

# Online Discussion Summary



International  
Labour  
Organization



## Circular Migration of Health Workers 3-14 September 2012

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## 1. Introduction

### 1.1 Asia Pacific Migration Network (AP-MagNet)

The Asia-Pacific Migration Network is an online community of practice initiated by the International Labour Organization's (ILO) Regional Office for Asia and the Pacific. This online platform, at [www.apmagnet.ilo.org](http://www.apmagnet.ilo.org), provides a forum for professionals and practitioners to share and leverage technical and practical knowledge on migration, debate and discuss migration-related issues and strengthen a common agenda for managing migration for decent work in the region.

AP-MagNet was first conceived in 2010, and joined the ILO's four other existing regional communities of practice on Youth Employment, Green Jobs, Skills and Employability and Industrial Relations. It currently has more than 300 members from around the globe and holds a continuously expanding library of approximately 450 knowledge resources on migration-related topics.

One of the key ways in which this community of practice contributes to ongoing debates and discussions on migration is by hosting regular online discussions on topics of interest. While this paper provides a summary of the September 2012 discussion on Circular Migration of Health Workers, past discussions have also examined issues such as the improvement and regulation of recruitment practices in Asia and the Pacific, public attitudes to migrant workers, the return and reintegration of workers.<sup>1</sup>

### 1.2 Online Discussion on Circular Migration of Health Workers

According to the World Health Organization (WHO), the world has some 8.6 million physicians to attend to a population of 6.7 billion, or about 780 people per doctor. There are also 1.3 million dentists, 17 million nurses and midwives, and 1.2 million pharmaceutical workers. Yet health workers are not evenly distributed. In 2006, the WHO reported that there was a global shortage of 2.4 million doctors, nurses and midwives and the shortage was critical in 57 countries<sup>2</sup>.

Contributing to the shortage visible in many developing countries is the emigration of health workers from poor countries. Loss of health workers through migration has caused global concerns prompting debate on policies that would allow for a more equitable sharing of these scarce human resources. Among these are policies to encourage periodic return or circular migration among the highly skilled, including limiting stay through temporary employment visas, granting of multi-year visas, guarantees of readmission, making return a condition for visa extension or conversion to permanent residence, recognition of dual citizenship, and partnership agreements which provide for financial incentives<sup>3</sup>.

In order to address this critical health issue, build the technical and practical knowledge base on its challenges and potential responses, and seek good practice examples on how to effectively manage circular migration, AP-MagNet hosted an online discussion on circular migration of health workers, between 3-14 September 2012. The online discussion was moderated by Manolo Abella, former Director of the ILO International Migration Programme, and sponsored by both the EU-funded *Decent Work Across Borders* project<sup>4</sup> and the CIDA-funded *TRIANGLE* project.<sup>5</sup>

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<sup>1</sup> For further information on past discussions, including background papers and consolidated replies, see <http://www.apmagnet.ilo.org/discussions>

<sup>2</sup> For full reference of sources cited in this document, kindly refer to the selected bibliography in the Annex 2 of this report.

<sup>3</sup> For further background information on the discussion topic, see discussion background paper reproduced in Annex I of this summary

<sup>4</sup> For further information, see: [http://www.ilo.org/asia/whatwedo/projects/WCMS\\_173607/lang--en/index.htm](http://www.ilo.org/asia/whatwedo/projects/WCMS_173607/lang--en/index.htm)

<sup>5</sup> For further information, see: [http://www.ilo.org/asia/whatwedo/projects/WCMS\\_145664/lang--en/index.htm](http://www.ilo.org/asia/whatwedo/projects/WCMS_145664/lang--en/index.htm)

Over a period of two weeks, the discussion received a total of 39 comments from 22 participants from around the globe, from countries including Thailand, Singapore, India, Sri Lanka, Poland, Philippines, Australia, Italy, United States of America, and Senegal. Participants came from a variety of backgrounds, including government and non-government organizations, United Nations organizations, international NGOs and academia.

## 2. Discussion Summary

The Discussion was initially framed around the broad following question: Is circular migration the optimal solution to address global health needs and, if so, how can it be best promoted through migration policies?

### 2.1 The Circular Migration Policy Conundrum

The participants to the on-line discussion raised a large number of fundamental issues starting with the rationale for a circular migration scheme for health workers and then going to the merit of various prescriptions.

