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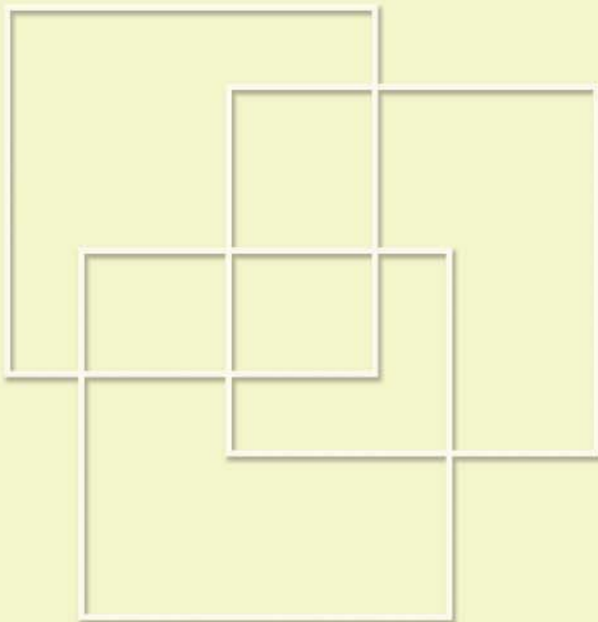
Circular migration of health-care professionals: What do employers in Europe think of it?

Tina Weber
Helen Frenzel
ICF International

October 2014



Promoting Decent Work Across Borders:
A Project for Migrant Health Professionals and Skilled Workers

Country Office for the Philippines

ILO Asia-Pacific Working Paper Series

Circular migration of health-care professionals: What do employers in Europe think of it?

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A report prepared for the EU-ILO Project on
Decent Work Across Borders:
A Pilot project for Migrant Health Professionals and Skilled Workers,
Manila, Philippines

Country office for the Philippines

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ILO Cataloguing in Publication Data

Frenzel, Helen; Weber, Tina

Circular migration of health-care professionals: what do employers in Europe think of it? Helen Frenzel, Tina Weber; International Labour Organization, ILO Country Office for the Philippines. Makati City: ILO, 2014.

ISSN: 2227-4391; 2227-4405 (web pdf)

International Labour Organization; ILO Country Office for the Philippines

nurse/medical personnel/labour migration/return migration/international migration/migrant worker/ management attitude/health service/EU countries

13.11.2

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Printed in the Philippines

Foreword

Circular migration has been hailed by many as a triple win solution to migration. It has been said to benefit destination and source countries and migrant workers themselves. Many have welcomed the concept as a process susceptible to increase the development benefits of labour migration.

Beyond the theoretical discourse around the concept, the real appeal of circular migration remains to be better understood. The concept remains a sensitive one, and is often understood differently by different stakeholders across the migration continuum. The existing literature on the concept of circular migration seems to remain at a rather general level and has, until recently, failed to investigate in greater detail the particular opinions of various stakeholders on the matter. More precisely, little information is available on the possible challenges and benefits the concept can bear from the view point of employers.

The ILO is proud to contribute to the debate around circular migration by filling some of the gaps identified by its European Union funded project called *Decent Work Across Borders*, a project focusing on the circular migration of health professionals between the Philippines, India and to some extent Viet Nam to selected destination countries in Europe. The ILO wishes that this new publication will expand the knowledge on the subject and contribute to the international dialogue on circular migration by documenting the source and destination's countries' private and public employers' perspective on the issue of circular migration.

The ILO is grateful for the expertise of the Ms Tina Weber and Ms Helen Frenzel from ICF International, consultants to the International Labour Organization in the context of this research endeavour.

Lawrence Jeff Johnson
Director
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Acknowledgement

The authors would like to thank all organisations who agreed to be interviewed for this study. Particular thanks are due to Catherine Vaillancourt-Laflamme, chief technical advisor for the ILO in Manila for her insightful comments and improvements in the drafting of this report.

Executive summary

This paper captures the findings of a study on employer views regarding the importance and feasibility of the implementation of circular migration policies. It is based on desk review and interviews with employers' organisations, individual employers, public employment services and ministries and agencies responsible for co-ordinating international migration of health-care personnel. Interviews focussed on the experience in a selected number of countries (Finland, Germany, Ireland and the United Kingdom), which are among the destination countries for health-care professionals from the Philippines and India.

It discusses the development of the policy debate around the concept of circular migration and contrasts this with the reality on the ground.

Circular migration as a panacea to address any negative impacts of the international migration of health-care professionals?

International migration of health-care professionals is by no mean a new phenomenon, but increased in intensity over the last decade as the impact of demographic change in many European countries led to an increase in demand for health-care services, while at the same time reducing the supply of labour. While labour demand has been affected by budgetary cuts in some countries in the years following the financial crisis and economic recession, in future it is likely that long-term demographic trends in Europe will mean that demand for foreign labour will remain a future of health-care systems.

Increases in migration flows have brought greater attention from policy makers on the positive, as well as the negative economic and social effects of migration. As awareness of the potential negative impact of migration for origin countries (e.g. brain drain), but also destination countries (e.g. issues around integration, discrimination, issues around the recognition of training and experience acquired in other countries etc.) has grown, there have been efforts to formulate policies to address such impact. This includes guidelines and codes or practice on ethical migration. In the European Union and a number of its member countries, this has led to the promotion of the concept of circular migration. While different definitions have been used to describe the concept, it essentially captures the idea of temporary, repeat migration, which would allow destination countries to benefit from the opportunity to fill labour and skills gaps, whilst encouraging/ensuring that foreign skilled workers return to their country of origin, having benefited from further training and work experience, thus enriching the health-care systems of the origin countries. As such, the model has been promoted as a "win-win-win" scenario. However, this concept of the "triple win" has been questioned in a number of studies. Most prominently, Wickramasekara (2011) sees it as an extension of the desire by destination countries to bring in "labour" but not "people", thus limiting potential benefits to migrants as well as origin countries. He argues that the emphasis on flexibility in approaches to managed migration only reflects the desire of destination countries to be able to use migrants as a way of meeting significant labour shortages, without the need for integration measures, as the flow of such migrants can be restricted and those who have already arrived can be sent home when demand declines.

In response to such criticisms, some countries have assessed their managed migration policies to ensure, for instance, longer periods of stay; the possibility of multi-entry visas; ensuring support for integration in the destination countries, as well as support with re-integration in the countries of origin. However, what has been almost entirely ignored in this discussion is the reality of migration on the ground and, crucially, the views of employers who are ultimately the source of demand for such labour.

The reality of circular migration: more fiction than fact

Desk research and interviews carried out for this study show that circular migration among health-care professionals coming to Europe is more of a myth than a reality.

Consultations with employers and government representatives demonstrate that even in managed migration policies, little emphasis is currently being placed on supporting the notion of circular migration, with more efforts expended to ensure ethical recruitment and the managed integration of migrant workers in the sector.

Where there have been efforts to introduce circular migration schemes in Europe (in the health-care sector and beyond), these are largely in their infancy or proved (as in the case of the Blue Birds scheme in the Netherlands) to be ultimately unsuccessful.

The main reason for this lies rooted with the interests and motivations of employers in the sector, whose main priority is to attract a highly qualified workforce to deliver a good and reliable standard of care to their patients in an effective and efficient way.

While there is some interest in transnational recruitment where relevant qualified workers cannot be found locally -- and a positive message from this study is that there is indeed growing awareness and willingness to respect codes of conduct on ethical recruitment -- there is generally little interest in time-limited recruitment of highly qualified workers. This is particularly true where the upfront investment in achieving the recognition of foreign qualifications and in integration measures is significant. The shortage of highly skilled labour in the health-care sector in many countries tends to be structural and employers are therefore keen to retain workers. Where there is a willingness to invest in training and integration this is very much targeted at retention rather than letting staff take these skills to other employers or abroad after a period of time. Understandably, employers therefore do not pursue development goals, but are concerned with the delivery of high quality health care to their patients.

While governments may have wider interests and seek to foster circular migration, these interests rarely coincide with those of employers in the health-care sector. The literature has previously emphasised that circular migration may appear more attractive to lower-skilled sectors and where demand is more seasonal.

To make circular migration more attractive for employers, it is important for more rapid and reliable processes for the recognition of qualification to be in place and for government support to be offered for the integration of migrants (thus reducing the overt and hidden costs of integration). A clear integration of all stakeholders into managed migration policies, going hand-in-hand with greater emphasis on clear monitoring of labour demand and workforce migration strategies, would ensure that demand for such migrants does not necessarily become permanent.

Such requirements can only be achieved through managed migration policies ensuring close co-operation between origin and destination countries, including the contribution of actors relevant to the health-care sector. Those include government, employers, trade unions and also professional organizations and recruitment agencies. At present, it appears that such all-inclusive design and management of migration systems remains limited, and even where they exist (e.g. Germany) they currently do not ultimately aim at circular migration. The number of participants in such managed migration programmes would have to be rather significant to help to create the momentum for change and to have a relevant economic impact. It has therefore been suggested that it would be beneficial if several European Union countries

would receive professionals. This kind of programme could be steered by the European Commission. To make the return home for participants easier and more attractive, it must be ensured that they return to key positions to integrate their knowledge, again requiring greater co-operation between different stakeholders in destination countries and countries of origin.

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This publication has been produced with the assistance of the European Union. The contents of this publication are the sole responsibility of Tina Weber and Helen Frenzel, consultant to the International Labour Organization, and can in no way be taken to reflect the views of the European Union.

1. Introduction

1.1 Background and purpose of the project

This report is prepared for the International Labour Organisation (ILO) within the context of its *Decent Work Across Borders: A Pilot Project for Migrant Health Professionals and Skilled Workers*, which has been under way since 2011 with funding from the European Union (EU). The project seeks to better understand schemes in line with circular migration of health professionals by engaging with governments, trade unions and employers' organisations around three main objectives:

- To strengthen mechanisms of policy dialogue among stakeholders
- To strengthen employment services for health-care professionals and skilled workers
- To enhance labour market information systems with regard to the migration of health-care professionals and skilled workers

The overarching goal is to facilitate an approach to migration that benefits the migrant worker, the origin and the destination countries within a rights-based framework for labour migration management. The project has a particular focus on health-care workers from the Philippines, India and Vietnam.

The ILO is the United Nation's international organisation responsible for drawing up and overseeing international labour standards. Integral to its mandate is to protect migrant workers[1]. The ILO has pioneered international conventions to guide migration policy and protection of migrant workers, specifically Convention No. 97 (Migration for Employment Convention, 1949) and Convention No. 143 (Migrant Workers' Convention, 1975). Further, in 2006, the ILO Multilateral Framework on Labour Migration was adopted in response for demands for practical guidance and action with a view to maximising the benefits of labour migration for all parties.

International migration among health-care professionals is not a new phenomenon, but migration flows of workers in this sector have increased significantly in recent years and are attracting more attention from policy makers because of their economic and social effects (both positive and negative). As awareness of the potential negative impact of migration for origin countries (e.g. brain drain), but also destination countries (e.g. issues around integration, discrimination, the recognition of training and experience acquired in other countries etc.) is growing, there have been efforts to formulate policies and guidelines on ethical migration. Examples are the *Global Code of Practice on the International Recruitment of Health Personnel* issued by the World Health Organisation in 2010, the Commonwealth Code of Practice for the International Recruitment of Healthcare Workers (2003) applicable to all employers (private and public, and recruitment agencies) in the 53 Commonwealth countries, as well as at 2008 the European level with the *Code of Conduct on Ethical Cross Border Recruitment and Retention* agreed by HOSPEEM and EPSU. At the national level, examples are the *Code of Practice for International Recruitment for NHS Employers* in the United Kingdom.

[1] This mandate was reaffirmed by the 1944 Declaration of Philadelphia and the 1998 ILO Declaration on Fundamental Principles and Rights at Work.

The EU and a number of its Member States have sought to address this issue by promoting the concept of circular migration. While different definitions have been used to describe the concept, it essentially captures the idea of temporary, repeat migration, which would allow destination countries to benefit from the opportunity to fill labour and skills gaps, whilst encouraging/ensuring that foreign-skilled workers return to their country of origin, having benefited from further training and work experience, thus enriching the health-care systems of the origin countries. As such, the model has been promoted as a "win-win-win" scenario. However, the question of the benefits for all parties concerned is not uncontroversial, as well as the desirability of it.

1.2 Aims and objectives of the study

The project aims to increase the existing knowledge base on circular migration among health-care professionals in particular and the strengthening of policy dialogue on this issue.

As indicated, circular migration has recently been heralded as a triple-win solution that can benefit both destination and origin countries, as well as migrant workers themselves. However, a clear definition or common understanding of how the concept can be implemented is yet to emerge.

Similarly, despite the emphasis placed by policymakers on the promotion of the concept of circular migration, little is known about how widespread the practice is in reality, including among health-care workers. The same is true for its implications both for migrant workers and health-care employers both in the origin and destination countries. A paper published by Wickramasekara (2011) argues that there is little evidence that circular migration benefits -- or is indeed desired by -- migrant workers. Instead, it is seen as a way for employers to engage in flexible hiring and firing whilst saving on integration costs. He argues that circular migration can be used to "bring in labour, but not people" (p. 86) and thus contributes to control population movements between countries. A critical interpretation of the use of facilitated circular migration schemes as a way to control migration, couched in terminology of triple-win benefits, has also been made by Cassarino (2013).

The starting point for this project is the recognition that very little is known about the employers' perspective on circular migration and it is this gap that this study sought to address. A paper documenting trade unions' perspectives on circular migration was published in 2011. The goal was therefore to gather the views of public and private health-care employers and employers' organisations to help foster a fruitful policy dialogue on the issue.

The focus of the study was on the migration of Filipino and Indian health-care professionals to Europe. Germany, Ireland and the United Kingdom were selected as case study countries, as they are among the main destination countries of health-care professionals from India and the Philippines. Information was also gathered in Finland, which has significant experience of the migration of health-care workers, and relevant experience of circular migration in other EU countries with regard to employers' perceptions was also taken into account.

The study supplements existing reviews of the literature on circular migration and gathered the views of health-care employers and employers' organisations through interviews at various levels. The study also reviewed relevant government and workplace policies on the recruitment of health professional migrants in circular migration schemes. As a result of the review of the literature and stakeholder

consultations, this document draws conclusions on reality of circular migration of health-care workers to Europe as they are impacted by the position of employers on this issue. The study provides policy recommendations on measures able to entice employers to adopt practices in line with circular migration.

