ease the pressures on long working hours but reaching these targets may require more public-private partnerships especially in funding the skills development required.

6.4.4. Extension of non-pecuniary incentive schemes that offset the low wages

Arbitrarily increasing wages for public health sector workers may not be possible within the regulatory framework that determines maximum wages. In recognition of the feminisation of the health sector and the persistent concern raised regarding struggles to maintain work-life balance, non-pecuniary benefits related to childcare and elder-care especially by extending subsidised care facilities as well as flexibility in terms of work hours and shifts, will act as strong incentives for all categories of workers including the Medical Officers.

6.4.5. Equitable access to educational facilities

Removing gender quotas that are based on traditional notions of which gender is most suited for a "caring" profession and the minimum qualifications in bio-sciences as a pre-requisite to pursue nursing will continue to hinder equitable access to these professions. Removal of these stipulations can lead to more youth uptake of these professions, especially given the potential for migration and opportunities to earn higher incomes.

6.5. Data collection, monitoring and analysis

6.5.1. Data related to health workers are available through multiple sources of the government. These include the data collected by the University Grants Commission, the Nursing Colleges, the Ministry of Health, the Sri Lanka Bureau of Foreign Employment. In addition, the Sri Lanka Medical Council and the respective professional Associations maintain their own databases, as does the respective trade unions. Importantly, the Department of Census and Statistics collects a nationally representative data sample for its Labour Force Surveys. In addition, the private sector hospital systems also maintain their own records. While these may all report in some way, to a central database at the MOH, the disparate nature and categories being used to collect data makes it challenging for the health system to set targets, make projections and predict retention and attrition rates. To this end, if not already in use, the WHO's National Health Workforce Accounts approach could be considered for adoption to streamline data collection and reporting.

6.5.2. Definition of health worker

A universal application of which categories of workers fall within the definition of a health worker is important. The ILO's International Standard Classification of Occupations (ISCO - 08) which is used by the DCS could be applied in this regard.

6.5.3. Streamlining disparate datasets from the private and public health sectors

This measure is instrumental to ensure that the MOH has a comprehensive grasp of the health care workforce in Sri Lanka. The process to digitise the employment profiles of the health workforce is a positive step in this regard and would also help minimise the bureaucratic red tape and ease the administrative hurdles workers have to overcome in order to secure long-term leave etc. The profile data could include history of migration and the experiences/skills gained. Importantly, such information is already filed with the MOH when health workers request long-term leave and therefore, merging of such datasets would be useful.

6.5.4. Maintenance of databases of migrant workforce

Disaggregated data on migrant workers from the health sector will be captured to some degree by the SLBFE. A data sharing system must be initiated between the MOH and the SLBFE as the former would require this data to determine attrition rates and to track the re-entry of possible migrant workers back into the health sector. However, a more robust system of collecting data on migrant workers in general must also be introduced as health workers may not always register with the SLBFE in the pre-departure phase, resulting in serious under-reporting.

6.5.5. Maintenance of database of health professionals in the diaspora/ diaspora groups

The Foreign Affairs Ministry has, for some time, attempted to promote its one-stop window to facilitate diaspora engagement in Sri Lanka. Health workers who have permanently settled down overseas have greater confidence in their Professional Associations rather than any dedicated division of the GoSL. Professional bodies affiliated to the health sector thus, can establish channels for diaspora members to engage. Rather than being filtered through the Foreign Affairs Ministry, the Professional Bodies/Associations can correctly and rapidly link Sri Lankan health workers with channels for contribution and engagement.

6.5.6. Use of disaggregated data to project demand and supply:

Conducting skills anticipation/future skills needs assessment at regular intervals are important for the health systems to address the changes in required skills in health workers. Accounting for changes due to technological advancements, climate change and economic recessions are important if the health system is to respond adequately and effectively to maintain standards.

Similarly, considering the demand for health workers, especially for caregivers and nurses, existing data on workers, young trainees/apprentices can be utilised to make projections on how best Sri Lanka can meet the demand for migrant labour. Since the MOH indicated the points in time when specific skills categories such as Medical Officers and Nurses would reach saturation point, such projections must be used in conjunction with data on destination countries' projections of demand and supply. This would lead to a more cohesive plan being developed over the next ten years, on sending trained/skilled workers overseas for these high-demand vocations

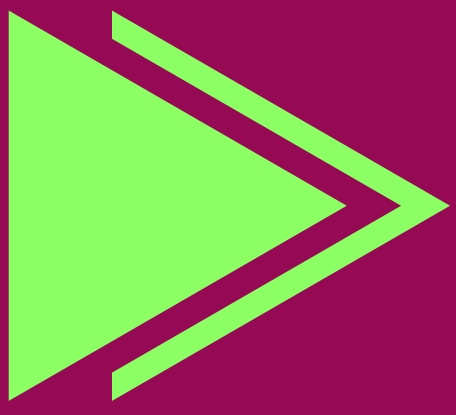
6.6. Coordination mechanism

6.6.1. An institutional level mechanism to improve coordination among multiple stakeholders

The SLBFE as the regulator and the State Ministry for Foreign Employment as the policymaker require closer coordination with the MOH and health sector's affiliated TVET and educational institutions as well as the Trade Union representatives in order to ensure that a skilled workforce is prepared for migration. This would also help balance the needs for a skilled workforce for the domestic sector. Furthermore, closer coordination would allow the creation of pathways for returnee migrant workers, to either join the public or private sector and thereby, respond to the shortages felt in the private health sector in particular.

