WP7 Report on Circular Migration of the Health Workforce

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The Joint Action Health Workforce Planning and Forecasting

The Joint Action on Health Workforce Planning and Forecasting is a three-year programme running from April 2013 to June 2016, bringing together partners representing countries, regions and interest groups from across Europe and beyond, but also non-EU countries and international organisations. It is supported by the European Commission in the framework of the European Action Plan for the Health Workforce, which highlights the risk of critical shortages of health professionals in the near future.

The main objective of the Joint Action Health Workforce Planning and Forecasting (JA EUHWF) is to provide a platform for collaboration and exchange between partners, to better prepare Europe's future health workforce. The Joint Action aims at improving the capacity for health workforce planning and forecasting, by supporting the collaboration and exchange between Member States and by providing state of the art knowledge on quantitative and qualitative planning. By participating in the Joint Action, competent national authorities and partners are expected to increase their knowledge, improve their tools and succeed in achieving a higher effectiveness in workforce planning processes. The outcomes of the Joint Action, among other things, should contribute to the development of sufficient health professionals, contribute to minimise the gaps between the needs and the supply of health professionals equipped by the right skills, through the forecast of the impact of healthcare engineering policies and of the re-design of an education capacity for the future.

This report contributes to achieving this aim by providing an overview on circular migration of the health workforce and preliminary guidance to European Member States on how source and destination countries may cooperate on this issue, so as to find a mutually beneficial solution within the framework of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

This document was approved by the Executive Board of the Joint Action on Health Workforce Planning & Forecasting on January 27th, 2016.

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Contributors and Acknowledgements

The preparation of this report was led by the Catholic University of Leuven, Belgium, in collaboration with the Medical University of Varna, Bulgaria.

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Glossary

Term	Definition
Affordability	Keeping the costs of healthcare services within the threshold of what is considered sustainable by the population, national government and/or EU definition.
Age groups	A division of the population according to age, in a pre-determined range, used to distinguish differences among populations. Examples: 0-4; 5-9; 10-14; …. 60-64; 65+.
Anticipation	Thinking ahead of an occurrence in order to determine how to handle it, or how to stop it from happening.
Big picture challenge	A fundamental challenge that policy makers are facing across the (healthcare) system. Meeting a big picture challenge requires focused action at the highest level across the health, social care, education and employment sector.
Circular migration	A form of migration that is managed in a way that it allows migrants some degree of legal mobility back and forth between two countries.
Cluster	A set of system factors and driving forces, similar to each other and linked through cause and effect relationships, which describe a key focal issue of concern.
Demand (of HWF)	Number of health professionals required to fill in open vacancies. It should ideally be expressed both headcount and in full-time equivalent (FTE), depending on the forecasting purpose.
Driver / Driving force	A factor that causes or might cause changes, measurable movements or trends in the HWF of a health care system.
Events	Occurrences that can impact the healthcare system.
Emigration (outflow)	The act of leaving one's current country, in this context with the intention to practice a profession abroad.
Factors	A circumstance, fact or influence that contributes to a result. Factors are linked to each other through cause and effect relationships. A change to a factor often will influence one or more other factors in the system.
Full-time equivalent (FTE)	Unit used to measure employed persons to make them comparable, as they work a different number of hours per week, in different sectors. The unit is obtained by comparing an employee's average number of hours worked to the average number of hours of a full-time worker of same kind. A full-time worker is therefore counted as one FTE, while a part-time worker gets a score in proportion to the hours he or she works or studies. For example, a part-time worker employed for 24 hours a week where full-time work consists of 48 hours, is counted as 0.5 FTE.
Healthcare production	The output of healthcare services that can be produced from the given combination of human and non-human resources.
Health professional	Individuals working in the provision of health services, whether as individual practitioner or as an employee of a health institution or programme. Health professionals are often defined by law through their set of activities reserved under provision of an agreement based on education pre-requisites or equivalent.
Health workforce	The overarching term for the body of health professionals (trained and care workers directly involved in the delivery of care) working in a healthcare system.