#### 1) *Why is there a global “shortage” of health workers?*

The background paper for the discussion, posted on the AP-MagNet website beforehand and included in Annex I of this report, presented the WHO findings that there existed a global shortage of some 2.4 million doctors, nurses and midwives and the shortage is critical in 57 countries, 36 of them in sub-Saharan Africa (WHO, 2006).

Participants to the discussion acknowledged that a contributing factor to the shortage of health professionals in the developing world is the emigration of health workers from lesser to more developed countries leading to a great imbalance between richer and poorer countries in the ratio of health workers to population.

Some participants focused on the reasons why shortages of health workers occur in developing countries. Aly Cisse, from the ILO Office in Dakar attributed the phenomenon to emigration, which is unlikely to abate because of the huge difference in wages, living conditions, and “effectiveness” of health services in many developing countries. The desire for a more secure future is a powerful motivation for migrant health professionals, according to Stephen Castles from the University of Sydney in Australia, who also stressed that migrants are not just motivated by higher wages but by their desire to have a secure future and to live in countries where they want to bring up children.

What drives health professionals to emigrate, as a UK Department for International Development (DFID) study in Malawi has found, are the inadequate staffing of health facilities, poor hygiene, lack of medicines and equipment, lack of training and promotion opportunities. Pawel Kaczmarczyk from the Center for Migration Research, University of Warsaw who studied the specifics of the mobility of health professionals in Europe<sup>6</sup> found the same “push factors” – namely differences in living standards, less secure environment, and conditions in the health system. In Central and Eastern Europe, he said, lack of access to modern equipment, poor management of health services and lack of professional advancement opportunities have driven many to emigrate. He noted that in Poland the education system can “produce” enough specialists needed by the national health services, even allowing for emigration. The excess supply of health graduates spilling over to other sectors in Poland is actually larger than the numbers of health workers spilling over to foreign labour markets. Kaczmarczyk mentioned, building on his study of

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<sup>6</sup>See : <http://www.mohprof.eu/LIVE/>

the health professionals' mobility in Europe, that a common feature of the health sectors worldwide is the mal-distribution of human capital (urban vs rural or public vs private sectors) observable in both well developed as well as the poorer countries.

Some countries, even less developed ones, can however provide a good environment, a pleasant lifestyle, safety, good educational facilities and democracy.

Phil Martin of the University of California – Davis, argued that institutional restrictions, such as licensing and certification of health professionals, are partly to blame for demand-supply deficits since such shortages have not been felt, for example, in the case of IT professions where almost nothing constrains anyone from entering this particular profession. On the other hand, John Skretny of the University of California – San Diego, laid the blame on destination countries for failing to increase their own supply of health workers and added that the policy of bringing foreign health workers to make up for temporary deficits simply created distortions in the labour market, making normal demand-supply adjustments even more difficult.

Ferruccio Pastore, of the Forum de Recherche Internationale et Européene in Italy, pointed to structural factors found in Southern European countries such as demographic ageing, as being behind the rising demand in the North for foreign health workers from the South. He raised an interesting point that while “elderly care” in general is not usually defined as part of the health sector, some of the services provided by elderly caregivers are indeed basic health services. In ageing societies, the boundary between institutionalized healthcare and domiciliary (public and private) elderly care is blurred and in constant evolution, not only due to shrinking public health budgets but also due to innovation in community medicine, domestics and domiciliary elderly care (DEC). Furthermore, he added, there is a strong interdependence between the two systems: a wide and efficient DEC system tends to reduce the demand for medical services and hospitalization (thereby reducing costs for public budgets).

Martin reminded that the market for health workers is not a normal one since in most countries the State plays a dominant role in determining both demand and supply. State spending for health services account for much of the demand while subsidy to training of medical workers is critical to determining supply. He also pointed out that in many countries including the USA significant proportions of those with training for medical work are actually employed in other occupations because of better employment conditions. Somehow the wage premium for this difficult profession is not seen to be sufficient to motivate some to stay. The under-valuation of health work was also raised by John Gee of the Transient Workers Count Too in Singapore.

Nevertheless some participants noted that there are exceptions to the shortage crisis. Ellen Sana from the Center for Migrant Advocacy in the Philippines cited the case of the Philippines, perhaps the biggest supplier of nurses abroad, which has “overproduced” nurses because of the lure created by the migration to richer countries. She pointed out that when demand abroad declined, many graduate nurses were faced with unemployment or had to settle for low wages and unattractive working conditions.