1.3 Method

The method for this study therefore involved a review of literature with a focus on employer positions and specific governmental agreements on circular migration (see the bibliography for sources used) and interviews with transnational and national employers' and workers' organisations in the health-care sector; and public and private health-care employers themselves. The table below lists the number of organisations contacted and the responses received. It proved particularly difficult to identify individual employer to respond, particularly as they considered the subject to be of limited relevance to them, either because few migrant workers are used or because the concept of circular migration had no application in practice in their organisation. The latter is confirmed by other research findings (e.g. Brand, 2012).

Other factors also impacted responses (or the lack thereof) from employers in the context of a project focussing on migration by health-care workers from the Philippines and India. All EU employers are required to recruit first among the EU/EEA health-care professionals to fill their positions. This is also politically encouraged at the national and EU-level, taking into account the high unemployment rate of young people in Europe in the aftermath of the economic and financial crisis. Hence, international recruitment did not seem to be a priority among employers during the time of study. Where circular migration between EU countries was discussed as a policy issue, any evidence from such practices has been taken into account for the discussion in this paper.

A semi-structured questionnaire was used to carry out telephone or face-to-face interviews (see Annex 1 for the questionnaires used with different stakeholders). A cascading approach was used to identify potential interviewees. International and European employers' organisations and trade union organisations were contacted first, who provided some details of their members in the relevant study countries. Subsequently, relevant ministries, public employment services and national employers' organisations were contracted and interviewed. These interviews were also helpful in identifying relevant employers known to have experience employing migrant workers.

Table 1. Organisations consulted

Type of organisation	Number of contacts	Number of responses
International		
International employers' organisations	5	3
International trade union organisations	4	2
Finland		
Government department	2	1
Individual employer	3	1
Academic expert	1	1
Germany		
Employers' organisations	5	3
Government department	3	2
Individual employer	4	2
Trade union organisation	1	1
Non-governmental organisational		1
Ireland		
Trade union organisation	1	1
Employers' organisation	1	
Individual employer	2	
UK		
Employers' organisation	1	1
Individual employer	1	
Academic expert	2	2
Total	**36**	**21**

The difficulty in identifying employers with relevant experience of employing migrant workers from countries outside the EU and particularly having experience of circular migration proved one of the biggest challenges for this project. All employers contacted were asked about their views of circular migration, even if they were currently not using such schemes. However, in the views expressed, the concept of circular migration was often conflated with that of ethical migration (which many were prepared and able to speak about). When the concept was explained, most employers considered this to be of little relevance to them, as will be discussed in subsequent sections of the document.

2. Circular migration of health-care workers: triple win, dead end or myth?

This section contrasts the "theory" or the policy thinking behind circular migration with the reality of the extent to which it is currently practiced for health-care workers coming to work in selected European countries, and the views expressed by employers on the desirability of using circular migration approaches. Beginning with a definition of the concept and the evolution of the policy debate and moving on to the reality of actual migration and migration policies, it shows a clear disconnect between the policy rhetoric of circular migration and its reality.

2.1 Definition and types of circular migration

Despite the increasing use of the concept of circular migration in policy discussions, there is no one agreed-upon definition of the concept. Indeed, the definitions applied have evolved over the years and can also be seen to reflect the perspective of the organisation formulating them. Essentially describing the temporary movement of individuals between locations, usually with a repetitive character, this term has been used for some time to describe the temporary movement usually of migrant workers either from rural area to cities or across borders. Wickramasekara (2011) describes circular migration as *"temporary movements of a repetitive character either formally or informally across borders, usually for work, involving the same migrants"*. A distinction can be drawn between spontaneous circular migration and regulated circular migration programmes.

Indeed, a definition from the European Commission (2007) only refers to the latter and defines circular migration as a form of *"migration that is managed in a way allowing some degree of legal mobility back and forth between countries"* (p. 8).

The concept of circular migration has also been referred to as "brain circulation" combining the concepts of "brain drain" and "brain gain". "Brain circulation" refers in a broad sense to the movement of skilled workers from and to a country. Yet brain circulation has also been used in the area of training and career development describing the exchange of trainees and scholars that seek an international work experience to secure more advantageous employment conditions in their home country. This type of brain circulation can be observed -- to a limited extent -- for doctors or highly specialised nurses, but is not a significant feature in the migration of other health-care workers. There are a number of models of migration that have been described as "circular" or circuit based, but which do not always imply a regular or repeat return to the destination country.

The existence of patterns of circular migration is not new, and the concept was used to analyse migration from rural to urban areas within one country or cross-border migration. It has previously also been described as a repeat, cyclical, seasonal or circuit based mode of migration. Germany tried to implement such a circular migration in the 1960s when inviting workers from southern Europe and Turkey to come as "Gastarbeiter" (guest workers), implying that workers are received on a temporary basis only. Yet once the wave of migration was stopped in 1973 due to the oil crisis, migrants had the choice to either return to their home countries or stay and move their families, who had remained in the home country to come to Germany. Between 1962 and 2005, for every 80 migrants arriving in Germany, there were 56 return migrants on average (Kirdar, 2013).

An example for circuit-based modes of migration could be seen in the migration of young Irish nurses migrating to the United Kingdom to receive furtherer training, gain work experience and return to Ireland once they are in a later stage in their career, to return later for further training and experience. Scandinavian countries experience similar circuit-based migrations when nurses from Finland left to work in Sweden and Norway and return at the end of their careers. Many European doctors migrate to other countries (the United Kingdom, Switzerland, and the United States) to gain in work experience in their training phase. Many return later to their home country to access leading positions in hospitals. Finally, it should be noted that the primary destination of many Filipino nurses, the United States, is reached after several years of "country hopping". They start in Gulf countries, having low entry levels to the profession. But due to the temporary nature of work permits, many continue to subsequently migrate then to the United Kingdom and other EU countries in order to finalise their careers in the United States -- immigration policies and visa restrictions permitting (e.g. Humphries et al., 2009).

With the exception of the experience of circular migration of Indian or Filipino nurses to the Gulf countries, few of the models described above qualify to meet the strict definition of repeat circular migration, which would require the same individuals to come to train or work in a destination country, return home for a period of time, and come back to work in the destination country on a repeat or regular basis. Such patterns are much more common in other sectors (e.g. seasonal agriculture or to some extent tourism). Such models of repeat migration were also more common among (home) elder carers in Western Europe prior to full mobility, when individuals were required to return home after a period of six months.

Overall, it is important to note that repeat circular migration is a very poorly understood concept. Where circular migration is referred to at all in the national policy dialogue, this usually simply refers to migration from an origin to a destination country in which the migrant worker usually returns to their home country after a period of time (without a particular intention to return again). No examples of repeat circular migration between European and third countries could be found in the health-care sector in the countries assessed for this study.

2.2 Policy debate

2.2.1 The rise of the concept of circular migration

It is primarily over the last decade that the concept of circular migration has received increasing attention in policy circles. In 2005, a report by the Global Commission on International Migration (GCIM) noted that "the old paradigm of permanent migrant settlement is progressively giving way to temporary and circular migration. The Commission underlined the need to grasp the developmental opportunities that this important shift in migration patterns provides for countries of origin." In order to make this shift, the GCIM recommended that "countries of destination can promote circular migration by providing mechanisms and channels that enable migration to move relatively easily between their country of origin and destination".

In the same year, the International Organisation for Migration (IOM) also endorsed the concept that circular migration could bring benefits, particularly for developing countries (IOM, 2005). Similarly, the European Commission in its "Communication on Migration and Development" (EC, 2005) suggested that circular migration policies could play an important role in fostering the transfer of skills to the developing world.

In this scenario, circular migration has been hailed as benefitting destination societies by allowing them to respond flexibly to rapid growths and declines in labour shortages. Migrants themselves not only have the possibility to find gainful employment, but also to enhance their skills and therefore, in theory at least, improve their opportunities for better quality employment and progression at home. Origin countries are also seen to benefit from the additional skills acquired by circular migrants (brain circulation rather than brain drain) as well as seeing their growth potential boosted by the remittances sent home by workers on foreign assignments (Vertovec, 2007). The idea of so-called "brain gain" for the origin countries is predicated on the assumption that migrant workers will be able to utilise any skills gained abroad in the field in which they were acquired (or in a related activity) and therefore positively contribute not only to the economy but also organisational or skills development back in their home country. This is by no means guaranteed. It could be argued that if skills acquired by working abroad cannot be used effectively upon returning, it could lead to disillusionment and could act as an incentive to leave again and potentially to never return. Another motivating factor in migration practice is the limitation of irregular migration practices through managed (circular) migration. The Commission Communication on circular migration and mobility partnerships from 2007 states that:

"Once certain conditions have been met, such as cooperation on illegal migration and effective mechanisms for readmission, the objective could be to agree on ***mobility packages*** *with a number of interested third countries, which would enable their citizens to have better access to the EU. There is a clear need to better organise the various forms of legal movement between the EU and third countries. Mobility packages would provide the overall framework for managing such movements and would bring together the possibilities offered by the Member States and the European Community, while fully respecting the division of competences as provided by the Treaty."*

However, such mobility pacts are not without their critics, particularly where they are not based on voluntary return (see also section 2.3.2) below.

The European Migration Network of the European Commission provides the following interpretation of the triple-win argument (EMN, 2010): *"Circular and temporary migration is reflecting globalisation, demographic change, new patterns of mobility and the growing demand for flexible labour markets. It also reflects a preference of many of the migrants themselves. Given this context, circular migration is a migratory phenomenon that is increasingly being discussed in worldwide terms of effective migration management, as well as a potential contribution to development. Covering migrants at all skill levels, it is viewed as a means to serve the labour market needs of countries of destination, promote development in countries of origin, and benefit the migrants themselves."*

Other observers of the migration debate have pointed out that the entire concept of circular migration seems to have been developed to tackle a number of political issues emerging in the destination countries. As such, the concept would have been coined to allow developed and destination countries a "good conscience" as circular migration pushes for the return of skilled migrants to their origin countries. The concept allows destination countries the possibility to address the brain drain situation facing developing countries with regard to skilled labour. In the context of the economic crisis that has affected many destination countries with an increase of unemployment rate, circular migration -- in other terms, temporary migration -- has been said to be a way for destination countries' governments to make migration more "palatable" to voters.

The assertion that circular and temporary migration also reflects the preference of migrants (and third country migrants in particular) is not clearly based on specific survey evidence. Overall, third country migrants may express a preference to ultimately return to their home countries where they have family, social and cultural ties, but such a decision is often dependent on the improvement of the economic or political situation in the home country. In case of such improvements in the origin country, it is unlikely that there would be a preference for repeat circular migration.

Circular migration has been seen as a concept with potential for migrant health-care workers, employers and destination countries if workers' employment rights, rights for equal treatment, recognition of professional qualification and experience, and portability of social protection entitlements are recognized and enforced. Naturally, the origin country would benefit once the migrant decides to return. It has been the opinion of most of the interviewees for this study that return should not be an obligation, and that it should not be imposed on migrants. Destination countries could rather provide funds for migrants wishing to return to their home country, allowing them, for example, to create a business.[2] Destination countries should furthermore make effects of migration in their home country more explicit to health-care professionals in specific trainings and provide further options to help build health-care systems back in their home country. One example that applies these principles in practice is the German "Triple Win Programme". The programme helps nurses from the Philippines, Serbia, Bosnia and Herzegovina and Tunisia[3] with the recognition of their diplomas, acquisition of language and approbation testing in Germany. It guarantees that nurses are engaged in a two-year work contract upon their arrival (can be extended to five years) and ensures that nurses are employed according to national labour laws, collective agreements and pay rules. The programme recruits nurses only via public employment service and not via private employment agencies, thus limiting costs for migrant nurses. In addition, Germany provides return funding. Through a separate development programme, Germany also invests in the Philippines in training programmes for long-term care to provide new opportunities for the Philippines health-care sector. While the German Triple Win Programme is generally considered one of the best examples of this type of arrangement, some concerns have been expressed[4] over the lack of precision regarding the portability of social protection entitlements. Furthermore, this agreement is not aimed at encouraging circular migration, but rather opens the door for permanent settlement. It should therefore be seen as an example of efforts to ensure regulated migration guaranteeing basic working conditions (through collective agreements), supporting training, and encouraging investment in countries of origin, but this is not done through a process of circular migration.

At another level, although this is not the focus of the current paper, it may be worthwhile mentioning that some origin countries, and India is one of them, have adopted pro-active measures to attract back health professionals who are now contributing significantly to the health outcomes of their country.

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[2] The entrepreneurship impetus of returned migrants has not yet been proven. Further, in the case of health professionals, whom may not have "by nature" the most entrepreneurial profile, establishing a health-related business requires access to significant funds, a strong network, a name and references.

[3] www.giz.de/en/worldwide.20322.html

[4] As indicated, for instance, by the ILO.

2.2.2 Challenges to the "triple win" argument

The concept of the triple win argument has been called into question in a number of studies. Wickramasekara (2011) sees it as an extension of the desire by destination countries to bring in "labour" but not "people", thus limiting potential benefits to migrants as well as origin countries. The emphasis on flexibility in approaches to managed migration only reflects the desire of destination countries to be able to use migrants as a way of meeting significant labour shortages, without the need for integration measures, as the flow of such migrants can be restricted and those who have already arrived can be sent home when demand declines. He points to the experience of the Gulf countries, with long-standing experience of such forms of temporary repeat migration and indicates widespread abuse and exploitation to be found in such employment relationships. Often dominated by poor working conditions and low wages, they also pose a risk of undermining employment conditions for the domestic workforce, thus heightening social tensions.

As indicated above, Cassarino (2013) also raises criticisms against the concept of circular migration, seeing this as another way that destination countries can control migration without giving significant consideration to the preferences or rights of the migrant worker.

The experience of circular migration (voluntary or not) is primarily being seen as a phenomenon in low wage, low-skilled sectors, where the potential for workers to obtain training and skills to benefit their origin countries -- and indeed to send home often vital remittances -- is rather limited. So far, the reality of the existence of circular migration patterns in the health-care sector has not been discussed in detail in academic studies, but evidence gathered for this study appears to confirm that the practice is indeed not widespread and where it exists, it is primarily on the basis of inter-governmental agreements.