Horizon scanning	A systematic examination of information to identify potential threats, risks, emerging issues and opportunities allowing for better preparedness.
Imbalances (major)	The uneven spread of the active health workforce across countries, regions or professions, resulting in *underserved/overserved areas*.
Indicators (key planning)	A quantitative or qualitative measure of a system that can be used to determine the degree of adherence to a certain standard or benchmark
Job retention	The various practices and policies which enable healthcare professionals to choose to stay in their countries to practise for a longer period of time, or to stay in their practice, or even to keep working full time.
Labour force	The total number of people employed or seeking employment in a country or region.
Megatrend	A large, social, economic, political, environmental or technological change that is slow to form and difficult to stop. Once in place, megatrends influence a wide range of activities, processes and perceptions, both in government and in society, possibly for decades. For example, the ageing population megatrend is composed of trends in birth rate, death rate, quality of healthcare, lifestyle, etc.
Migration (inflow)	The act of (either temporarily or permanently) moving into a country, in this context in order to practice a profession.
Minimum data set (MDS) for Health Workforce Planning	A widely agreed upon set of terms and definitions constituting a core of data acquired for reporting and assessing key aspects of health system delivery
OECD countries	See www.OECD.org for an overview of all OECD countries.
Planning process	A process of defining health workforce planning perspectives, based on needs assessment, identification of resources, establishing the priority of realistic and feasible goals, as well as on administrative measures planning to achieve these goals
Planning system	Strategies that address the adequacy of the supply and distribution of the healthcare workforce in relation to policy objectives and the consequential demand for health labour force
Population	A group of individuals that share one or more characteristics from which data can be gathered and analysed.
Population healthcare needs	The requirements necessary to achieve physical, cognitive, emotional, and social wellbeing, at the individual, family, community and population level of care and services.
Professions (within JA scope only)	The professional qualifications of physicians, nurses, midwives, pharmacists, and dentists, included in the Directive 2005/36/EC of the European Parliament and of the Council.
Qualitative information	Information collected using qualitative methodologies to identify and describe key factors in the health workforce system which are likely to affect the supply and demand of workforces.
Qualitative methodologies	Methods used to gather qualitative information on key factors which are likely to affect the supply and demand of health workforces through techniques such as interviews, document analysis, or focus groups. Includes methods to quantify uncertain parameters for forecasting models.

Reliance on foreign health workforce	The share of foreign (trained & born) health professionals within a country's health workforce in a given year, expressed as a percentage of the stock of the workforce
Retirement	Period or life stage of a health care worker following termination of, and withdrawal from the healthcare system. It is expressed in the number of healthcare professionals retiring from the labour market.
Scenario	A description of a sequence of events, based on certain assumptions. Scenarios are used for estimating the likely effects of one or more factors, and are an integral part of situation analysis and long-term planning.
Shortage	The negative gap between supply and demand.
Stakeholder	Groups or individuals that have an interest in the organisation and delivery of healthcare, and who either deliver, sponsor, or benefit from health care.
Stock (of HWF)	Number of available practising and non- practicing health professionals in a country, recorded in a registry or database. It should ideally be expressed in headcount and in full-time equivalent (FTE)
Supply (of HWF)	Number of newly graduated health professionals available to fill in open vacancies. It can be expressed in headcount or in full-time equivalent (FTE)
System	A network of interdependent components that work together to try to accomplish the aim of rendering medical and other health services to individuals.
Threat/ opportunity	A future event or system state which may occur due to changes in the system. The impact to the system may be viewed as detrimental (a threat) or beneficial (an opportunity); or a combination of both.
Training	The process by which a person acquires the necessary skills and competencies for delivering healthcare, possibly through post-graduate training programmes (in the framework of Continuous Professional Development) in addition to graduate training programmes
Trend	An emerging pattern of change, likely to impact a system.
Universal coverage	A healthcare system that provides effective, high quality and free of expense preventive, curative, rehabilitative and palliative health services to all citizens, regardless of socio-economic status, and without discrimination
Underserved areas	A region or area that has a relative or absolute deficiency of medical personnel or healthcare resources. This deficiency could present itself in shortages of professionals/specialities/skills required to deliver health services
Variables	A characteristic, number or quantity that can increase or decrease over time, or take various values in different situations.
Weak signal	Barely observable trends or events that indicate that an idea, threat or opportunity is going to arise. Sometimes referred to as *early signals*.
"Wild card"	A situation or event with a low probability of occurrence, but with a very high impact in a system. Sometimes they can be announced by a weak signal.
Healthcare Workforce planning	Strategies that address the adequacy of the supply and distribution of the health workforce, according to policy objectives and the consequential demand for health labour (National Public Health Partnership, 2002).
Workforce forecasting	Estimating the required health workforce to meet future health service requirements and the development of strategies to meet those requirements (Roberfroid et al, 2009; Stordeur and Leonard, 2010).

Executive summary

Background
The rapidly increasing demand for healthcare professionals in high income countries is producing a net migration loss of these workers from low income countries, many of whom themselves are also experiencing an increase in demand for healthcare. Circular migration is being advocated as a potential solution to this.