## ***2) Can “circular migration schemes” mitigate the shortages of health workers in the developing South?***

Some participants to the on-line discussion were of the opinion that circular migration is just another form of temporary migration. Binod Khadria of the Jawal Nehru University in India referred to it as “old wine in a new bottle”. Other participants showed their concern about the workability of the concept of circular migration, particularly where both the employers and the workers are interested in long-term relationship for a number of reasons. Kaczmarczyk warned that circular migration would not work in the

case of professionals who embody considerable human capital but he conceded that it may work in the case of seasonal or unskilled jobs. Gee shares Kaczmarczyk's scepticism. He was of the opinion that circular migration would not work for highly qualified health professionals for whom there is little incentive to return to their country of origin: "their earnings are good, there are usually no big obstacles to them having a family and remaining in the more developed countries and, once they have children growing up there, the arguments for staying put far outweigh those for going back to their countries of origin". Jennifer de la Rosa, of the ILO Country Office for Philippines in Manila, expressed similar scepticism about the workability of circular migration for the highly skilled migrants and very little evidence is available to support this strategy.

Having broadened the concept of health workers to include all those taking care of the aging people, Pastore argued that "there is not an intrinsic rationale for introducing circularity in this sector, if not for avoiding to take responsibility to provide elderly care to the carers themselves in the future, or for reasons connected with the preferences of the migrants themselves or with the interests of the state of origin".

Some participants raised the issue of the "rights" implications of circular migration schemes. As Catherine Vaillancourt-Laflamme of the ILO Country Office for the Philippines in Manila pointed out, migration and migration of health care professionals in particular is "at the intersection of three of the basic human rights: the right of people to freedom of movement, the right to health and the right to decent work", making it a very complex phenomenon to handle. Castles and Kaczmarczyk both cautioned that circular migration schemes may restrict the labour market rights of migrants such as the right to change jobs, or deprive migrants of the possibility of settling permanently in their host countries. Castles added that seeing migrant health professionals as second-class colleagues, employers may not give them access to career progression opportunities

In the view of Agnieszka Makulec of the Center for Migration Research of the University of Warsaw, circular migration has the potential to be an effective solution to address the shortage of health workers in the developing countries facing high emigration but she shared her concerns that migration often entails a "loss of skills" because many health workers are forced to accept work "below their qualifications". She claimed that, in her research, she has found no evidence of "brain gain" from the migration of health workers and thus would not count on migration for skills transfers. From the individual worker's point of view, she noted problems with return migration, since there are formal and informal barriers to recognition of work experience gained abroad. This same problem was raised by both Aradhana Srivastava and Indrajit Hazarika of the India Public Health Foundation, who informed that in India the non-recognition of overseas skills and work experience for a career in the public sector is a serious deterrent to return or to going back to health occupation upon return.

Some developments in origin countries are creating motivations for voluntary return. According to Srivastava a recent study in India revealed that there are two major drivers of return-migration. Firstly, the expansion of private super-specialty care institutions which provide opportunities for better salaries and working conditions to migrant health professionals, and secondly greater engagement with the diaspora and policies such as the 'Person of Indian Origin' or PIO status which helped non-resident Indians live and work in India without having to surrender their overseas citizenship. Aside from family, life-style and socio-cultural factors, the "glass ceiling" which limits advancement in professional careers abroad was also cited as a powerful motivation for return.

Shiv Chandr Mathur, an independent public health specialist in India noted that increasing "privatization" of medical services may be reducing the "drain" in health professionals. Indian health professionals who earn well abroad are investing at home particularly in private hospitals. The primary challenge to the

health system in India is how to find manpower for its public health facilities given the conditions in public service employment.

**3) *What other measures could be taken to mitigate shortages due to the emigration of health workers?***

Several participants argued on the basis of fairness and equity for some form of “burden-sharing” or compensation to increase or “replenish” supplies of health workers in origin countries. Carmelita Dimzon of the Overseas Workers Welfare Administration in the Philippines said that circular migration can serve as the optimal solution to global health needs only if the health needs of the sending country are addressed first. Receiving countries which stand to benefit from the in-migrating health professionals must compensate labour-sending countries for the “loss” of their qualified and more experienced healthcare workers. Receiving governments must share in the development of global human resources, in such ways as, for example, aid grants and scholarships, measures also proposed by Cisse. Agreements should be negotiated to replace or replenish skills.