In particular, programmed temporary migration linked to seasonal employment has been seen as a trap for migrants. Basok (2003) examined such circular seasonal migration programmes between Mexico and Canada and found that returning year after year to the same employer and region had a stagnating effect on migrant's careers in the destination country. They were not able to improve skills or participate in training programmes. On the other hand they were able to use remittances to improve their lifestyle back home e.g. for education of their children or medical treatment or start an own company. Yet long periods of circular migration are necessary for the worker to substantially improve his/her personal situation in their home country, leading to a strong dependency on work in the destination country -- and sometimes accepting abuses from employers.[5]

Frequent separations from families at home are similarly considered to bring with it potential human and social costs.[6]

For the above mentioned reasons, the benefits of circular migration are therefore seen to be exaggerated and it is called into question whether these forms of migration are indeed the "natural preference" of migrants as is argued in some policy documents. Managed, as well as ad-hoc temporary migration patterns, can limit migrant's job choices and often their ability to change employer, thus tying them into structures of dependency and powerlessness with little say over work patterns or terms and conditions, or indeed the timing of return and family reunification.

[5] Basok, T. 2003. "Mexican seasonal migration to Canada and development: A community-based comparison", in International Migration Vol. 41, No. 2, pp. 3-26.

[6] Asis, M. 2004. "Not here for good? International migration realities and prospects in Asia", in The Japanese Journal of Population, Vol. 2, No. 1.

2.2.3 Policy developments in light of criticisms of the "triple win" argument

Codes of ethical recruitment

In recent years, there have been increasing efforts to steer international recruitment of health-care professionals via codes of practice laying down ethical standards of recruitment in order to avoid the worst issues surrounding brain drain from countries that are often also facing labour shortages in the sector. While such codes sometimes mention the potential for origin countries to benefit from migrants' skills gained abroad upon their return, they do not actively seek to promote circular migration. One exception is the WHO Code of Practice on International Recruitment of Health-care Professionals from 2010. In Article 3.8 it states that "Member States should facilitate circular migration of health personnel so that skills and knowledge can be achieved to the benefit of both origin and destination countries". The Code has been promoted and implemented in most EU destination countries. Germany, Ireland and Finland adopted and recognised the Code. According to interviews carried out for this study, in Germany the employers' associations of the long-term care sector particularly encourage its application. Finland has also recognised the WHO Code and the government is keen to apply principles of ethical recruitment going beyond this standard. An employer in Finland recognised the shortage of doctors and nurses in some Eastern EU countries and did specific research in order to implement targeted international recruitment only from countries where there is no domestic shortage of health-care professionals.

However, as the WHO Code is an entirely voluntary instrument, the impact of the code is difficult to assess as it primarily addresses Member States (rather than employers directly). Recent research[7] demonstrates that the WHO Code is not yet widely known. The study surveyed sub-national actors in Australia, Canada, the United Kingdom and the United States of America and 60 per cent of respondents believed their colleagues were not aware of the Code; 93 per cent reported that no specific changes had been observed in their work as a result of the Code, and 86 per cent reported that the Code has not had any meaningful impact on policies, practices or regulations in their countries. Hence, the systems of monitoring seem to be incomplete and implementation would need to be strengthened to improve efficiency. As a consequence, the WHO has created a tool for Member States to do a self-assessment every three years to check on the implementation of the Code's principles. The results of the first assessment of the implementation of the WHO code were discussed recently.[8]

In 2008 the European Sectoral Social Partners in the health-care sector EPSU (trade union) and HOSPEEM (employers) developed a Code of Conduct on Ethical Cross-Border Recruitment and Retention in the Hospital Sector. The Code elaborated 12 principles to guide health-care employers and health-care workers to develop appropriate solutions to a broad range of challenges of a practical and ethical nature related to cross-border mobility and migration. The principles include fair and transparent contracting, transparent publication of vacancies across the EU, equal access to career development and training, equality and non-discrimination of migrant workers and ethical recruitment practices in particular by private employment agencies.[9] The Code is actively promoted by the European Commission and a

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[7] Edge, J.; Hoffmann, S. 2013, "Empirical impact evaluation of the WHO Global Code of Practice on the international recruitment of health personnel in Australia, Canada, UK and USA", in *Globalisation and Health*, Vol. 9, No. 60.

[8] Amani Siyam; Pascal Zurn; Otto Christian Rø; Gulin Gedik; Kenneth Ronquillo; Christine Joan Co; Catherine Vaillancourt-Laflamme; Jennifer dela Rosa; Galina Perfilieva; Mario Roberto Dal Poz. 2013. "Monitoring the implementation of the WHO Global Code of Practice on the international recruitment of health personnel", in *Bulletin of World Health Organization*, Vol. 91, pp.816–823.

[9] More information about the Code and full description of principles can be found at the following website: http://www.epsu.org/a/3715

User's Guide and Reporting Instrument is available to Member States. As part of a follow-up project in 2012 by EPSU and HOSPEEM, it was highlighted that according to a survey that was carried out among members of both organisations, eight Member States have made use of the Code to raise awareness or to assess the national situation regarding cross-border recruitment (Bulgaria, Denmark, Finland, Germany, The Netherlands, Norway, Slovakia and Sweden).

England, Wales, and Scotland have a national Code of Practice for international recruitment for NHS employers. In England and Wales, this dates back to 2001, whereas in Scotland this is more recent (2013). The English Code of Practice was revised in 2003 in order to also be applicable to recruitment agencies, temporary staff and private employment bodies providing funded NHS care. The Code states that: "*Any international recruitment of health-care professionals should not prejudice the health-care systems of developing countries. Health-care professionals should not be actively recruited from developing countries, unless there is a Government-to-Government agreement to support recruitment activities.*" The Code furthermore enhances equal protection rights for migrant health-care workers and provision of training and career enhancement opportunities. The Code also states that NHS employers should only make use of recruitment agencies that adhere fully to the principles of the Code. Many private commercial recruitment agencies in the UK adhere to the Code of Practice on International Recruitment. The implementing body (NHS Employers) keeps records of these private recruitment agencies. Yet it seems that not all private employers and agencies have signed up to the Code.

It is also important to note that the NHS Code does not cover "passive" recruitment, meaning health-care workers that work first with independent private health-care providers who allow them to register as professionals after an adaptation course. Once registration is obtained, migrants move quickly into NHS-run care facilities where rewards and working conditions are often more favourable. In fact, some studies having examined the migration of nurses from Malawi found out that even if the Code restricts possibilities to find employment directly with the NHS, many nurses still migrate to the United Kingdom via the above described passive routes.

Even if there seems to be quite a high inflow of international nurses to the United Kingdom, recent new patterns of migration are observed. While only approximately 200 Australian nurses migrate to the United Kingdom per annum, more than 6,000 UK-trained nurses migrate to Australia (2010). One reason for this migration is recent budget cuts for health services in the United Kingdom. Even if the United Kingdom has restricted recruitment from South Africa, sub-Saharan Africa and other countries where no bilateral recruitment agreements exist, many nurses from these countries continue to leave their country of origin or change profession at home. Therefore, even in the absence of support or encouragement of destination country for migration, retention of nurses in the country of origin cannot be guaranteed without further development of, and investment in, the health-care sector of these countries.[10]

Blacklock et al., (2012) shows that the UK code was not as effective as expected in decreasing the number of recruits coming from developing countries experiencing health workforce shortages. It has been rather the use of Bilateral Agreements and changes in immigration law that decreased the inflow of international health-care professionals from these countries.

[10] Policy Brief Nr.33/2011 from the London Kings College, Nursing Research Unit.

There is also a Commonwealth Code of Practice for the International Recruitment of Health-care Workers (2003) applicable to all employers (private and public, and recruitment agencies) in the 53 Commonwealth countries. The Code states that origin and destination countries should provide a regulatory framework for recruitment agencies; countries need to enter a dialogue about the requirements of destination and origin countries and bilateral labour agreements should be signed. Finally, the Code suggests ways to minimise the impact of health-care workers lost to the health-care systems of their origin countries. For example, recipient countries should consider providing compensation or reparation to origin countries through:

- the transfer of technology and skills;
- training programmes to enable those who return to bring back new skills; and
- arrangements to facilitate the return of recruits.

However, there are doubts about the legal status of the Code for the Commonwealth as only health ministers from Commonwealth countries have signed the Code, and it is not clear to what extent further national implementation is needed to give the Code a more binding nature.

Most of the Codes cited here foresee that destination countries, when recruiting health-care professionals from developing countries, should invest in the development of health-care workers in the origin countries. A bilateral agreement between the Philippines and the Canadian province of Saskatchewan[11] makes such provision. However, these were never enforced. Mackay and Liang (2012) found that little discussion on human resource development occurs during continued negotiations on international funding for global health interventions in resource-poor countries. Neither bilateral, multilateral, nor international disease-specific aid seems to have taken into account the factor of human resources development. In addition, NGOs intervening to provide specific disease aid can create a perverse effect. By attracting the local staff in resource poor countries with high salaries and good working conditions, NGOs compete with the local public health-care services. While those projects can indeed improve outcomes on treatments of disease, they can have the effect to decrease outcomes on general health services -- in particular in rural areas where shortages are even more critical. This led to the signing of a Code of Conduct for NGOs to help strengthen health systems in 2008[12]. The Code stipulates in particular that specific disease help should be channelled via the public health system in order to harmonise operations of NGOs active in one country, and that investments should be made in the local health-care workforce.[13] At this stage, no further evaluation of the impact of this Code could be found.

The discussion shows that Codes can certainly enhance the raising of awareness and induce decline in migration flows from resource-poor countries; however, they need close monitoring from governments in order to be effective. All employers interviewed for the purpose of this study also support Codes of Conduct, because it demonstrates in their countries that staff recruited internationally is not creating competition with local staff -- for example, by paying lower wages.

Finally, few Codes of Conduct have made reference to any specific concept of circular migration (e.g. the WHO Code of Conduct). The main aim is to promote ethical recruitment, sensitise destination countries to invest also in health systems in resource-poor countries, and promote equal opportunities of international staff. However, as will be further demonstrated below, keeping professionals "locked" in their home countries because destination countries officially avoid recruiting them does not seem to

[11] www.pdea.gov.ph/lmi_kiosk/Bilateral per cent20Agreements/BLA-SASKATCHEWAN.pdf
[12] The following page provides details of the code and signatory organisations: http://ngocodeofconduct.org/
[13] http://www.thelancet.com/journals/lancet/article/PIIS014067360860937X/fulltext

be the solution, as many try "informal" routes to migrate anyway.

The development of migration governance policies

Managed migration programmes and policies try to steer the stay and return of migrants in destination countries. A typical tool for regulated migration is the bilateral labour agreement.

A report by the European Migration Network (EMN, 2011) acknowledges that the promotion of such policies of temporary and circular migration in the EU Member States are at a very early stage and evidence of a triple win for temporary and circular migration remains inconclusive.

According to the same report, in light of criticism of the triple win argument, some improvements have been made in models of managed migration in a number of EU countries, involving:

- longer periods of stay;
- possibility to change employers;
- ensuring some integration support in the destination countries as well as re-integration support at home;
- the provision of multi-annual and multi-entry visas;
- the portability of acquired social security benefits;
- provisions to ensure training; and
- the opening of pathways for permanent residence for repeat migrants.

A temporary migration scheme was implemented in Ireland between 2000 and 2006 issuing "fast track" visas for professions facing acute shortages, including nursing. The work visa scheme offered better conditions than those previously available to migrant nurses in that work visas were issued for two years and provided the holder with improved entitlements to family reunification, the right to change employer without reapplying for a visa and the right to obtain multiple re-entry visas, including for third country nationals.

The EU has established a Blue Card Scheme, providing a work permit for highly skilled professionals such as doctors or specialised nurses to work in any of the EU countries (excluding Denmark, the United Kingdom and Ireland). The permit is valid for two years with the possibility of renewal. It includes extended rights for family reunification and an EU-wide right to mobility and thus the possibility to change employers. Reactions from third countries to the scheme were mixed. In particular north African countries complained that this type of scheme fosters brain drain of highly skilled workers, while the EU takes the view that remittances from these migrants help to develop the origin countries. It should be noted that the EU Blue Card Scheme has not yet been implemented in all participating Member States.

The question remains whether such "fast track" visas for specialised workers in shortage occupations will ultimately favour the return of migrants once the visa expires. In fact, it has been argued that managed migration schemes also need to provide incentives for migrants to return and build up networks for exchange. For example, in 2004 the UK House of Commons published a report on migration and development discussing temporary migration. The report argues that comprehensive temporary migration policies in the destination countries should also include policies on return of migrants, including for example the possibilities to have periods of absence from employment so that migrants can appropriately prepare for return and include training on how to make use of the developed skills (e.g. set up a company) back in their home country. Exchange programmes need to be well targeted to specific professionals or within research and development programmes between countries.

Bilateral labour agreements can also help to foster such targeted migration schemes with a view to encouraging circular migration. It has been highlighted by employers interviewed for the study that such agreements should regulate the recognition of qualifications[14] so that red tape for migration and "transfer" times (during which migrants are often unable to work utilising their full range of skills) can be effectively reduced. At the moment none of the bilateral labour agreements in the countries part of this analysis have used such a strategy. It should be noted, however, that the recognition of qualifications is not as complex in the United Kingdom and Ireland as in Germany and Finland. In the United Kingdom and Ireland nurses and doctors simply need to fulfil all admission criteria to the professional registers. Sometimes adaptation periods of a maximum of one month are required, which allow fort the provision of specific professional and language training. While in Germany and Finland the procedures for recognition of diplomas are much more time-consuming and complex. In addition, candidates have to prove language proficiency of up to level B1 (EU standard) before applying for positions. In Germany the recognition process generally takes almost one year (while working already in the country excluding time to prepare for migration) and in Finland up to three years for nurses, due to their system of licensing requiring the completion of specific courses.[15]

Another aspect that managed migration schemes need to take into account is the length of periods for stay, so that the scheme is also interesting for employers. For instance, a study of the Dutch "Blue Birds" scheme demonstrates challenges in implementation not insignificantly linked to concerns by employers about recruiting particularly skilled workers on this basis. Here it is argued that any period of stay of less than two years is often perceived to be too short to offer a return on investment (Siegel, M. et al., 2012). The employers' organisations interviewed for the purpose of this study claim that three to five years would be the optimal period for stay for highly skilled workers to ensure a return on investment. While managed migration schemes could provide the basis for circular migration it should be highlighted that such schemes need to leave the choice open to the migrant whether or not they ultimately wish to return home. All interviewees referred to the importance of the voluntary nature of the return. The International Council of Nursing (ICN) Position Statement on Ethical Nurse Recruitment also highlights that the individual's freedom of movement should be protected. Further, a growing body of literature points out to the sub-optimal impact of forced or "assisted" return programmes.[16]

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[14] The EU-funded ILO Decent Work Across Borders project has commissioned a comparative assessment of the nursing education and practice between the Philippines, Norway, Finland and Denmark; see http://ilso.org/manila/info/public/pr/WCMS_173607/lang--en/index.htm

[15] Information based on interviews with relevant ministries and PES in Finland and Germany.