Aim of the report
This report provides an overview on circular migration of the health workforce and provides European Member States with preliminary guidance on how source and destination countries may cooperate in order to find a mutually beneficial solution in terms of circular mobility of the health workforce, within the framework of the WHO Global Code of Practice.

Methodology and scope of the report
The scope of the report is limited to an explorative review of the literature and an analysis of evidence produced in the framework of the JAHWF and its partners on circular migration of the health workforce. It does not aim to provide a detailed analysis nor does it claim to be exhaustive. As circular migration of the health workforce is a global issue, the report takes a global perspective while aiming to tailor its guidance and advice to EU Member States. It will focus on circulation migration from non-EU countries as well as intra-EU circular migration. The report aims to be relevant for the five health professions covered by the Joint Action, but it is acknowledged that most data available relate to nurses and doctors. Hence, any preliminary conclusions that can be drawn may have less relevance for pharmacists, midwives and dentists.

Definition of circular migration and the 'triple win' situation
The report follows the definition of the European Commission: "*Circular migration is a form of migration that is managed in a way that it allows migrants some degree of legal mobility back and forth between two countries*". Further subdivisions can be made in managed and spontaneous circular migration, as well as in circular migration of third-country nationals settled in the EU and persons residing in a third country. These subdivisions are hard to distinguish in practice though.
In recent years, circular migration has been promoted as a 'triple win' solution, bringing benefits to source and destination countries and migrant workers. Yet this idea has also been contested, especially for migrant workers and, to a lesser extent, the source countries.

WHO Global Code of Practice on the International Recruitment of Health Personnel in relation to circular migration
While the WHO Code does not say a lot directly about circular migration, its various articles are of relevance to the topic and can be taken as a starting point for developing circular migration initiatives, as was also brought to light by the JAHWF. The same applies to the EPSU-HOSPEEM Code of Conduct Ethical Cross-border Recruitment and Retention, which is especially relevant for circular migration initiatives in the hospital sector.

Evidence on circular migration of the health workforce

There is a severe lack of empirical data and research on circular migration of health workers, its prevalence and health workforce impacts in sending and receiving countries.

Formal and informal cooperation on circular migration of the health workforce

Immigration policies are still the traditional mechanism for managing international migration flows. Mobility partnerships, specifically focused on circular migration, are rarely used up to now and only a small number of EU Member States have adopted specific tools to promote circular migration, including health professionals from non-EU and EU countries. Many initiatives and collaborations take place outside the realm of formal legislative and policy mechanisms and structures. These mainly take the form of temporary projects and often involve NGOs to help execute them.

Education and training in relation to circular migration of the health workforce

There are two distinct ways in which education and training can be part of circular migration of the health workforce. The first is where education and training are the sole purpose of the circular movement of health workers or students. This is not often the case. The second is where education and training are part of circular migration which has employment as main purpose. This refers to the way in which education, training, qualifications, skills and diplomas, and their recognition in the country of destination, affect the circular migration of health workers who migrate for employment purposes. This report found that both health workers and healthcare institutions involved often experience difficulties with this.

Preliminary guidance on cooperation in circular migration

In view of the lack of knowledge and evidence on circular migration of the health workforce and the limited scope of this report, we cannot provide countries with clear-cut recommendations or best practices on how to deal with circular migration. Based on the overview on circular migration of the health workforce that was provided, the following preliminary guidance on cooperation in circular migration can be presented.

Six guiding principles for cooperation in circular migration of the health workforce:

- Consider circular migration of the health workforce as one option among others
- Circular migration should be based on the principles of the WHO Global Code of Practice and aim for a 'triple win' outcome
- Cooperation structures for circular migration of the health workforce should be chosen primarily based on the health workforce needs of the source country and adapted to the envisioned goal
- Circular migration of health workers is a joint process and should involve all relevant parties
- The importance of language skills and recognition of professional skills needs to be acknowledged and better integrated in circular migration processes
- More data and research on circular migration of the health workforce are urgently needed

1. Introduction

As indicated by the Grant Agreement of the Joint Action on Health Workforce Planning and Forecasting, one of the tasks of Work Package 7 is to take in specific requests for advice and formulation of a recommendation. One request to handle was a request for **advice and guidance on cooperation between source and receiving countries in training capacities and circular mobility, within the framework of the WHO Global Code of Practice on the International Recruitment of Health Personnel**[1].

1.1 What is this report?

This report is not a Deliverable, but a Milestone of the Joint Action. Milestones signal importance and provide analyses and advice on specific topics connected to and relevant for the core deliverables of the Joint Action. This report provides guidance on circular migration, and is naturally linked to the WHO Global Code of Practice on the International Recruitment of Health Personnel[2] and the report on the applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel within a European context[3] that was issued by Work Package 4. Furthermore, the report provides input for Work Package 7 that could extend the findings on circular migration into sustainability recommendations.