This was echoed by Stella Go of De LaSalle University in the Philippines, who considered it a “social responsibility” of destination states to practice ethical recruitment and to give back to source countries. Go added that source countries can develop "Brain Gain" programs which spell out incentives such as accreditation to practice in home country with host country credentials. Networking with professional diaspora communities abroad is also important so that governments can formalize the “transfers of knowledge and skills” as illustrated by the “Balik-Turo” (return teaching) initiative of the Commission on Filipinos Overseas and the Philippine Nurses Association in the US. On skills and knowledge transfer Mathur pointed out that possibilities have greatly increased with the use of technology in education (e-learning courses).

Unilateral measures by origin countries such as the requirement for compulsory service at home before allowing graduates to leave may mitigate the brain drain, but both Sana and Cisse felt that the long-term solution really lied in devoting more resources to health care. Sana stressed that origin states have the dual obligation to provide adequate health care delivery services to their citizens and to not treat health workers as “cheap labour”. In India, however, Mathur informed that the Ministry of Health recently announced that it would require a ‘No Objection’ certificate for Indian doctors planning to work in western countries. He said this is in keeping with the intent of the WHO Global code of practice on Ethical Recruitment of Health Personnel.

The migration of health workers from developing countries to developed countries, according to Steffi Jochim from the ILO Regional Office for Asia and the Pacific, simply reinforces existing inequalities between the global centre and periphery; between higher skilled workers and lower-skilled workers; between higher skilled workers from developing countries and higher skilled workers from developed countries, etc. This particular migration pattern also leads to a decline in incentives for both developed and developing countries to invest in public healthcare and training of health professionals. For developed economies, the import of health workers makes it less necessary to invest in training and the influx of nurses and care givers suppresses already low wage levels (for mostly female workers) and decreases the bargaining power of trade union organizations. For developing countries, returns to higher investments in health training are diminished if doctors and nurses work overseas. In Jochim’s opinion this kind of migration provides a strong disincentive for governments to invest in public health and it also means lower wages for health professionals in the developing world and a worsening health care in the developed world. The real solution is for more training of health professionals in the developed world as well as tackling the long overdue health system reform and expansion (including raising public revenues) in developing countries.

A different perspective was offered by Jeremy Prepscius from Business for Social responsibility, in Hong Kong who believed that since there is a business case for attracting and retaining the best talents, employers can differentiate themselves in ways that will not only serve the needs of the migrants themselves, but potentially also that of the communities. For example, transparency in recruiting practices and employment standards, opportunities to align with sending country's training and education programs, sabbatical programs, training endowments and community health matching funds. He suggested that these could lead to a virtuous circle based on transparency and fair competition.

Finally, Khadria raised a larger issue not limited to circular migration or to health workers. He argued that destination countries gain undue advantages since they employ younger temporary migrant workers at low wages and no or little rights to pensions. He added that destination countries benefitted from younger students with latest technologies embodied in them.

## **2.2 Conclusion**

This on-line discussion on circular migration of health professionals yielded some very important insights into why migration policy alone cannot adequately resolve the so-called "global shortage" of health workers.

In the first instance, demand-supply deficits are certain to continue on account of ageing populations and rapidly rising cost of health care in the developed countries. As part of the solution, developed countries must do much more than what they are already doing to motivate their own nationals to pursue occupations in health services, while ensuring foreign workers equal treatment in employment and access to greater security.

Origin countries in the developing world, on the other hand, must give higher priority than before to improving their own health services, including improving conditions of employment for health professionals and reforming practices that discourage their workers abroad from returning. The cost of educating and training health workers is high everywhere, and often involves public subsidy. In most situations the pursuit of better employment conditions in other countries imposes social costs or negative externalities on communities left behind whose health services are adversely affected as a consequence.

Since some countries' dependence on foreign health workers is likely to continue, it will only be fair and equitable for them to share with the states of origin the costs of training and educating such workers. Circular migration schemes can constitute an important part of a global architecture for the resolving the crisis in health care but only if the many complex economic, social, human and ethical consequences of migration can be adequately addressed through cooperation among all affected states.