[16] Franco Pitto; Antonio Ricci; Giuliana Urso. 2009. "Programmes and strategies in Italy fostering assisted return and re-integration in third countries", European Migration Network, Rome.

2.3 Circular migration of health-care workers in Europe: the reality

2.3.1 Introduction

In this part of the report we discuss the reality of migration patterns in the EU Member States under study (with a specific emphasis on migration from India and the Philippines) and any attempts at making circular migration a reality, for instance through managed migration schemes. This section discusses the views of employers on the feasibility and attractiveness of such schemes to help understand why there is currently limited use of circular migration schemes and approaches.

This country-by-country presentation makes it clear that there is little evidence of circular migration patterns being a reality in the health-care sector in the EU today, with the exception of a few limited managed migration schemes. The lack of interest among employer organisation in such arrangements has an important role to play in circular migration being more of a policy myth than a reality in the health-care sector today. For each country, the paper begins by briefly discussing the extent of labour and skill shortages in the health-care sector, which sets the backdrop for potential approaches to migration policies. It then discusses key migration flow patterns to ascertain the extent to which third country migration, particularly from India and the Philippines, is currently taking place and which form this takes. In this context, existing managed migration policies are discussed. These aspects provide the background for the discussion of employer views regarding the relevance and reality of the concept of circular migration.

In this context it must be noted that many countries in Europe and elsewhere currently cannot monitor with any accuracy the stocks and flows of migrant health workers. This limits their capacity to assess the impact of policies and means that they cannot be clear about the impact of migration policy or indeed the level and scope of circular migration.[17] To assist in remedying this situation, the EU has set up a project where Member States work together to improve health-care workforce planning.[18]

2.3.2 The United Kingdom

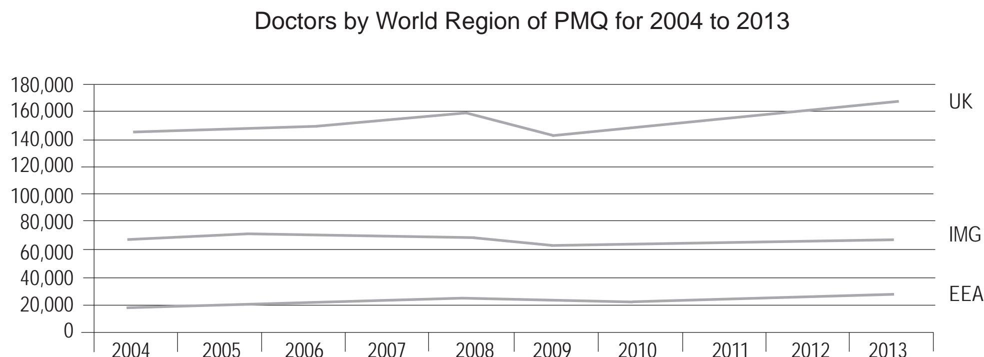
Migration trends of health-care professionals to the United Kingdom

Historically, the United Kingdom has witnessed significant migration flows among health-care professions both to and from the country. To get a picture on trends of migration of doctors, the statistics for the registry of the General Medical Council (GMC) provides further insights. The figure below shows the share of doctors by world region.

[17] Buchan, J. 2007. "Health worker migration in Europe: assessing the policy options", in Eurohealth, Vol. 13, No. 1, pp. 6-8.

[18] Further information on this project is available under the following website: http://euhwforce.weebly.com/

Figure 1: Doctors by World Region of PMQ[19] for 2004 to 2013



Source: UK General Medical Council

The top-20 countries of qualification in 2013 in the register indicates that 9.7 per cent of doctors are Indian, 3.6 per cent are Pakistani and 2.1 per cent originate from South Africa. In 2012, 17 per cent of newly registered general practitioners had an international medical qualification (acquired outside the United Kingdom). Additionally, 24 per cent of newly registered specialist doctors had an international medical qualification. To contrast these figures, 14 per cent of newly registered specialist doctors and 6 per cent of newly registered general practitioners had an EEA medical qualification. This indicates that doctors from outside the EU have still a high propensity to work in the United Kingdom, as immigration policy provided this opportunity, even though their number has continued to decline since 2007. In 2010, the United Kingdom introduced stricter rules for work visas for doctors, allowing employers to recruit abroad only when a shortage occurs and when no other UK or EEA worker could be recruited. When looking at the cohort of licensed doctors aged over 50 years, 52 per cent of doctors had an international qualification in 2012.

Interestingly, the latest GMC report on the state of medical education and practice in the United Kingdom[20] states that in 2012, 11,378 doctors left the medical register or gave up their licence to practise. 7,288 provided the reason for why doctors are leaving: 49 per cent intend to go overseas, 40 per cent were retiring and 3 per cent did not intend to renew their registration. The report, mentions that only one out of 20 newly graduated UK students left the register in 2012. This could thus provide an indication that doctors return later in their career either to their home country or to another country (most probably the United States).

Mirroring strong migration flows among doctors, between 1999 and mid 2005 a large number of nurses from abroad migrated to the United Kingdom. The reason for the increase of health-care professionals was a directive from the Department of Health in 2000 addressing labour and skill shortages in the health-care workforce. Targeted countries for recruitment were English-speaking, those with historical ties to the United Kingdom, or where the United Kingdom played a role in development. Approximately 10,000 international nurses per annum registered in the United Kingdom during that period compared to around 2,500 in 2010. When migration of international nurses peaked in 2001, the Code on ethical

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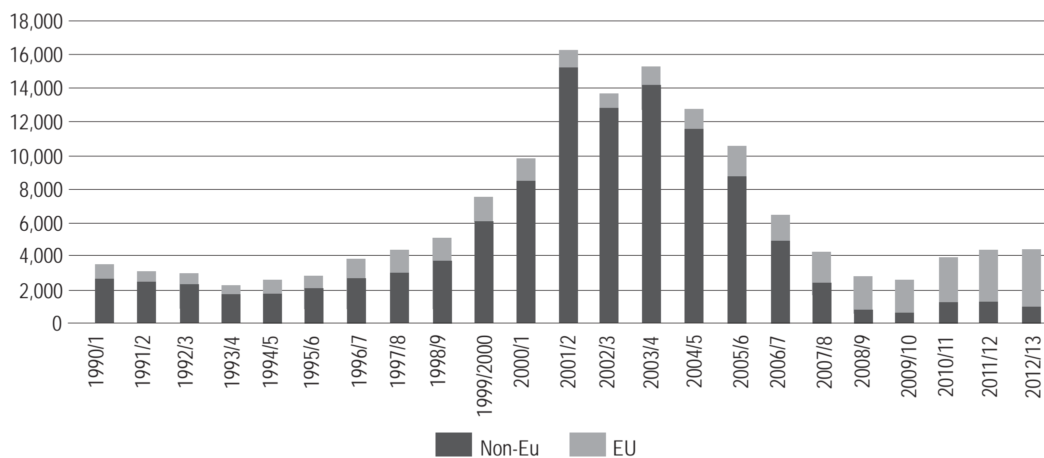
[19] PMQ stands for Primary Medical Qualification; IMG for International Medical Graduates.
[20] Can be accessed at the following website: http://www.gmc-uk.org/publications/23435.asp

recruitment applicable to the NHS came into force aiming to prevent active recruitment from countries that experience a shortage of health-care personnel and receive development aid. The United Kingdom further introduced stricter rules on migration after 2005. The figure below demonstrates that the Code, and more particularly stricter immigration rules, reduced the number of international nurses that registered, while the number of nurses from EU countries registering to work in the United Kingdom increased.

Figure 2: Admissions to the UK register of nurses from EU and non-EU countries between 1990/91 and 2012/2013



Source: Royal College of Nursing, Staffing Report 2013

Currently there are no official estimations about the number of international nurses working for private health-care providers or nursing homes, as such data are only held for nurses working in the NHS.

Managed migration policies in the health-care sector

The United Kingdom concluded four bilateral agreements in the period 2000-2005 with Spain, the Philippines, India and South Africa.[21] The bilateral agreements with Spain and the Philippines have been concluded to facilitate recruitment of health care professionals. The agreement with South Africa intended to set up a project of training exchange of a group of doctors coming to the United Kingdom. The latter project has successfully taken place and doctors returned to their home country after two years. The bilateral agreement with India ensured that no targeted recruitment strategy will take place for health-care professionals from regions in India that experience shortages of health-care professionals. The agreement states that the freedom of mobility should be guaranteed for individuals originating in other regions. All agreements highlighted the need to ensure ethical recruitment standards according to the NHS Code of Practice.

Since 2006, the United Kingdom has put in place managed migration schemes such as the Medical Training Initiative (MTI). The MTI allows international trainees to come to the United Kingdom for a maximum of two years to train under the NHS. The idea is that international medical graduates benefit from the knowledge, skills and techniques offered by the UK NHS and will use the skills they learn to

[21] Bach, S. 2007. "Going global. The regulations of nurse migration in the UK", in British Journal of Industrial Relations, Vol. 45, No. 2.

improve the level of patient care in their home country on their return. On the other hand, UK hospitals benefit from increased workforce capacity and the skills and knowledge that international medical graduates can bring. The scheme can be arranged between medical colleges or between employers. Currently, no statistics are publicly available on the number of international medical graduates that have participated so far, or any assessment regarding its success, as no relevant research has been conducted.

Challenges of international recruitment to the United Kingdom were discussed at a workshop of the Public Policy Network in 2012[22]. Overseas nurses are often considered to be overqualified for the positions they take up in the United Kingdom and their professional careers stagnate. Deskilling was a major problem expressed by migrant nurses working in UK hospitals and care facilities.[23] On the other hand, employers expressed concern about the difficulty of successfully integrating internationally recruited nurses. Negative attitudes of the general public and hospital colleagues towards migrant nurses are hard to manage.[24] Further challenges of international recruitment relate to the conception of the nursing profession between the country of origin and the United Kingdom. It was highlighted by Allen (2007) that overseas nurses were not aware of the distinction between nursing and care. It happened to nurses recruited via an employment agency not having the exact job description, and realising that they were working in elderly care homes only providing basic care, instead of a mixture of typical nursing and care activities. This is one of the sources of frustration for many nurses working for the NHS or private care providers, in that they were often given care tasks, or tasks with less nursing responsibilities.25 It gives an indication that circular migration programmes also need to offer employment opportunities in which professionals from developing countries are fully integrated among other staff providing tasks that are adapted to their skills, and offering life-long learning opportunities. This needs, however, major coordination and guidance during recruitment.

From reports on international recruitment experiences of NHS trusts[26], it has been noted that while the recognition of diploma or licences gained abroad are not a major concern, the actual induction of newly arrived international staff proved to be more time consuming. In some cases integration, accompanying training to adapt to UK standard technical skills and practices, as well as supervision, could take up to one year. However these, "hidden" costs have not been assessed by the NHS when evaluating their international recruitment practices. It certainly shows that international recruitment on a large scale (which happened during 2000-2006) is not a "quick fix" solution for workforce shortages, and the United Kingdom would need a more comprehensive policy on international recruitment and possibly reflections about circular migration.[27]

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[22] For more information, see http://www.publicpolicynetwork.ed.ac.uk/about_us/news/2011/international_nurse_recruitment_recent_challenges_and_future_prospects

[23] See also O'Brien, T. 2007. "Overseas nurses in the National Health Service: a process of deskilling", in Journal of Clinical Nursing, Vol. 16, pp. 2229-36.

[24] Adhikari, R.; Plotnikova, E.V. 2012. "International nurse recruitment: recent challenges and future prospects", Policy Brief. Available at: http://www.publicpolicynetwork.ed.ac.uk/about_us/news/2011/international_nurse_recruitment_recent_challenges_and_future_prospects

[25] More detailed information about challenges experienced by overseas nurses can be found for example in the study commissioned by the Royal College of Nurses, "We need respect: experiences of internationally recruited nurses in the UK", prepared by Allan, H.; Aggergaard, J. Available at http://www.rcn.org.uk/__data/assets/pdf_file/0008/78587/002061.pdf

[26] For example, Buchan, J. 2003. "Here to stay? International nurses in the UK", report commissioned by the Royal College of Nurses.

[27] Young, R. et al., 2010. "Evaluation of international recruitment of health professionals in the UK", in *Journal of Health Services and Research Policy*, Vol. 15, No. 4, pp. 195-203.

Circular migration models could indeed be of benefit in times of restructuring of health services or budget cuts, when it would be an opportunity to place overseas professionals back into employment in their countries of origin, provided that their fundamental rights at work are respected. This needs carefully developed policies and health services structures that allow for these flexible fluctuations of the workforce. It was advocated that circular migration should be conceived in a rather long-term perspective with open end entry, and not just one fixed-term employment contract.[28] However, these suggestions appear not to be in line with the concept of circular migration, which relies on voluntary repeat migration between countries. It demonstrates the potential contradiction between the concept of voluntary movements and such schemes. Indeed none of the managed migration initiatives mentioned above qualify as examples of circular migration, as no repeat movement between countries is foreseen.

Despite the challenges of international recruitment, UK employers continue to see the need for international recruitment, in particular for highly specialised services and care services. With the restrictions on work permits currently in place, employers have to prove the need for recruitment outside of the EEA area. NHS and private care employers seem to be highly aware of ethical recruitment policies and turn to agencies that apply the NHS Code on ethical recruitment. No specific practice example of circular migration or a public statement by NHS employers regarding circular migration policies could be identified.

Employer views on the feasibility of circular migration

Circular migration is not currently in evidence in the practice of the NHS and no information on such recruitment practices is available from the private sector. As a result of the *Code of Conduct on Ethical Cross Border Recruitment and Retention* agreed by HOSPEEM and EPSU and the *Code of Practice for international recruitment for NHS employers* in the United Kingdom and other migration policy guidelines, there is an emphasis on meeting existing staff shortages with recruitment from countries not currently experiencing their own shortages in the health-care sector. However, there is little or no emphasis on these workers returning to their home countries, let alone to follow a circular pattern of repeat migration. There was therefore a limited interest from employers to participate in the study. The employer (and employers' organisation) that did participate emphasised the importance of the Code and the importance of ensuring good integration policies for migrant health-care workers, again pointing to a policy of long-term integration rather than circular migration. The responding NHS Trust emphasised the importance of investing in cultural and professional language training of staff and cultural sensitisation among patients. It was highlighted that it is not so much a diploma or the medical education (general medical knowledge) that is of concern if putting into practice successful migration policies, but rather professionals skills (communication, organisational skills etc), knowledge about specific expectations with regard to the national approach to care (also status of the elderly in a society in case of elderly care), and the specific terminology and language skills necessary to build up a relationship of trust with the patient.