1.2 Background of the report

The rapidly increasing demand for healthcare professionals in countries facing shortages is producing a net migration loss of these workers from other countries, in particular from countries which offer less attractive working conditions or lower remuneration. In their turn, many of these countries are also experiencing an imbalance between demand for healthcare and the available health workforce – with the exception of countries which are experiencing a severe reduction in population size, such as Bulgaria. This situation creates severe challenges and weakens the sustainability of health systems in these countries. Circular migration is being advocated as a potential and partial solution to a number of the challenges surrounding these migration flows (Hugo, 2014). Yet little is known about circular migration of the health workforce and no overview currently exists (Castles & Ozul, 2014; Hawthorne, 2014). Before we go deeper into circular migration, it is important to have an understanding of the magnitude of health workforce migration that the world is dealing with today and the trends that can be observed.

1.2.1 An overview of health workforce migration

The *International Migration Outlook 2015*, published by the OECD, shows the scale of health workforce migration flows - not necessarily circular migration - and recent trends, the dependence

[1] Grant Agreement, Agreement number 2012 22 01, Annex 1b. Page 78.
[2] Available at: http://www.who.int/entity/hrh/migration/code/WHO_global_code_of_practice_EN.pdf?ua=1
[3] Available at: http://healthworkforce.eu/wp-content/uploads/2015/09/150618_wp4_d041_terminology_gap_analysis_final.pdf

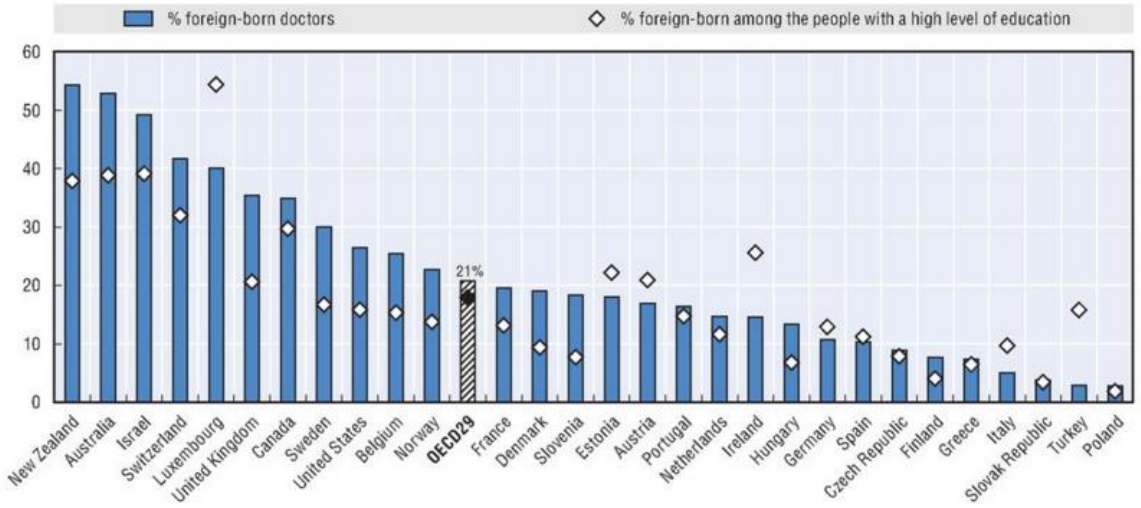
of host countries' health system on foreign practitioners and how this impacts host countries and countries of origin. A summary of the main findings is provided below.

Trend: growing share of foreign-born doctors and nurses in OECD countries

Foreign-born doctors and nurses account for a significant share of the healthcare professionals working in the OECD area. Doctors' share grew in most countries between 2000/01 and 2010/11 from an average (across 22 countries) of 19.5% to more than 22%, while that of nurses rose from 11% to 14.5% (OECD, 2015). See Tables 1 and 2 on this page.