## Annex I: Background note to the discussion

### Background Facts and Figures

- According to the WHO World Health Report, the world has some 8.6 million physicians to attend to a population of 6.7 billion, or about 780 people per doctor. There are also 1.3 million dentists, 17 million nurses and midwives, and 1.2 million pharmaceutical workers, but health workers are not evenly distributed. In 2006, the WHO reported that there was a global shortage of 2.4 million doctors, nurses and midwives and the shortage was critical in 57 countries, 36 of them in sub-Saharan Africa (WHO, 2006). Contributing to the shortage is the emigration of health workers from poor countries. Loss of health workers through migration has caused global concerns prompting debate on policies that would allow for a more equitable sharing of these scarce human resources. Among these are policies to encourage periodic return or circular migration among the highly skilled including limiting stay through temporary employment visas, grant of multi-year visas, guarantees of readmission, making return a condition for visa extension or conversion to permanent residence, recognition of dual citizenship, and partnership agreements which provide for financial incentives.
- The Americas region (North and South combined) has only 10 per cent of the global burden of disease, according to WHO, yet accounts for more than 50 per cent of the world's financial expenditures on health and employs 37 per cent of the global health workforce (WHO, 2006). Differences between developed and developing countries are immense. In the region, Japan's per capita expenditure on health care (in current exchange rate for US dollars) are 85 times more than of India, 19 times that of China, and 57 times that of the Philippines.
- India with a population of 1.2 billion has 757,000 physicians (or a physician to population ratio of 6.5 per 10,000), while the UK has only a fifth of that number of physicians but there are 27.4 physicians per 10,000 people. The WHO estimated that per capita expenditure on health in the UK in 2009 was 78 times more than in India. The Planning Commission of India estimated that the country is short of 600,000 doctors but only about 30,000 new doctors graduate each year (and 45,000 new nurses).
- The Philippines with a population of over 90 million has about 105,000 physicians (or a physician to population ratio of 11.6 per 10,000). Many Filipino nurses and doctors have emigrated to work in foreign countries. High salaries abroad have motivated many to pursue careers in nursing with some 28,000 to 30,000 new nurses passing the licensure exams each year. However, in the case of doctors only 1,500 graduates of medicine pass the physician board exams each year representing a mere 1.5 per cent increase in the country's supply of licensed physicians.
- Vietnam has a population of about 90 million and has 107,000 physicians (or a physician to population ratio of 12.2 per 10,000). The country lost through emigration many highly-trained professionals during the war but this appears to be no longer a problem. Lack of proficiency in the English language has also limited possibilities for Vietnamese nurses to get jobs abroad.
- About half of foreign-born doctors or nurses working in OECD countries are located in the United States, almost 40% in Europe and the remainder in Australia and Canada. Many have migrated with their families and those in the US, Canada, and Australia are likely to have acquired permanent residency status. Statistics on the return of these professionals are not systematically

collected (or at least are not reported) but the continued growth of various migrant populations in OECD countries suggests that return flows have not been significant.

- Foreign-born nurses represent a sizeable proportion of all nurses employed in several OECD countries as shown below:

Table 1 Percentage of foreign nurses employed per country of residence, selected OECD countries, 2008.

Country of residence	Foreign nurses as a % of total nurses employed
Australia	24.8
New Zealand	23.3
Canada	17.2
UK	15.2
Austria	14.5
Ireland	14.2
USA	11.9
Germany	10.4

- Some Asian countries provide many of the health professionals employed in the OECD countries. In the United States more than half of the foreign-born doctors and 40% of the nurses originated from Asia. In Australia, Asian doctors represented 43% of all doctors, in Ireland 48% and in the United Kingdom as much as 55% (OECD).
- The Philippines and India are the biggest sources of foreign health workers for the OECD countries. According to an OECD report in 2010, Filipino-born nurses and Indian-born doctors each represent about 15% of all immigrant nurses and doctors in the OECD. About 56,000 (8%) of doctors trained in India have migrated to OECD countries. There are no statistics on how many return but there are anecdotal evidence of overseas Indian doctors returning for short periods of stay to share their skills and know-how with their counterparts in India. Some overseas Indian doctors have established modern hospitals in India and return annually to practice. OECD statistics indicate that about 16,000 physicians and 110,000 nurses born in the Philippines are working in Europe and North America. There are no statistics on how many return, but in recent years about 75 per cent of nurses leaving the country each year go to the Gulf States for short-term contractual employment, and return home or move to another country after the end of their contracts.
- In recent years other countries have also emerged as important destinations, but mainly for temporary contractual employment. According to Philippine authorities some 12,000 nurses leave the country annually to work abroad, some 74 per cent of them bound for destinations other than the OECD such as the Gulf States. Most of these health workers do return to the Philippines after completion