6.6.2. Partnerships with private TVET institutions

Independent of the state mechanisms, ALFEA and educational institutions are exploring how best to respond to the demand for lower-skilled categories such as caregivers through the provision of the necessary qualifications. Incentivising such partnerships is in the best interest of the GoSL especially in its stated transition to shift towards skilled migration.



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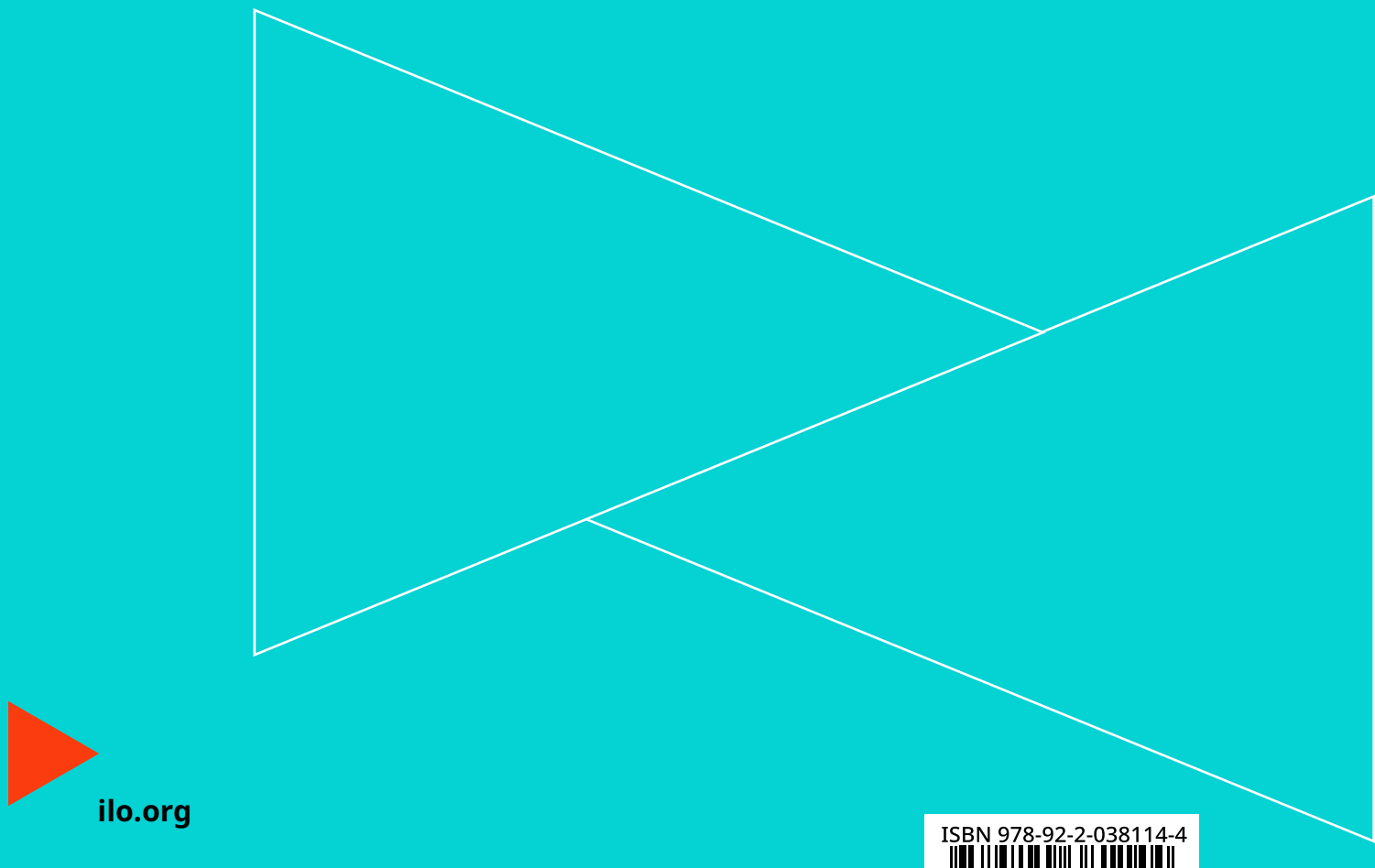
Framework for Sri Lanka's health workers' mobility adopting fair and ethical recruitment practices



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