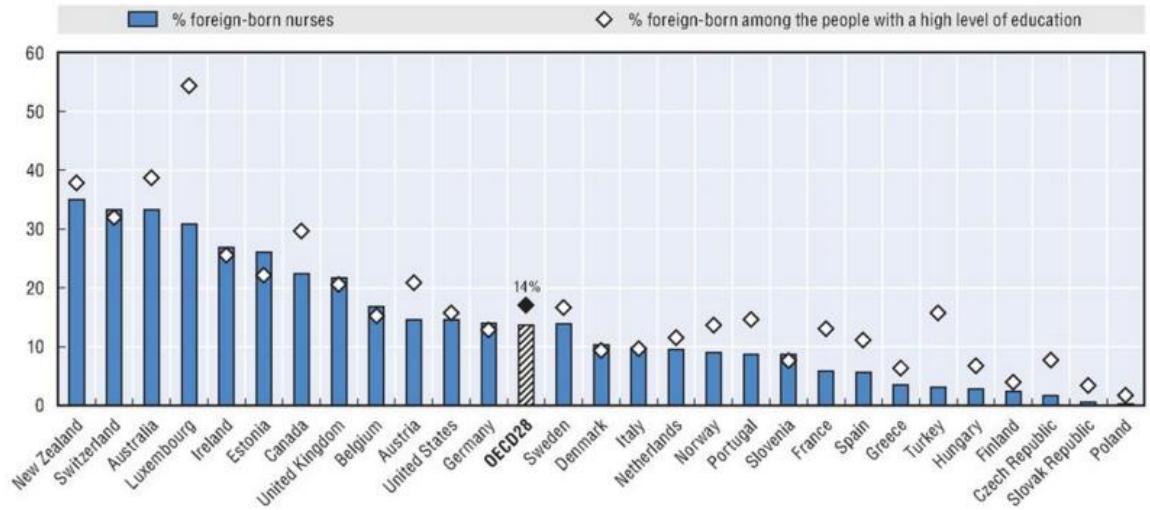
It should be noted that in most OECD countries, the proportion of health workers trained abroad is lower than that of health workers born abroad, which points to the fact that host countries provide part of migrants' training and education. In most OECD countries that supplied data, the proportion of nurses trained abroad tends to be much lower than that of doctors.

Table 1. Percentage of foreign-born doctors in 29 OECD countries, 2010/11



Source: OECD (2015)

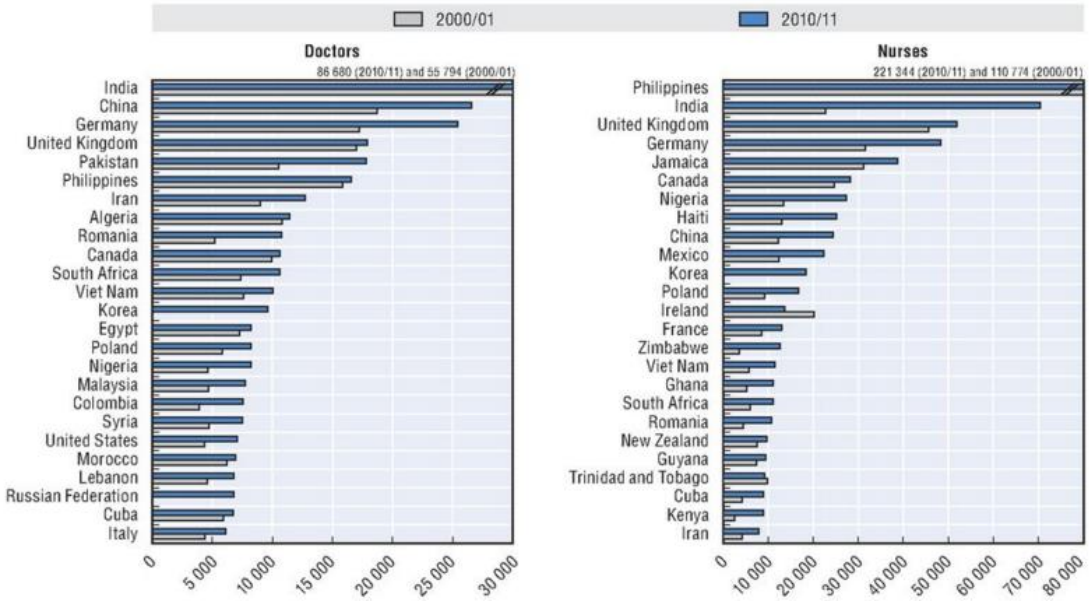
Table 2. Percentage of foreign-born nurses in 28 OECD countries, 2010/11



Trend: growing negative impact of emigration on health systems in countries of origin
In 2010/11, doctors and nurses who had immigrated to the OECD area from countries affected by severe shortages of healthcare professionals (as defined by WHO) accounted for 20% of estimated healthcare workforce needs in their countries of origin, compared to 9% in 2000/01.

The OECD International Migration Outlook (2015) also mentions doctors' and nurses' expatriation rates by the level of income of the country of origin. Generally speaking, the lower the income the higher the expatriation rate; see also Figure 1 below.