### **Demand for Health Professionals**

Highly educated professional workers are generally welcome everywhere and physicians and related medical professionals are among those given high priority for admission especially in the OECD countries. The US alone has 337,000 foreign-born nurses, the UK 82,000, Canada 49,000 and Australia

47,000 (OECD, 2007). The demand for foreign medical workers is driven by an aging population, an aging health workforce and the introduction of new technologies needing health professionals in developed countries. It may also be driven by spending for health care in the developed countries which rose rapidly over the past decade until the financial crisis led to a virtual freeze by 2010. The Association of American Medical Colleges estimates that in 2015 the US will have 62,900 fewer doctors than needed. And that number will more than double by 2025, as the expansion of insurance coverage and the aging of baby boomers drive up demand for care. Even without the health care law, the shortfall of doctors in 2025 is expected to still exceed 100,000 (Lowery and Pear, 2012).

### **Cost of Out-Migration of Health Professionals**

Training of physicians who end up working abroad is an enormous burden on origin states. In India medical education is highly subsidised by the state and the cost is very high. The Grant Medical College in Mumbai estimated that it costs the Government up to \$ 62,000 to train one physician over 5 1/2 years. About 60 per cent of graduates are trained in state universities. In the Philippines subsidy for medical education is only in a few state universities which produce only a few hundred new physicians each year. The bulk of the 1,500 new physicians each year are trained in private medical schools. In Vietnam a rather dated study estimated that in 1997 it cost \$ 9,527 to produce one physician or medical doctor in local currency or about 14 times the cost of training one nurse (Bicknell et al, 2001).

To origin countries the emigration of health professionals represent lost investments and a subsidy to the rich countries which benefit from their services. A study estimated the loss suffered by nine sub-Saharan countries (Ethiopia, Kenya, Malawi, Nigeria, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe) that invested through subsidies in physician's education. The estimated costs of a physician's education ranged from \$ 21,000 in Uganda to \$ 58,700 in South Africa. The overall estimated loss of returns from investment for all physicians currently working in the destination countries was \$ 2.17 billion, with costs for each country ranging from \$ 2.16 million for Malawi to \$ 1.41 billion for South Africa. Expressed as a percent of gross domestic product the losses were largest in Zimbabwe and South Africa. The benefit to destination countries of recruiting trained physicians was largest for the United Kingdom (\$ 2.7bn) and United States (\$ 846m) (Mills et al 2011). In the US, in the late 1990's it was estimated that medical education cost \$72,000 to \$83,000 per student/year, or about \$ 288,000 to \$ 332,000 for a 4 year course needed to produce one physician (Bicknell et al).

### **Consequences related to achieving Better Health Outcomes due to the Migration of Health Professionals**

In India and the Philippines only 58 percent and 62 percent, respectively, of childbirths have been attended by skilled health personnel, while almost all births are so attended in the developed world (WHO 2010). Fewer individuals and families have access to a health worker, more so, to quality health care in these developing countries. The emigration of health professionals is not helping narrow the health equity deficit between countries. Infant mortality rate (IMR) and maternal mortality rate (MMR) are still very high in both India and the Philippines which supply the OECD with many health professionals. In 2008, the IMR and MMR in India were 52 and 254, respectively, and in the Philippines, 26 and 162, respectively. By comparison in the United Kingdom, the IMR was 5 and the MMR was 7; in the United States, the figures were 7 and 13, respectively (WHO 2010).

Finding a satisfactory solution to this global problem has proven very illusive. In the U.S. reported median annual earnings for registered nurses in 2002 was \$ 48,090; in hospitals and nursing homes where foreign nurses worked, earnings averaged \$ 49,190 and \$ 43,850, respectively. By comparison in the Philippines, registered nurses were paid annual salaries of between \$ 2,000 and \$ 2,400 in 2002.

Economic gains through better salaries and potential amount of remittances are often seen as pull factors for migration. Closing the gap between salaries for health workers in the OECD and in the source countries is not a real option given the wide difference in levels of development. In fact the income gap between these countries has been widening instead of narrowing over the past decades. Migration management was perceived as a way to ensure the right to health in source countries and the right of health professionals to move and seek employment overseas. Codes of practice and government to government agreements were designed to balance these interests.