In the United Kingdom, the level of English proficiency is evidenced by academic certificates. However, the level of proficiency in practice is of much more importance due to a close communication between staff and patients. There is no general test or training required in the United Kingdom to test or prove practical levels of language proficiency in the specific context of medical care. In practice, it

[28] Lawrence, A. 2010. "Circular migration and the potential to improve health outcomes", in Public Policy Research, Vol. 17, No. 1, pp. 49-54.

would be important as many issues can arise within a team that can impact on the general performance outcomes and level of care. Thus, the employer found that it would be necessary to introduce these cultural and technical language aspects in recruitment procedures and inform or train candidates already before arrival or before leaving the home country. The extended intercultural and multi-disciplinary training programme that was rolled out in this particular Trust focuses not just on new arrivals, but also established international staff. It uses peer groups, workshops and individual coaching in a trusting environment. Despite the recent start of the programme, Trust was convinced that this type of training was needed for a long-term period and it shows that intense long-term exchange among staff is needed to make inter-culturalism work to the benefit of the organisation. It was argued that if circular migration was to be reality, this type of accompanying measure would be required.

2.3.3 Ireland

Ireland is one of the major destination countries for foreign-trained doctors and nurses, in particular from the Philippines and India. It is, however, also an origin country of many of its trained doctors and nurses (e.g. to the United Kingdom, the United States and Australia).

Migration trends of health-care professionals to Ireland

The proportion of foreign-trained doctors rose from 13.4 per cent of all registered doctors in 2000 to 33.4 per cent by 2010. The largest increase was among foreign-trained doctors from outside the EU, rising from 972 (7.4 per cent) in 2000 to 4,740 (25.3 per cent) in 2010. The biggest origin country in 2000 was Pakistan. By 2010, South Africa had become the most significant origin country. The number of foreign-trained doctors from other EU countries doubled from 780 in 2000 to 1,521 in 2010.[29]

Foreign migration is partly due to a shortage of doctors, which is an ongoing issue in Ireland. This became imminent for NCHDs (non-consultant hospital doctors) and general practitioners in 2009. By 2011, the number of unfilled vacancies was considered to be critical.

One of the problems in Ireland seems to be that many doctors that are trained in the country are not retained after completing their studies. Approximately 60 per cent of the intakes of medical students are non-EU nationals. Key factors affecting doctors' decisions to leave Ireland centre around the lack of structured career paths and the perceived lack of ongoing training.

Targeted international recruitment for nurses and doctors mainly took place during the years of high economic growth between 1997 and 2007. In those years it was possible to initiate registration at the Medical Council of Ireland (MCI) at centres in Oman, India, Pakistan and Egypt, thereby facilitating this process. In the recent past only passive international recruitment has taken place, meaning that migrants chose themselves to come to Ireland. Before the economic crisis, Ireland was seen as one of the EU economic tigers, thus attracting migrants with different professional backgrounds. Prior to 2011, Ireland only conducted to a limited extent targeted recruitment campaigns for doctors.

The economic downturn has affected the international recruitment of doctors heavily. In order to address the critical shortage of NCHDs, in July 2011 Ireland conducted an active international recruitment

[29] Analysis taken from Bidwell et al., "The national and international implications of a decade of doctor migration in the Irish context", Health Policy & Management, Trinity College Dublin, Ireland, Department of Epidemiology and Public Health Medicine, Royal College of Surgeons in Ireland, Dublin, 2012.

campaign in India and Pakistan in order to attract doctors and fill 450 posts. In 2011 an active international campaign to recruit junior doctors from India and Pakistan resulted in the recruitment of a further 230 doctors. Since then there has been criticism of the treatment of doctors recruited from these countries in Ireland, including from the Irish Medical Association, which it argues has led many of these doctors to leave the country again.[30]

It should be noted that NCHDs are technically doctors in training, however in many cases they are working in positions that were not part of a formalised training programme. Many believe that these positions are occupied by foreign-trained doctors.[31]

Furthermore, Ireland began actively recruiting nurses internationally in 2000. Between 2000 and 2010, 35 per cent of new recruits into the health service were non-EU migrant nurses. Ireland is more heavily reliant upon international nurse recruitment than the United Kingdom, New Zealand or Australia.[32]

International recruitment of nurses was used in Ireland mainly as a low cost way to reply to unforeseen labour shortages (in favour of training locally). Between 2000 and 2010, 14,546 non-EU and non-Irish EU-trained nurses joined the Irish nursing workforce, alongside 17,264 Irish-trained nurses.

According to a study[33] having surveyed 309 nurses from abroad, 51 per cent of the nurses were from the Philippines, 33 per cent from India and the remaining from 16 different countries. Most of the nurses had between six and 15 years of professional experience. Many nurses from the Philippines and India migrated from the Middle East to Ireland. The study also asked professionals how long they intended to stay -- the result showed that 32 per cent intended to stay between two and five years, and only a small proportion wished to stay for a longer period or permanently.

Nurses were mainly recruited via international and local Irish employment agencies. The majority of them started their career in public hospitals and only a minority worked in elderly care homes.

The current economic crisis impacted strongly on the public health sector in Ireland, implying budget cuts in hospitals. As a result, according to trade unions in the sector, many migrant nurses are unsure of their job security and uncertain about their length of stay.

Managed migration policies in the health-care sector

The following table describes the policies initiated to facilitate migration of health-care professionals to Ireland. It shows a number of distinct phases in Irish migration policy, with the most "liberal" scheme applying between 2000 and 2003. During this period, an employment contract was sufficient to gain access to a two-year work visa. In the years 2000-2007, the immigration of health-care professionals was actively encouraged, latterly with a particular emphasis on highly skilled staff. The change in approach post-2007 mainly resulted from the emphasis being given to EU-migration. Entry conditions for non-EU doctors and nurses were changed, but remained possible, with some targeted recruitment campaigns in some non-EU countries (see above).

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30 See http://www.imo.ie/news-media/news-press-releases/2013/imo-statement-on-the-over/
31 HSE. National Audit of SHO and Registrar Posts. Dublin: Health Executive Board (HSE), 2007.
32 Information taken from: Humphries, N.; Brugha, R.; McGee H. 2012. "Nurse migration and health workforce planning: Ireland as illustrative of international challenges", in Health Policy, Vol. 107, No. 1, pp. 44-53.
33 Idem 12.

Table 2. Migration Policy in Ireland in relation to health workers (2000-2010)

Year	Policy
2000	Visas were issued for two years on presentation of an employment contract from an Irish employer. Holders could change employers without having to reapply for a visa.
2003	April: End of "employer-led" work permits -- restriction of migration and granting of work permits for workers on a "positive list" including mainly highly skilled workers. May: Doctors were included in the work authorisation/visa scheme (WA/WV), which was initially introduced 2000 to facilitate the active recruitment of nurses from non-EU countries.
2004	February: The WA/WV scheme was modified to entitle spouses to work in Ireland.
2006	December: WA/WV scheme was discontinued.
2007	February: Green Card scheme to facilitate the entry of non-EU skilled workers, including doctors. Green cards were issued to an employee for two years.
2010	June: Revised conditions for non-EU doctors working within the Irish public health system.

Source: Study Bidwell et al., 2012

While Ireland experienced a strong increase in health workforce migration during its economic upswing, helping to fill gaps in its health system, the country also experienced emigration of its (migrant and domestic) health sector workforce during its economic downturn. The economic crisis in Ireland led to significant budget cuts in the health-care sector. Migration flows are also significantly impacted by economic factors affecting a country as a whole. Hence, much of Ireland's international health-care workforce intends to move on either to a different country or back home[34]. Reasons are uncertainty about their residency permit and job security, as well as failure to ensure extended family reunification (apart from children and spouse) and long-term perspectives of naturalisation or insufficient career developments.

Employer views on the feasibility of circular migration

The concept of circular migration is currently not discussed in Irish migration policy, or indeed among employers. The lack of interest in this issue meant that it proved difficult to conduct employer interviews in Ireland. Despite cutbacks in the sector, a shortage of staff remains in evidence in particular regions and specialties. The focus therefore remains on the retention of migrant workers, particularly during a time when the country is not as attractive to migrant workers as it once was. It also demonstrates that relying on foreign workforce can be highly precarious for the destination country. Stakeholders referred to a growing practice of agencies and individuals recruiting migrant workers from third countries under poor and often exploitative conditions. No official data are available on this phenomenon. Ireland also shows no patterns of circular migration and no discussion on the issue. Instead there is a focus on finding ways of ending exploitative practices which tie workers, including from the Philippines, to exploitative conditions without an opportunity of moving employer, or indeed to return home.

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[34] Humphries, N.; Brugha, R.; McGee, H. 2009."I won't be staying here for long: a qualitative study on the retention of migrant nurses in Ireland," in Human Resources for Health, Vol. 7, No. 68. This study is based on a survey among migrant nurses (N=337) and 21 in-depth interviews with migrant nurses.

2.3.4 Germany

The health and care sector is one of the most significantly expanding sectors in Germany. The sector grew between 2005 and 2010 by 9 per cent (translating into an additional 409,000 full-time equivalent jobs).

Germany faces skills shortages mainly among doctors, nurses and care professionals in elderly care.

Migration trends of health-care professionals to Germany

More than 68 per cent of hospitals have problems to recruit doctors. The shortage is particularly acute for hospitals in the rural regions and is less pressing for health care institutions in the large cities. As a result of these shortages, around 50 per cent of hospitals have recruited doctors from abroad. Among the most represented origin countries are Spain, Austria, Eastern Europe countries, Russia and Syria.[35]

For nurses, the shortage is not as severe as for doctors. Here, only 37 per cent of hospitals reported having recruitment difficulties. However, 37 per cent fear having recruiting problems in the future. This concerns mainly hospitals in larger cities due to the increase of the population of cities themselves. More than 69 per cent of hospitals could imagine hiring personnel from abroad in future. So far, hospitals have recruited nursing professionals primarily from Eastern Europe countries, Spain, Italy and France.[36]

Teaching hospitals usually already have significant experience of working with foreign professionals. There is much experience for doctors in specific exchange programmes and training programmes. Doctors in training have the choice to complete parts of their obligatory training as assistant doctors in other countries.

In the 1960s and ’70s, some significant processes of migration took place from India, the Philippines and South Korea. A significant number of these individuals began to work as health-care professionals in West Germany and Vietnamese workers came to work in East Germany. These individuals are generally well integrated by now and are close to retirement. In the 1980s further significant migration took place in the health-care sector, primarily from European countries. Nevertheless, until recently no publicly targeted recruitment of international health-care professionals occurred.

Today, it is not possible to say how many foreign nationals work in nursing in hospitals in Germany as there is no central registration. On the basis of social security registrations only, the latest figures available show that in 2008 approximately 860 nationals from Asian countries were active in the health-care sector in Germany. Most foreign national nurses come from the EU (21,000). Better data are available for doctors. All doctors need to register with the chamber of doctors in the region where they are active (regrouped in Bundesärztekammer). There are no doctors from the Philippines in Germany, but there were 157 Indian doctors active in 2012. Most doctors from the Asian area come from Syria. In 2012, 1,077 doctors from Syria practiced medicine in Germany; the second largest group are Iranian doctors. Yet most foreign doctors come from the EU -- more than 16,000 are active in Germany.

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[35] TDS Institut für Personalforschung an der Hochschule Pforzheim , Dr. S. Fischer, Recruitment in Krankenhäusern eine Analyse der Recruiting Aktivitäten in deutschen Krankenhäusern, 2012. The study has surveyed 131 hospitals across Germany.

[36] Ibid.

The recruitment situation in the long-term care sector is of even greater concern than in the health-care sector. Labour market statistics show that since the end of 2009, the number of unfilled vacancies in the care sector exceeded the number of total unemployed with related skills registered in the German Public Employment Services. At the beginning of 2012, more than 10,000 vacant positions were registered compared to 3,268 unemployed care professionals. Demand is estimated to increase by more than 28 per cent -- or 180,000 additional full-time equivalent positions since 2010. At the same time, the actual overall labour force available will decrease by 9 per cent until 2025. Even if all policy means were to be used -- meaning using all of the potential workforce, increasing the labour force through encouraging higher female labour force participation, longer professional careers, and improvement to labour conditions by increasing wages to make the sector the most attractive workplace, the forecasts for 2030 predict that the number of available professionals will not satisfy the demands to fill all vacant positions.[37]

Hence, one of the strategies among others to overcome the shortage is to recruit foreign professionals. Since July 2012 this has been strongly supported by the Federal Government.[38] Currently it is not possible to say how many foreign workers work in the long-term care sector, in particular from the Philippines. There are some workers from India that came via religious organisations to Germany who work in hospitals and care, which are managed by the church.

The recognition of diplomas from Third Country Nationals is crucial to be allowed to exercise a health-care profession in Germany.

Doctors in general need a licence to practice. Foreign nationals (from outside the EU) that come to Germany to practice medicine need to pass a test to obtain this licence. They also have to further demonstrate their German language skills by passing a language test. Level B2 (EU classification) is sufficient. Obtaining a licence is a time consuming process, as it also involves the responsible authority checking the equivalency of the foreign diploma. Should the equivalence not be recognised then the person could receive a work permit allowing him or her to work for two years to prepare the equivalency test. Once a licence is issued it has lifelong validity.

In contrast, for EU doctors the diploma is automatically recognised and they do not need to pass the test to receive the licence. The language competencies of any doctors are left to the employers to assess.

A similar process is required for non-EU nursing staff: first, the responsible authority checks the equivalence of the foreign diploma with German standards, then a test to demonstrate practice specific knowledge and a task specific German test has to be passed. The tests have to be undertaken within one year of commencing work. The practice shows that tests are passed between six and eight months after starting work, depending on the level of German acquired before arrival. These administratively heavy procedural requirements (which can have an uncertain outcome) have an impact on the willingness of employers to recruit from outside the EU. Once such staff are recruited and have passed their test, the emphasis is on retention to ensure the time invested in obtaining the relevant permits pays off.