Figure 1. Number of foreign-born doctors and nurses in OECD countries by 25 main countries of origin, 2000/01 and 2010/11



Composition by country of origin of foreign-born doctors and nurses in EU countries
If we look specifically at the EU Member States, we see that foreign born doctors and nurses account for a significant share of healthcare professionals in the EU countries (16% among doctors and 11% among nurses). In the majority of EU countries, health workers from outside the EU/EFTA predominate, although this varies across Member States (see figures 2 and 3 on the next page).

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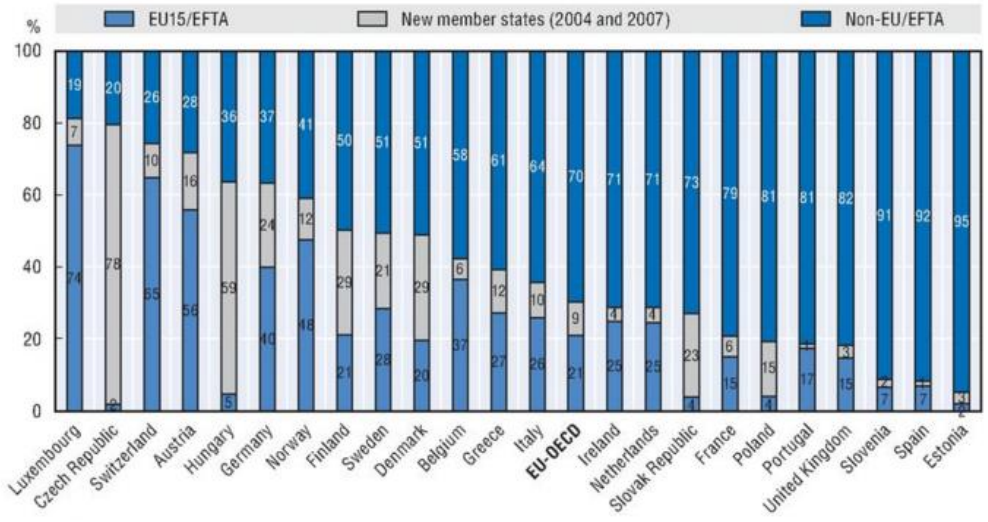
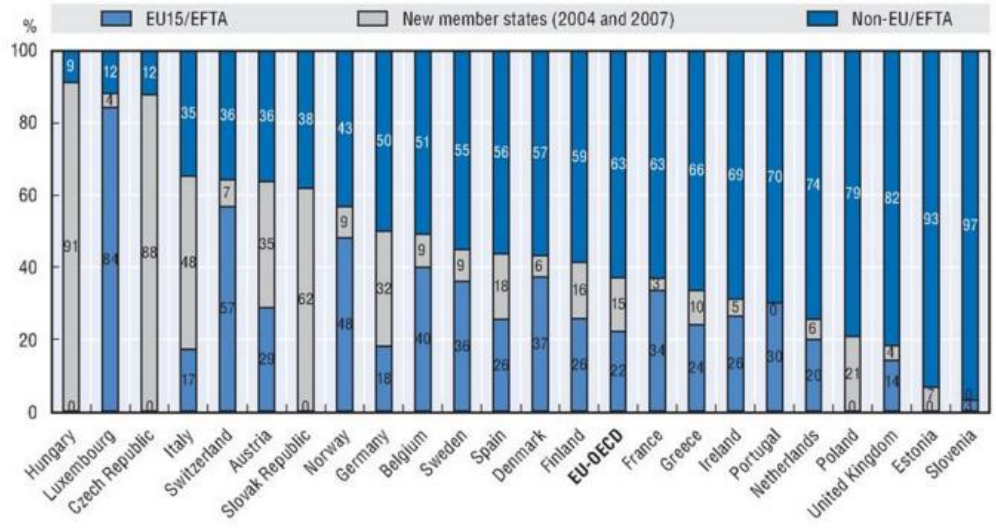
Figure 2. Share of doctors born in EU/EFTA country among foreign-born doctors practising in selected OECD countries, 2010/11



Notes: Only percentages higher than 2% are indicated.
Source: DIOC 2010/11, LFS 2009/12.

StatLink http://dx.doi.org/10.1787/888933261524

Figure 3. Share of nurses born in EU/EFTA country among foreign-born nurses practising in selected OECD countries, 2010/11



Notes: Only percentages higher than 2% are indicated.
Source: DIOC 2010/11, LFS 2009/12.