### **Suggested issues for discussion**

1. Have there been government to government agreements which sufficiently satisfy the right to health of families in source countries, the right of health professionals to move and seek employment overseas and their right to decent work? If not, how can agreements be designed to achieve more acceptable compromises?
2. The European Commission has promoted “partnership policies” to address problems of illegal migration as well as the adverse consequences of health worker migration. One important form of partnership is the promotion of “circular migration”, an approach involving some kind of “rotation” through periodic return of health workers to their home countries. Policies to promote it include guarantees re-admission, recognition of dual citizenship, multiple-entry and multi-year visas, etc. Because trained health workers can also render services in their countries when they return this can be a “win-win” approach to mitigate shortages of health workers. However, the approach has been criticized as unrealistic: employers want to keep their experienced foreign workers, while the workers want greater job security, family reunification and maintenance of their families’ standards of living in the destination countries. Workers seeking to maintain their incomes also tend not to return to their own countries, but seek employment in another.
  - For the health worker who returns to his or her country of origin, how can disadvantages from disrupted service and loss of seniority be mitigated through employment guarantees? What are the options for returning health professionals?
  - Is there a way to ensure that employers benefit from such policies? How can resistance of employers to rotation be reduced by subsidizing or minimizing the cost of recruitment? For example, at present hospitals in the US are reported to incur costs of between US\$ 5000 to \$ 10,000 to recruit one nurse from the Philippines.
  - There is a “trade off” between income security for the health workers and better access to health services for communities left behind? What information is necessary to make these alternative benefits comparable?
3. The Commonwealth countries have adopted the so-called “ethical recruitment policies” and the WHO Global Code of Practice on Ethical Recruitment of Healthcare workers was recommended to member states in order to protect countries “at risk” of losing more of their much needed health workers. There is however little evidence on how such policies work.
  - Have these policies actually been implemented?
  - Have they managed the “drain” in health professionals in source countries?
  - If not, how can they be made more effective?

4. It has been suggested that the better option is to increase the supply of skilled workers (especially health workers), in source and in destination countries. In the case of health workers the cost of training is much higher than for most other fields of study. Training a medical doctor involves a huge investment requiring at least 5 years. There is also the need to motivate graduates of medical training, such as nurses who leave the health workforce because of poor employment conditions in health services, to return. Destination countries may contribute technical and financial resources for training more health workers in source countries.
  - How can the responsibility (and thus the burden) for training highly-skilled migrant workers be shared between origin and destination states? What principles should be considered for such sharing?
  - Are there public as well as private sector arrangements outside the health sector that can serve as models for organizing mutually-beneficial migration of health workers?
  - Should licensing overseas-educated medical workers be an integral part of such schemes?

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## **Annex II: List of participants**

### **Moderator:**

Mr Manolo Abella, independent consultant and former Director of the ILO's International Migration Programme ILO Decent Work Across Borders.

### **External Participants:**

Ms Agnieszka Makulec, Center for Migration Research of the University of Warsaw, Poland

Ms Aradhana Srivastava, Public Health Foundation of India, India.

Mr Binod Khadria, Jawal Nehru University, India

Ms Carmelita S. Dimzon, Overseas Workers Welfare Administration, Philippines

Ms Ellen Sana, Center for Migrant Advocacy, Philippines

Mr Ferruccio Pastore, Director – Forum de Recherché Internationale et Européene, Italy

Mr Indrajit Hazarika, India Public Health Foundation, India

Mr Jeremy Prepscius, Business for Social Responsibility, Hong Kong

Mr John Gee, Transient Workers Count Too, Singapore.

Mr John Skrentny, University of California – San Diego, United States of America

Mr Pawel Kaczmarczyk, Center for Migration Research, University of Warsaw, Poland

Mr Philip Martin, University of California – Davis, United States of America

Mr Shiv Chandr Mathur, public health specialist, India

Ms Stella Go, De LaSalle University, Philippines

Mr Stephen Castles, University of Sydney, Australia

### **ILO Participants:**

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Ms Catherine Vaillancourt-Laflamme, ILO Country Office for the Philippines, Manila, Philippines

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### **AP-Magnet Facilitator:**

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