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[37] Policy Paper by the Federal Ministry of Economy to promote the hiring of foreign professionals in the care sector, Chancen zur Gewinnung von Fachkräften in der Pflegewirtschaft, available here: http://www.bmwi.de/BMWi/Redaktion/PDF/Publikationen/Studien/chancen-zur-gewinnung-von-fachkraeften-in-der-pflegewirtschaft,property=pdf,bereich=bmwi2012,sprache=de,rwb=true.pdf

[38] Position Paper Federal Ministry of Labour and Social Affairs, Fachkraftesicherung, Ziele und Massnahmen der Bundesregierung, available here: http://www.bmas.de/SharedDocs/Downloads/DE/fachkraeftesicherung-ziele-massnahmen.pdf?__blob=publicationFile

Managed migration policies in the healthcare sector

As a consequence of the shortage of labour in health and long-term care, the German Federal Government took action to promote international recruitment. In particular, the Federal Government wishes to make Germany an attractive country for foreigners and wishes to create a positive "welcoming culture" inside Germany.[39]

In 2012 the German authorities introduced legal changes to make it easier for doctors trained outside the EU to work in Germany. In addition, Germany has signed agreements with nine partner countries, which make available grants for doctors keen to undertake a further five to six years post-graduate study in Germany. There are now 1,500 non-EU doctors in Germany, most of whom are expected to return home after they qualify. This has been a successful model of circular migration, although some doctors have experienced language, bureaucratic and cultural difficulties, and some want to continue to work in the EU.

There are currently four targeted pilot programmes in place to recruit health care and care professionals (mainly nurses and long-term care professionals) internationally (outside the EU):

- Triple Win Project -- recruitment of health-care professionals from the Philippines, Tunisia, Bosnia-Herzegovina and Serbia. Germany has with all three countries specific bilateral labour agreements.
- Pilot Project -- hiring care professionals from Vietnam.
- Pilot Project -- hiring care professionals from China.
- TAPiG Programme -- hiring nurses from Tunisia.

It must be noted in advance that none of the projects are aimed at circular migration, but rather steer managed migration in terms of number of entries, training provided, working conditions, etc., as well as (in some cases) support for countries of origin.

In March 2013 Germany signed a bilateral labour agreement (BLA) with the Philippines. Due to this agreement international recruitment is possible.

However, Germany generally focuses its recruitment within Europe, and here mainly on countries such as Spain, Portugal and Greece. This can be mainly explained by the fact that the EU has put in place a system of recognition of diplomas[40]. The German public employment services (Bundesarbeitsagentur) currently implements a programme called MobiPro for young Europeans that are unemployed who wish to gain work experience in Germany. The programme funds language courses and other integration measures.

International recruitment of health-care and care professionals from outside the EU is only possible via the Public International Recruitment Service ZAV for the countries represented on the list for recruitment.[41]This makes direct hiring by employers of health-care professionals from India and other countries not on the list impossible. Since July 2013, the Philippines is no longer on this list, which allows also for direct recruitment of employers and private employment agencies.[42] However, this is the

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[39] A specific website was created for this purpose: http://www.make-it-in-germany.com/en/

[40] Qualification Directive.

[41] Beschaeftigungsverordnung para. 38 since 03.11.2013, Annex list can be accessed here: http://www.gesetze-im-internet.de/beschv_2013/anlage_52.html

[42] This is considered by some to be against the spirit of agreements reached in the Triple Win programme (see below).

technical legal situation, in practice this has not happened and the BLA also stipulates that recruitment should take place via public employment services. This practice of international recruitment limits possibilities of abuse or cost intensive migration for migrants having to pay fees to private employment agencies. It can further be assumed that the public employment services have better opportunities to match interests of employers and international health-care professionals.

Generally, work permits are granted by the public employment service. If an employer wishes to recruit directly from outside the EU from countries where the ZAV does not have the exclusive rights, they need to take care of the application for residency and work permits for themselves. This can be a lengthy and challenging process.

Another exception has recently been introduced: in summer 2013 the Law on Employment introduced a "positive list" defining professions where there is a workforce shortage in Germany, and where international recruitment is possible without having to go through the procedures to obtain a work permit from the BA. Long-term care professionals are represented on this list, and given the increasing demand in this sector, migration flows among workers in this area are likely to increase.

The aforementioned pilot projects are attractive for employers because the ZAV pre-arranges work permits and helps participants with the process of recognition of diplomas. Due to the fact that employers (in particular in the care sector) do not yet have a longstanding experience of recruiting from countries like the Philippines, employers currently prefer to do so via these projects. Furthermore, it should be noted that organisations providing elderly care are typically rather small enterprises that often lack the means to engage personnel from abroad on their own. SMEs would need a specific framework for support to hire international staff. Nonetheless, the German employers' association in the care sector promotes the standards of recruitment according to the WHO Global Code of Practice on the International Recruitment of Health Personnel.

Typically, the migration of Indian nationals to Germany is rather marginal. Only the number of doctors with Indian nationality is known (see above). Due to the fact that India figures on the list where recruitment is not possible directly by employers (only through ZAV), and taking into account that India is a country that figured on the WHO code of ethical recruitment practice as one where no hiring of health-care professionals should take place, no targeted campaign has occurred. It is, however, reported that migration of Indian sisters (monasteries) has occurred in exchange programmes with hospitals managed by religious organisations in Germany. In 2010, approximately 1,000 Indian sisters were active in 40 different sister/monk communities, working in hospitals as nurses. Religious organisations benefit in Germany from a specific labour law regime that also arranges for exceptions regarding the qualification standards. Sisters would generally get training in hospitals in Germany, and after some time spent in Germany they would return. The sisters' community in Germany would also encourage returning Indian sisters to disseminate practices that they have learned.[43]

Triple Win Project

This project started only recently and aims to recruit health professionals from the Philippines, Bosnia and Herzegovina, Tunisia and Serbia between early 2013 and the end of 2014. As indicated above, its goal is to manage migration and not to encourage circular migration.

[43] Policy Paper by the Federal Ministry of Economy to promote the hiring of foreign professionals in the care sector, Chancen zur Gewinnung von Fachkräften in der Pflegewirtschaft, p. 31.

After a successful pilot project phase, the scheme intends to bring to Germany 2,000 health-care professionals, mainly nurses and care professionals. A first group of five professionals arrived in December 2013, and a further contingent of 20 arrived January 2014.

Employers who wish to participate in the project engage themselves upfront to take on a certain number of professionals. The labour contract foresees a two-year period of employment, during which the professional will need to pass the above-mentioned language and knowledge specific tests. It is estimated that at least one year will be needed to pass these. The German Association for Development, GIZ, is responsible for carrying out the programme, together with the ZAV and the CIM (the German Centre for Migration and International Development). The GIZ already organises language training prior to departure and provides an introduction to the German cultural context. Upon arrival the individual will follow a one week intensive training course that introduces German administration and culture. While employed and working as assistant nursing professionals, the worker will follow specific training to pass the language and knowledge test. The worker is allowed to work as a professional nurse upon successful passage of the tests and reception of certification of recognised diplomas.

However, the employer is required to pay the professional a salary as a professional nurse while being trained. This has the effect that the employer needs to invest up-front without having any guarantee of whether the person will actually pass the tests or is finally suitable to work in his business. The employer, however, only pays for salaries, whereas training costs (costs related to training providers) are paid by the ZAV.

Once the two-year contract is completed the person can decide whether he or she wants to stay or return to their home country. As indicated above, there is no particular intention to foster circular migration in this project.

Take-up of the project is currently limited, due to the fact that employers find that they have high upfront investments (e.g. training costs for recognition of foreign diploma, mentoring programmes at the workplace, integration courses, language courses) without having any idea about the professional level of the person and whether the person will actually pass the necessary tests. These investments are higher for non-EU candidates (mutual recognition of qualification agreements existing between EU countries) because of additional training costs, including for language and cultural awareness training, etc. Furthermore, the opening up of private recruitment channels in July 2013 does not support the recruitment through the Triple Win agreement.

The BLA with the Philippines did not take any specific approach regarding the recognition of diplomas in Germany (e.g. in relation to easing administrative processes, thus reducing uncertainties for employers). The concept of circular migration was only known by the German employers' associations due to a nation-wide debate about international recruitment strategies and circular migration.

Employer views on the feasibility of circular migration

Having analysed the current situation of migration among health-care professions entering Germany, it appears that circular migration is not currently practiced. All existing schemes leave the decision to the individual, whether to extend their stay or to return home, and in some cases a clear preference is expressed for a long stay in Germany. This is partly because international recruitment of highly qualified professionals generally means high investments -- in particular to train foreign-recruited persons and to get their diploma recognised.

In a general study on circular migration published by the ad-hoc expert group of German foundations on migration and integration[44], it was highlighted that in order to make circular migration work, employers find that origin countries need to have high qualification standards and training programmes making the transition time in the destination country shorter. Similarly, requirements would also have to be in place in the origin countries to ensure that any skills obtained abroad can be utilised.

Circular migration would work best if the need for labour was seasonal/temporary (which is not the case in the health-care sector). In the case of a structural need to recruit workers, a long-term stay is generally preferred. In cases where there is a crucial structural need to recruit personnel, the concept of circular migration is rather counterproductive for employers.

The study further highlights[45] that circular migration could still be envisaged for targeted development programmes with third countries. These programmes should be organised on the basis of bilateral agreements, taking into account the labour market situation of origin and destination countries. As part of this, work permits should be granted only on a temporary basis and should encourage return once the stay in the destination country comes to an end. The paper further notes that for the origin country to gain from circular migration, training has to be provided while in the destination country. Such programmes are most effective with highly qualified workers having earned already a higher degree in their home countries. This assumption relies on the fact that higher qualified workers would return to their home countries in key positions, making use of the knowledge gained, and generating a higher spill-over effect than would be the case for lower qualified workers.

The paper does not provide any evidence for this and the concept of circular migration being discussed is not one of repeat circular migration. It also appears inclined to limit the possibility of voluntary return -- indicting that return to the origin country should be encouraged. As there is limited experience of circular migration in practice, it is not possible to say how many workers would indeed return home to create their own companies and take up leading positions. Such developments could be hampered in reality by lack of access to funds and infrastructure to create such companies (e.g. for the delivery of elderly care, which often remains in the hands of families in the origin countries). The number of "key positions" available is clearly limited and particularly for women, there can be a perception that access to such possibilities is more difficult in the cultural environment of the home country.

It is further noted in this paper that in order to have significant economic development effects in the origin countries from circular migration programmes, the number of participants needs to be quite significant to help to create the momentum for change and to have a relevant economic impact. The paper suggests that it would be beneficial if several EU countries would receive professionals rather through a bilateral programme. This kind of programme could be steered by the European Commission. Should the destination country only intend to receive a small number of candidates, then a relative small partner country would be most suitable for circular migration to create the most efficient economic development effect. Finally, to make the return for participants easier and more attractive, it must be ensured that they return to key positions to integrate their knowledge. It should again be noted that there is no assumption here of circularity in the sense of repeat migration, as the paper does not discuss, for instance, access to repeat visas, which would need to be ensured to encourage circularity.

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[44] Sachverstandigenrat Deutscher Stiftungen, fur Migration und Integration. 2011. Triple-Win oder Nullsummenspiel? Chancen, Grenzen und Zukunftsperspektiven für Programme zirkulärer Migration im deutschen Kontext, Berlin. Retrieved at: http://www.svr-migration.de/content/?page_id=3492

[45] Ibid. ft 9, p. 17.

The paper concludes that as Germany is currently facing a significant shortage of labour in the health-care sector, the promotion of circular migration is not the focus of targeted recruitment strategies. The attractiveness of migration programmes with limited work and residence permits is questioned amongst German employers' associations. This is due to the high recruitment investments that would have to be made upfront, which might not be recovered over a period of three years. Therefore, the paper supports the migration of middle or lower-qualified professionals (with at least an apprenticeship or comparable qualification) to reduce the overall cost of recruitment, and training in particular, even if the impact for origin countries may not be as high for projects targeting highly tertiary trained staff. Finally, it is argued that circular migration could also be imagined with regard to migrants who have already been residing in the destination countries for longer by providing incentives to return to their home country through specific programmes.

Interviewed employers find that Germany is not in the best position for migration at this stage. It is not perceived by foreign nationals as a primary destination. This is certainly a language problem. In many countries German is not a language taught in schools. Successful professional integration in particular in the health-care and care sector is only possible if the person has sufficient language skills. Furthermore, the current process for recognition of equivalence of the foreign diploma is quite a time intensive process that has also worried many employers regarding the attractiveness to migrate to Germany. This process does not always follow identical rules in all federal states, which make a targeted recruitment programme difficult to organise. Finally, most of the small and medium-sized enterprises in the care sector often do not have the necessary structural means to successfully integrate the foreign worker. According to employers' views, successful integration is best achieved by mentoring and accompanying programmes. Regional networks could be of use in this regard.[46]

According to interviewed employers, they are open to circular migration in general in order to advance development aims. It is, however, a question of what should be their concrete contribution and what could be the right process. The concept of circular migration is still relatively new to most employers as they are mainly searching for suitable staff that can fill a specific position and bring the right technical and team skills. This has led to reflections in particular in the care sector about cultures and "best fit" of cultures to ensure that culture gaps between native and migrant professionals, as well as patients, are limited. Employers have high expectations regarding the integration of migrants and efforts of migrants to fully integrate into the national cultural context. In particular, SMEs are considered to be required to be more attentive to this cultural fit and to also be a more "personal" fit. This is also one of the reasons why most SME employers from the care sector refrain in participating in the Triple Win project, not because there are financial costs involved, but because they need to be sure about the "personal fit". So they avoid signing up with fixed objectives upfront.

Efforts by employers have rather concentrated to find reliable sources of well-qualified and trained international staff that meet the requirements of the German health-care system. Hence, employers also invest in concrete training programmes in origin countries that are estimate to be "a fit" to make sure that training fulfils the standards of the German qualification systems for either the hospital or care environment. However, reflections have not been made to go beyond this (e.g. to encourage a potential return to the origin country). These initiatives are rather seen as a way to provide young people in the origin countries with a perspective for employment, taking into account that employment perspectives

[46] See the following article: Merda, M. 2013. Pflegekräfte aus dem Ausland gewinnen, IEGUS GmbH, access at: http://www.iegus.eu/

in their home countries are often poor. Concepts such as bilateral regular co-operation through twinning or staff exchange programmes with the objective for development of health-care outcomes in the origin countries were not mentioned. Employers see potential for such types of programmes, in particular for doctors. The benefits for such types of programmes are considered by employers to be more limited for nurses, as it appears less clear who would finance such training.