StatLink http://dx.doi.org/10.1787/888933261531

Based on some of the charts and tables presented by the OECD, the European Commission[4] estimated the following figures as regards the share of doctors/nurses among practitioners across EU Member States for which data was made available (21 out of 28 Member States):

- Among doctors: the share of foreign-born among practicing doctors was in 2010-11 around 16% in the EU[5], with great variation; from less than 5% in Italy, Slovak Republic and Poland to 25% to more in Belgium, Sweden, the UK, Luxembourg and Ireland. The majority of foreign-born doctors originate from third-countries (around 70%) while the others come from other EU Member States (30%), though these shares vary strongly across Member States.
- Among nurses: the share of foreign-born nurses among practicing nurses was in 2010-11 around 11% in the EU[6], with great variation; from less than 5% in Greece, Hungary, Finland, Czech Republic, Slovak Republic and Poland to 20% or more in the UK, Estonia, Ireland and Luxembourg. As for doctors, the majority of foreign-born nurses originate from third-countries (around 63%) while the others (37%) come from other EU Member States, again with great variation across Member States.

1.2.2 Circular migration as potential solution to the challenges produced by health workforce migration

The net migration loss of health workers from low to high income countries[7] usually results in a brain drain for their country of origin and in a brain gain for their destination country, which benefits from their skills and experience. Even though it should be noted that the extent of brain drain is dependent on where health workers are trained and whether the country of origin has a deficit, as is most frequently the case, or a surplus, as in the exceptional case of the Philippines for instance. Yet the pattern of brain drain and gain is most common and increases existing inequalities while further weakening already weak health systems[8]. During the *Global Mobility and Triple Win Migration Session*[9] of the Joint Action on Health Workforce Planning and Forecasting, a presentation on Africa stated that the loss of a sizeable number of highly skilled health professionals from African countries severely impacted the functioning of the already weak health systems. Furthermore, in countries such as Zimbabwe and Cameroon, the extent of migration of health professionals has made it necessary for non-qualified personnel to perform duties that are normally beyond their scope of practice.[10]

An alternative to the brain drain - brain gain dichotomy is presented by circular migration – a form of migration that is managed in a way that it allows migrants some degree of legal mobility back and

[4] *European Dialogue on Skills and Migration. Workshop on Health and Care. Background Note*. Brussels, January 28, 2016.
[5] Commission calculations, based on the 21 EU Member States for which data is available in OECD *IMO 2015*.
[6] Commission calculations, based on the 21 EU Member States for which data is available in OECD *IMO 2015*.
[7] Following the World Bank, for 2016, low-income economies are defined as those with a GNI per capita, calculated using the World Bank Atlas method, of $1,045 or less in 2014; middle-income economies are those with a GNI per capita of more than $1,045 but less than $12,736; high-income economies are those with a GNI per capita of $12,736 or more. See also: http://data.worldbank.org/about/country-and-lending-groups
[8] See Health Workers for All (HW4All): http://www.healthworkers4all.eu/fileadmin/docs/hw4all%20-%20European%20press%20release%20for%20launch.pdf
[9] Moderated by Linda Mans, Wemos Foundation
[10] Presentation "*Austerity and mobility of health workers in Eastern & Southern Africa*" by Yoswa M Dambisya, University of Limpopo, EQUINET HRH Programme of Work, available at: http://www.euhwforce.eu/web_documents/JAHWF-CONFERENCE-1-BRATISLAVA/DOCUMENTS/140129_BOSESSION3_EQUINET.pdf

forth between two countries. Circular migration is generally expected to open up the potential of brain sharing or brain circulation (Hugo, 2014).

In order for circular migration to have a positive effect on source and destination countries as well as the individual health workers, the systems of circularity must be properly managed and well-governed. Most importantly, **destination and origin countries must cooperate to build coherent systems that work for the benefit of all three parties** (Hugo, 2013). The Joint Action on Health Workforce Planning and Forecasting received **a request for advice and guidance on how to shape this cooperation between source and receiving countries in circular migration.**

1.3 Aim and scope of the report

In view of the limited information available on circular migration of the health workforce (Castles & Ozul, 2014; Hawthorne, 2014), this report aims to present a first basic overview of cooperation forms in place: formal and informal, between source and destination countries. The report covers circulation migration from non-EU countries as well as intra-EU circular migration. Additionally, it aims to provide more insight into the complicated relationship between education and training on the one hand and circular migration of health workers on the other hand. It approaches education and training both as the sole purpose of circular migration and as part of circular migration which has employment as main purpose. The report aims to cover all five health professions covered by the Joint Action, but acknowledges that most data which are available relate to nurses and doctors. Hence, the preliminary conclusions that can be drawn may have less relevance for pharmacists, midwives and dentists.