Providing long-term perspectives to improve health-care outcomes in the origin countries has been seen as an objective where the national level and also employers have to work together. Germany has made efforts to provide help to the Philippines regarding possible return migration. The GIZ currently funds a programme that aims to provide training in long-term care. This type of profession is not as such known in the Philippines as it is mainly families that care for older family members. However, long-term care homes could also be a potential future market in the Philippines, and it could provide an opportunity for those Filipinos having worked in the long-term care sector in Europe.

Germany also provides active help to migrants that wish to return (not just in particular health-care professionals). The scheme “Rückkehrende Fachkräfte” (returning professionals) is carried out by ZAV and CIM, providing help with search for employment in home countries, counselling and financial assistance for return migration.

2.3.5 Finland

Finland is not a traditional destination country for health-care professionals but instead tends to “export” more health-care workers than it imports. Typically Finnish nurses emigrate to other Scandinavian countries, mainly Sweden and Norway. Foreign doctors working in Finland tend to come from Estonia and Russia, and other EU countries.

Migration trends of health-care professionals to Finland

For nurses and doctors the outflow is around 3.5 per cent and 1.5 per cent respectively; around 1 per cent of nurses in Finland are of foreign origin or with passports that are not Finnish. About 6.5 per cent of active physicians are of foreign origin. The data for 2012-2013 provided by the Finnish Ministry of Health hints that some doctors of Estonian origin have returned to their home country after working in Finland.

In 2010, there were approximately three times more Finnish nurses residing abroad than foreign nationals working as nurses in Finland. There were fewer Finnish doctors residing abroad than there were foreign doctors in Finland. The emigration of Finnish working-age health-care professionals decreased considerably between 2000 and 2012.

At the end of 2010, social welfare and health-care service personnel included approximately 6,100 foreign nationals and approximately 13,300 people not of Finnish origin. Foreign nationals accounted for just over 1.5 per cent and people not of Finnish origin for 3.5 per cent of all social welfare and health care service personnel. Approximately 6.2 per cent of nurses and 4.6 per cent of doctors were of Asian background (data provided by Finnish Ministry of Health).

Managed migration policies in the health-care sector

The changing policy environment and labour shortages in the health-care sector have, however, created new grounds for international recruitment of health professionals. Since 2006, the recruitment programmes for foreign health professionals have gained more attention as a measure for tackling workforce shortages in the health-care sector, especially in frontline health-care services.

In its *"Future of the Immigration Strategy 2020"* the government stated in 2013 that in order to succeed in the current changing demographic context, Finland needs active, well-planned and targeted labour migration. According to the decision, especially in the social and health-care services (as a branch with the biggest share of labour) the international recruitment and the cooperation required for it shall be developed. According to a study carried out by the Ministry of Employment and the Economy in 2012, there will be a shortage of at least 18,000 health-care professionals in Finland by 2025.

Finland has no bilateral labour agreement with either the Philippines or India. Nursing professionals from the Philippines have been recruited in the recent past by one of the biggest care providers and the Helsinki University Hospital (HUH).

The HUH engaged in a recruitment project back in 2008 and in 2010 hired 20 young Filipino nurses. The reason for starting this project was related to an intermediary shortage of nurses experienced in 2008. This shortage was a result of cuts in public spending on health-care so that many Finnish nurses were searching for positions outside of Finland. The HUH was very keen to follow an ethical recruitment procedure and they had studied several countries for recruitment purposes. They did in fact not recruit from Poland or Estonia as governments have indicated shortages of labour in the health-care sector. The HUH also recruited nurses from other EU Member States such as Spain, but turned also to Asian countries. The hospital used a Finnish recruitment agency that organised for the selection and transfer of candidates. Language training was provided already prior to travel to Finland, as well as training about Finnish culture and living conditions. The diplomas from the Filipino nurses were recognised, however any nurse in Finland has to have a Finnish nursing licence in order to be allowed to work in the profession. The Filipino nurses had to engage in a two-year training programme in order to get the Finnish nursing license. Having the Finnish nursing licence is a condition in order to receive a work permit. The group graduated in 2012 successfully and 16 of the original recruited Filipino nurses stayed with the HUH, while only four returned. Finland also promotes family reunion so that the nurses could stay for a long-term period. The recruitment project was based on a long-term intention; however nurses are free to return any time to the Philippines.

Employer views on the feasibility of circular migration

Circular migration has not been mentioned in current policy documents and does not seem to be a concept familiar to employers in Finland. As the requirements to obtain nursing or medical accreditations in Finland are rather arduous and learning the language is a prerequisite met by few migrants, the investment required to facilitate such migration leads employers to desire long-term, or indeed permanent migration, to ensure a return on their investment.

2.4 Strengths, weaknesses, opportunities and threats of approaches to circular migration for migrants, employers, origin and destination countries

The results of this study have shown that circular migration among health-care professionals in Europe is more myth than reality. The lack of reliable data on migration flows is certainly a factor that hampers any meaningful assessment -- or indeed management -- of such circular movements. However, the review of the literature and interviews with policy makers, employers' organisations and employers clearly demonstrate that despite some awareness of the policies required to prevent the pitfalls of circular migration, activity in this area is limited. This section discusses the reasons for the lack of practical use of the concept in reality in the health-care sector, by assessing its strength, opportunities, weaknesses and threats from the perspective of employers and destination countries. These are briefly summarised in Table 3. As this table and the subsequent discussion makes clear, what can be a strength to one party to the "circular migration equation" can easily be a weakness or threat to another and some opportunities can only be realised by putting in place a suitable policy framework to ensure political and employer support for the idea.

2.4.1 Employers in destination countries

In seeking to establish the views of employers with regard to the reality of circular migration, two things are immediately evident from interviews and a review of the literature: few employers in destination countries are directly involved in circular migration initiatives or practices and are therefore not able and not willing to speak about such matters, and those employers who did respond to researchers' questions equated migration issues with the importance of codes for ethical recruitment. Even in countries where there are efforts at managed migration policy -- which take into account employer requirements and where return is considered a potentially positive step for the migrant and the origin country (given the presence of particular circumstances) -- in no instance is there reference to circular migration in the context of repeat migration flow. The complete absence of an understanding or policy approach to such repeat circular migration patterns must therefore be noted.

The positive conclusion that can be drawn from this is that most employers are aware of the importance of preventing brain drain in origin countries and have knowledge of the requirements of codes of ethical recruitment. They are keen to respect the provisions of such codes, to the extent that in countries where such provisions are made (e.g. the United Kingdom), the larger employers in particular ensure that they only use recruitment agencies that are signed up to such codes. Ethical recruitment is therefore increasingly actively discussed among employers in Europe and is a policy message that appears to have been clearly understood.

Furthermore, it is also evident and understandable that the first priority of health-care employers is to address any skills gaps and to fill their vacancies with the best qualified personnel available, who are immediately able to contribute to the efficient and effective running of their health-care institution to the benefit of their patients. To achieve this, their first preference is to recruit locally (domestically) from a workforce that has been trained to recognise standards, and who have a full understanding of the language and cultural conditions of the country. In areas of recognised labour or skill shortages and predictable demand, recruitment is generally done on a permanent basis (subject to any trial periods of initial fixed-term arrangements). Where greater flexibility is required and demand is more short-term, health-care providers tend to draw on agencies to meet such manpower demands, expecting the workforce to be immediately available and ready to meet day-to-day patient requirements.

While transnational recruitment offers the possibility of overcoming long waiting periods required to train additional workers and to address short-term labour shortages with greater potential for flexibility than the recruitment of domestic workers, there are a range of practical obstacles that tend to mean that recourse to transnational recruitment (let alone recruitment on the basis of a circular migration pattern) is relatively limited. These relate to administrative obstacles, cultural differences, the recognition of qualifications and the potential need to deliver additional training.

There is a strong awareness that transnational recruitment, albeit potentially helpful to plug labour or skills gaps, brings with it a range of "costs" and risks. The most obvious is the need to obtain the recognition of qualifications and competences gained abroad. Within the EU, such processes have been eased through the mutual recognition of key qualifications, but similar arrangements are only achieved on an ad-hoc basis with countries outside the EU. Employer and stakeholder responses clearly indicates that such recognition processes can be very time consuming and depend on the origin countries involved. In the meantime, migrant health-care workers are often unable to work at their full potential as they tend to be required to work in functions below their standard of training achieved while recognition is obtained (the latter is not always guaranteed).[47]

Often, additional training will be required, ranging from language over health and safety to technical training. In some cases, recruitment costs themselves can also be high (depending on who covers travel costs and the cost of accreditation). Furthermore, there are some evident and some more hidden "integration" costs to be taken into account if the migrant worker is to be fully integrated into the workplace and its surrounding community, as indicated by employers during interviews. This would include for instance cultural training, emotional support (particularly in cases of family separation) and other support needed to assist integration.

Less obvious integration issues can centre on perceptions of hierarchy and the ability to intervene in situations where a patient may be put at risk. Some stakeholders argue that nurses from some non-EU backgrounds may be less likely to be willing to challenge the authority of a superior, even in situations where such a superior is in error and decisions may endanger a patient. Others focus on cultural perceptions and nuances both vis à vis fellow members of staff and patients. Employers may also have to contend with negative perceptions or overt discrimination of migrant staff by domestic workers, patients and the public.

Whereas significant pecuniary or time investment is required in order to be able to use a migrant worker to their full potential, this investment is often seen only to be justified if such recruitment is permanent, or at the very least considered long-term. Estimates for the number of years of how long a migrant would need to stay in order to make the investment beneficial for the employer vary across type and size of employer, as well as geographic location (differences between rural and city). In the countries of study it was estimated that migrants would need to stay with the employer between three to five years, whereby most employers prefer five years.

[47] For more information, refer to a study on the comparability of the nursing education and practice between the Philippines and Finland, Norway and Denmark, produced by the ILO-Decent Work Across Borders project, in collaboration with the Commission on Graduate of Foreign Nursing Schools, available on the ILO-DWAB project site at: http://ilo.org/manila/whatwedo/projects/WCMS_173607/lang--en/index.htm

The more experience a worker accumulates and the better integrated he/she is, the more costly the loss of such a staff member becomes. In the context of persistent shortages in the health-care sector, it is therefore unlikely for employer attitudes to change in this respect.

Research from writers such as Vertovec (2007), Massey (1987), Duany (2002), and Constant and Zimmermann (2004) shows that circular migrants are more likely to be male and low skilled. Questions have therefore been raised over the suitability of this approach for the health-care sector, with a highly skilled and female dominated workforce (McLoughlin et al., 2011).

Overall, circular migration is therefore not seen to offer any immediate benefits to employers in the health-care sector in the destination countries. While employers can see their role in respecting ethical recruitment standards, they are not in a position to perceive their role in developing and training a workforce that will ultimately benefit another employer in a different country. Employers see the concept of circular migration as promising, in particular in cases of neighbouring countries (e.g. Germany, Czech Republic, Poland) or for peaks and troughs in demand.

Table 3: Strengths, weaknesses, opportunities and threats of circular migration of health-care professionals for employers, and destination countries

	Strengths	Weaknesses	Opportunities	Threats
Employers in destination countries	• Overcomes long waiting periods to train domestic workforce • Potential to address more “seasonal” and/or short-term shortages • Overcoming threats to health and eldercare provision resulting from labour and skill shortages without significant investment cost of training of health-care workforce	• Pecuniary and time costs to achieve recognition of qualifications and competences obtained in another country • Cost of language and integration training • Less likely to be able to meet short-time requirements if significant investment in recognition of qualifications is needed • Demand for workforce is more structural and therefore long-term • Lack of interest in training workers who are only scheduled to remain in the short-term • Lack of interest and knowledge on how to train national on including workers from other cultures in the workplace (induction program)	• Opportunity to meet short-time labour and skills gaps (if rapid recognition is ensured) • Circular migration can be beneficial regarding workforce in neighbouring countries • Possibility to demonstrate credentials as “socially responsible” employer if coupled with relevant integration, training, etc. policies • Potential to offer greater flexibility (but only if policy approaches allow for shorter terms of migration)	• “Backlash” by national health-care workforce, trade unions, patients, public to recruitment of migrants • Lack of cultural fit (e.g. different understanding of hierarchies) • “Hidden” integration issues and costs not budgeted among other known costs • Lack of longer term investment in training of domestic health-care workforce resulting from over-reliance on migration
Destination countries		• Lack of reliable system of monitoring migration flows • Lack of investments in the cost of adequate social integration policies and mechanisms in some countries • Lack of coordinated approach among destination countries, which is a factor in the implementation of comprehensive and global ethical recruitment practices	• Meet aspirations for development policy and addressed “brain drain”	• Lack of emphasis on “brain circulation” in managed migration policies undermines development aspirations of destination countries • Volatility of migration flows means overreliance on such sources of labour can lead to continued shortages

2.4.2 Destination countries

For destination countries, the main potential benefit derived from circular migration is the ability to shore up its health and care sector and prevent difficulties in ensuring high-quality care arising from temporary (or indeed more structural) labour and skill shortages. Some countries may also have specific aspirations in supporting the development of the economy and health-care systems of significant origin countries and use circular migration policies as part of a wider international development approach. In reality, if the only goal is to assist employers in filling unfilled vacancies, while at the same time keeping control on migration flows, the simplest solution tends to be to grant time-limited work permits directly linked to specific skill shortages. Should skill shortages become more structural, the possibility is open to renew or extend work permits and ultimately offer naturalisation. For destination countries, an over-reliance on migrant labour could, in the long-term, lead to endemic under-investment in initial (and ongoing) training of the health-care workforce, detrimentally affecting the development of the health-care system, particularly if migration flows prove unreliable.

The evidence reviewed on existing migration policies show that the development of specific policies of managed circular migration remains limited, with more emphasis being placed on ethical recruitment and managed integration of migrants -- generally with an intention for long-term retention.

Germany and Finland are not typical destination countries for Philippine and Indian health-care professionals, despite some minor recruitment initiatives, to the contrast of the United Kingdom and Ireland. While employers and governments see a "fit" for international health-care recruitment cooperation in the countries of study, initiatives that contribute to long-term perspectives of the development of health workforce in the origin countries or brain circulation has not been reflected in bilateral agreements or other managed migration schemes. While the concept of circular migration has been quite prominent in Europe to manage migration flows, concrete debates about how to make use of the concept in particular for the health-care sector remain in their infancy.[48] Germany is the only country studied that currently tries to put into practice circular migration schemes for nurses from developing countries.

Similarly, existing Codes of Conduct do not mention ways of implementation of circular migration policies but rather focus on ethical recruitment and investments that destination countries should make in the training of the health-care workforce or reimbursement of training costs to the origin countries. Best practices of such initiatives are lacking and questions arise on how such investments could achieve such aims. Further, the question remains about who should contribute financially, and to what extent. Here also the participation of international NGOs and international development funds should be discussed.

One major aspect for destination countries is the knowledge about their own health-care system and future skill shortages. While in Germany and Finland the focus of such kind of mapping is to ensure that the workforce can be found within their own labour markets, or by restructuring the delivery of health and care services, the United Kingdom and Ireland have made international recruitment a pillar of their efforts to meet requirements for shortage professions in health-care services. As indicated above,

[48] The European Network of Migration provides country case studies examining EU countries' migration rules and schemes that either put into practice circular migration or are providing room for the implementation of circular migration policies. See the following web link: http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/studies/results/circular-migration/index_en.htm

one major threat for destination countries making international recruitment a part of the system in the provision of workforce is the volatility of migration flows adapting to changes affecting destination countries, such as reputation of the health-care system at large and connected working conditions, or the general economic situation (e.g. Ireland strongly affected by the current economic crisis). When relying on an international workforce, destination countries need to be even more attentive to push and pull factors and should closely monitor migration flows. However, in the United Kingdom and Ireland, such kind of monitoring is part of a very limited extension of current international recruitment policies.

3. Conclusions

The debate around the potential of circular migration policies to offer a triple win for all parties concerned and the criticisms that have been levied against these assumptions formed the starting point for this paper. Its goal was to bridge the evidence gap in the literature regarding the knowledge of the actual practice of circular migration in the health-care sector (in Europe and involving India and the Philippines as origin countries). Particular limitations were perceived in relation to the position of employers and employers' organisations in the sector on the concept and realities of circular migration.

In assessing the views of employers, the paper was to contribute to the international policy debate on circular migration.

The most evident finding from this study is that circular migration in the health-care sector in the countries under study remains very much a myth. An assessment of the phenomenon is hampered by the fact that reliable data are largely missing. Despite this, consultations with employers and government representatives demonstrate that even in managed migration policies, little emphasis is currently being placed on supporting the notion of circular migration, with most efforts expended to ensure ethical recruitment and the managed integration of migrant workers in the sector.

Where there have been efforts to introduce circular migration schemes in Europe (in the health-care sector and beyond), these are largely in their infancy or proved (as in the case of the Blue Birds scheme in the Netherlands) to be ultimately unsuccessful.

The main reason for this lies rooted in the interests and motivations of employers in the sector, whose main priorities are to attract a highly qualified workforce to deliver a good and reliable standard of care to their patients in an effective and efficient way.

While there is some interest in transnational recruitment where relevant qualified workers cannot be found locally -- and there is indeed growing awareness and willingness to respect codes of conduct on ethical recruitment – there is generally little interest in time-limited recruitment of highly qualified workers. This is particularly true where the upfront investment in achieving the recognition of foreign qualifications and in integration measures is significant. The shortage of highly skilled labour in the health-care sector in many countries tends to be structural and employers are therefore keen to retain workers. Where there is a willingness to invest in training and integration, it is very much targeted at retention, rather than letting staff take these skills to other employers or abroad after a period of time. Understandably, employers therefore do not pursue development goals, but are concerned with the delivery of high-quality healthcare to their patients. While governments may therefore have wider interests and seek to foster circular migration, these interests rarely coincide with those of employers

in the health-care sector. The literature has previously emphasised that circular migration may appear more attractive to lower-skilled sectors and where demand is more seasonal.

Table 4 seeks to summarise the complex web of factors that need to be in place to support the successful implementation of circular migration policies. As with the SWOT analysis presented above, this also demonstrates the risk of potentially conflicting requirements. These would need to be addressed, also taking account of the push and pull factors pertaining to specific countries.

To make circular migration more attractive to employers, the following factors appear most critical from among those mentioned in the table below:

For employers

- Rapid and reliable recognition processes and government support for integration policies, thus reducing the overt and hidden costs of the integration of migrant workers. This can contribute to reducing the number of years a migrant would be required to "compensate" for this upfront investment.
- Managed migration policies have to be coupled with clear monitoring and workforce development strategies at home to ensure that demand for migrant workers is not permanent.
- Clear integration of all stakeholders into managed migration policies to ensure all interests are taken into account and migration does not lead to conflict with the domestic workforce and their representatives.

Table 4: Factors which need to be in place for successful circular migration practices

Factor	For destination countries (where separate from requirements for employers)	For employers
Regulatory measures		
Regulation of entry/exit/re-entry	Flexible migration policies which allow, for example, family re-integration, dual citizenship or ease of re-application visas.	Availability of easy-to-administer multi-entry visas; priority to former temporary migrants to obtain new work and residence permits.
Recognition of qualifications	Skills recognition mechanism needs to be developed to facilitate the recognition of skills through the collaboration between origin and destination countries' education systems.	Processes must be in place to recognise and validate qualifications gained abroad. These must be reliable to ensure patient safety and ethical treatment. Possibility to validate language competences.
Naturalisation rights	Potential to retain skilled foreign workers long-term by ensuring naturalisation rights are retained.	
Portability of benefits	Availability of easy-to-administer procedures to allow migrants to port social insurance benefits.	

Factor	For destination countries (where separate from requirements for employers)	For employers
Measures governing employment relationship		
Length of contract	The duration of visa must be aligned with employers' minimal return on investment estimations.	Must be of sufficient length to offer return on investment (e.g. in recognition of qualifications, training, integration, etc). In the health-care sector it is generally felt that two years is too short to offer return on investment.
Flexibility of contract	Policies must be in place to ensure that the need for flexibility of the labour market is not detrimental to migrant workers' fundamental rights at work.	Must be sufficiently flexible to accommodate rises/decline in demand while ensuring migrant workers' fundamental rights at work
Availability of training Equal treatment	Public policies and programmes to write off some of the initial training costs (e.g. language) needed by migrant workers. Policies must be in place to ensure that migrant workers' fundamental rights at work are respected.	Migrant workers must be able to avail to the same on-the-job training opportunities as other national workers. Relevant international experience should be recognised in all aspects of working.
Socio-economic measures		
Integration	Ensuring integration services, even for circular migrants, lessens potential tensions with native workforce or population and increases likelihood of return.	Integration support helps workers to become more productive more quickly, also by ensuring greater satisfaction.
Cost of migration	Public policies and programmes to write off some of the initial training costs (e.g. language) needed by migrant workers.	Design and implementation of induction programmes for national workers.
Type of worker/ occupational targeted	Efficient labour market information systems to project and forecast the demand for health professionals.	Ensure there is clarity over who covers the cost of migration. These should be equitably shared to avoid undue costs on individuals. Avoid exploitation of migrant workers.
Development of health-care sector	Policies to contribute to the development of the health-care and education systems of country of origin. Efforts made by country of destination to develop own health-care workforce.	Ability to target workers in shortage occupations while respecting ethical recruitment practices. In origin countries health-care sector would have to develop further to ensure technical, care and leadership skills gained abroad can be fully utilised.

The requirements outlined above can only be achieved through managed migration policies ensuring close cooperation between origin and destination countries including the contribution of actors relevant to the health-care sector. Those include government, employers, trade unions and also professional organizations and recruitment agencies. At present, it appears that such all-inclusive design and management of migration systems remains limited, with some promising examples at a national level (e.g. Germany) which remain to be evaluated. It must be noted that even these do not ultimately aim at circular migration. A report assessing the impact of German-managed migration programmes argues that in order to have significant economic development effects in the origin countries from circular migration programmes, the number of participants needs to be quite significant to help to create the momentum for change and to have a relevant economic impact. It is suggested that it would be beneficial if several EU countries received professionals. This kind of programme could be steered by the European Commission. To make the return home for participants easier and more attractive, it must be ensured that they return to key positions to integrate their knowledge. Provisions would also need to be made for access to repeat visas and work permits, which would need to be ensured to encourage circularity. Such a programme would require wider EU-level, or indeed more international, coordination.

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Annex 1:
Stakeholder questionnaires

Questionnaire for employers'/sectoral organisations at European/international level:

- What is your definition of circular migration?
- How important is the hiring of migrant health-care workers/circular migration for the sustainability of health-care systems in origin/destination countries?
- What are the main benefits of circular migration to health-care systems/employers in the destination countries?
- What are the main benefits of circular migration to health-care systems/employers in the origin countries?
- What are the main drawbacks of circular migration to health-care systems/employers in the destination countries?
- What are the main drawbacks of circular migration to health-care systems/employers in the origin countries?
- What are the main benefits of circular migration to health-care workers?
- What are the main drawbacks of circular migration to health-care workers?
- To what extent is circular migration a reality at present?
- What are the main origin/destination countries of circular migrants?
- What are the patterns of circular migration in terms of how long migrants stay in the origin/destination countries respectively? Are there differences depending on the origin/destination countries concerned? (Comment specifically on India and the Philippines).
- To what extent is circular migration encouraged by national policies/practices?
- What are relevant national policies and practices to encourage and support circular migration?
- To what extent is circular migration encouraged by organisational policies/practices?
- What is the impact of circular migration on employer policies in destination countries (e.g. integration policies, contractual practices etc)?
- What are the main supporting/hindering factors of making the concept of circular migration work? What can policy makers at the international and national level, employers and migrants do to make this more successful?
- Is current policy emphasis/guidance sufficient to make circular migration a win-win-win scenario for employers and migrants in origin and destination countries? If not, what is needed to improve policy and practice?
- Please provide any examples of good practice (or poor practice) that you are aware of.

Questionnaire for employers'/sectoral organisations at national level:

- What is your definition of circular migration?
- How important is the hiring of migrant health-care workers/circular migration for the sustainability of health-care systems in origin/destination countries?
- What are the main benefits of circular migration to health-care systems/employers in your country?
- What are the main benefits of circular migration to health-care systems/employers in the origin countries?
- What are the main drawbacks of circular migration to health-care systems/employers in your country?

- What are the main drawbacks of circular migration to health-care systems/employers in the origin countries?
- What are the main benefits of circular migration to health-care workers?
- What are the main drawbacks of circular migration to health-care workers?
- To what extent is circular migration a reality at present?
- What are the main origin countries of circular migrants in your country (if there is no circular migration, what are the main origin countries of health-care migrants (how many from India and the Philippines)?
- Can you provide details of the types of professionals coming from India and the Philippines and where they mainly work?
- Does your country have special arrangements to receive health-care workers from India and the Philippines? Please provide details of these arrangements/agreements.
- What are the patterns of circular migration in terms of how long migrants stay in the origin/ destination countries respectively? Are there differences depending on the origin/destination countries concerned? (Comment specifically on India and the Philippines).
- To what extent is circular migration encouraged by national policies/practices?
- What are relevant national policies and practices to encourage and support circular migration?
- To what extent is circular migration encouraged by organisational policies/practices?
- What is the impact of circular migration on employer policies in destination countries (e.g. integration policies, contractual practices, etc)?
- What are the main supporting/hindering factors of making the concept of circular migration work? What can policy makers at the international and national level, employers and migrants do to make this more successful?
- Is current policy emphasis/guidance sufficient to make circular migration a win-win-win scenario for employers and migrants in origin and destination countries? If not, what is needed to improve policy and practice?
- Please provide any examples of good practice (or poor practice) that you are aware of.

Questionnaire for public employment services/national bodies responsible for circular migration issues:

- What is your definition of circular migration?
- How important is the hiring of migrant health care workers/circular migration for the sustainability of health-care systems in origin/destination countries?
- What are the main benefits of circular migration to health-care systems/employers in your country?
- What are the main benefits of circular migration to health-care systems/employers in the origin countries?
- What are the main drawbacks of circular migration to health-care systems/employers in your country?
- What are the main drawbacks of circular migration to health-care systems/employers in the origin countries?
- What are the main benefits of circular migration to health-care workers?
- What are the main drawbacks of circular migration to health-care workers?
- To what extent is circular migration a reality at present?
- What are the main origin countries of circular migrants in your country (if there is no circular migration what are the main origin countries of health-care migrants (how many from India and the Philippines)?

- Can you provide details of the types of professionals coming from India and the Philippines and where they mainly work?
- Does your country have special arrangements to receive health-care workers from India and the Philippines? Please provide details of these arrangements/agreements.
- What are the patterns of circular migration in terms of how long migrants stay in the origin/ destination countries respectively? Are there differences depending on the origin/destination countries concerned? (Comment specifically on India and the Philippines)
- To what extent is circular migration encouraged by national policies/practices?
- What are relevant national policies and practices to encourage and support circular migration?
- To what extent is circular migration encouraged by organisational policies/practices?
- What is the impact of circular migration on employer policies in destination countries (e.g. integration policies, contractual practices, etc)?
- What are the main supporting/hindering factors of making the concept of circular migration work? What can policy makers at international and national level, employers and migrants do to make this more successful?
- Is current policy emphasis/guidance sufficient to make circular migration a win-win-win scenario for employers and migrants in origin and destination countries? If not, what is needed to improve policy and practice?
- Please provide any examples of good practice (or poor practice) that you are aware of.

Questionnaire for employers:

- What is your definition of circular migration?
- How important is the hiring of migrant health-care workers for your organisation?
- How important is circular migration for your organisation (does it take place)?
- Are there relevant national policies and practices to encourage and support circular migration?
- Are you working with national bodies to implement this concept in your organisation, and if so, what kind of support do you receive from them in this regard?
- How many migrants to you receive/from, which countries/in, which professions (specifically, how many from the Philippines and India per year)?
- How long do they remain with you on average?
- Which policies are in place for professional and social integration and how is integration assured?
- Do any migrants (and if so what share of migrants, particularly from the Philippines and India) arrive with an intention for circular migration? Is this based organisational/national policy?
- What are the benefits of migration/circular migration for the organisation (what would you see as the benefits/ drawbacks if it did take place)?
- What are the drawbacks (are these what hinder the implementation of the concept in your organisation)?
- What are the key challenges associated with circular migration and how might these be overcome to make this more attractive to your organisation (and to migrants themselves)?
- How is equity ensured in relation to the access of professional training and other benefits?
- What are the costs involved in circular migration for the employer (e.g. related to recruitment and selection, induction processes, accreditation of qualifications, cost of possible errors due to be new on the job)?
- What is needed to support circular migration and make this a successful approach?

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ISSN: 2227-4391