The ultimate goal of this report is to provide a much needed overview on circular migration of the health workforce and to provide European Member States with preliminary guidance on how source and destination countries may cooperate in order to find a mutually beneficial solution in terms of circular mobility of the health workforce, within the framework of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

The scope of the report is limited to an explorative review of the literature available and an analysis of evidence produced in the framework of the JAHWF and its partners on circular migration of the health workforce. It does not aim to provide a detailed analysis nor does it claim to be exhaustive. As circular migration of the health workforce is a global issue, the report takes a global perspective while aiming to tailor its guidance and advice to EU Member States. At the same time, it should be noted that because of the small evidence base, relevance may at times be limited to EU cooperation with third countries and at other times to intra-EU migration.

1.4 Methodology

This circular migration report is based on two main activities:

- An analysis of **recent literature reviews on circular migration of the health workforce** that were produced by interns at DG SANTE – Healthcare Systems (Praxmarer, 2014) and the Wemos Foundation, a collaborating partner of the Joint Action on Health Workforce Planning and Forecasting (Bulthuis, 2015). The snowballing technique (i.e. scanning of the reference lists

of these reports) was used to identify further relevant material, and key reports such as the Feasibility Study by Matrix Insight (2012) and PROMeTHEUS study (Health PROfessional Mobility in The European Union Study[11]) were included as well. Given the limited scope of the report, we have not attempted to be exhaustive and provide only basic reference to the literature on circular migration of the HWF.

- An analysis of **evidence produced in the framework of the JAHWF on circular migration of the health workforce**, including an analysis of material produced by JAHWF associated and collaborating partners. Most importantly these include:
    - Summary of the Break-out session on Global Mobility & Triple Win Migration, organized by Wemos during the Joint Action Conference in Bratislava, 28-29 January 2014[12].
    - WP4 Report on the Applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel within a European context[13].

1.5 Structure of the report

The report starts by exploring the definition of circular migration and its main components, including the 'triple win' situation. Subsequently, the WHO Global Code of Practice on the International Recruitment of Health Personnel is discussed in relation to circular migration of the health workforce, followed by an overview of the available evidence on circular migration of the health workforce. The report then provides an overview of formal and informal cooperation practices which take place across Europe, followed by a short discussion on the distinct yet related ways in which education and training can be part of circular migration of the health workforce. The report ends with a conclusion and some preliminary guidance on cooperation in circular migration of the health workforce.

[11] See: http://www.euro.who.int/en/about-us/partners/observatory/activities/research-studies-and-projects/prometheus

[12] Moderated by Linda Mans, Wemos Foundation. See: http://www.healthworkers4all.eu/eu/project/2014bratislava/

[13] Available at: http://healthworkforce.eu/wp-content/uploads/2015/10/150609_wp4_who_applicabilty_report.pdf

2. Definition of circular migration

There is no common definition of circular migration and many variants exist (Wickramasekara, 2011; Castles & Ozkul, 2014). In this report, we use the definition of the European Commission[14]:

> *"Circular migration is a form of migration that is managed in a way that it allows migrants some degree of legal mobility back and forth between two countries"*
> (European Commission MEMO 07/197)

Even though there is not one common definition on circular migration, it is important to emphasize that all existing definitions include at least the following dimensions (Newland, 2009):

1. Spatial: at least two poles are involved; the country of origin and the country of destination
2. Temporal: the migration is non-permanent
3. Iterative: the migration process includes more than one cycle
4. Developmental: this refers to the idea that the country of origin, country of destination and the migrant worker will benefit from circular migration, the so-called 'triple win situation' (see also section 2.1 below).

Especially the last two dimensions clearly distinguish circular migration from temporary migration (i.e. guest worker models); circular migration denotes a migrant's continuous engagement in both country of origin and destination country and involves return and repetition.

Further subdivisions of circular migration are sometimes made. We won't go into detail about this, but provide two common distinctions. Firstly, circular migration can be further subdivided in:

- Managed circular migration: referring to migration programs organised by the country of origin and/or by the destination country, most often implemented in the form of a bilateral agreement (Wickramasekara, 2011; Praxmarer, 2014).
- Spontaneous or voluntary circular migration: migration that occurs without a program and is mainly caused by fluctuation in supply and demand (Praxmarer, 2014).

In the EU context, the European Commission has provided another relevant distinction in circulation migration:

- Circular migration of third-country nationals settled in the EU: this category of circular migration gives people the opportunity to engage in an activity (business, professional, voluntary or other) in their country of origin while retaining their main residence in one of the EU Member States.
- Circular migration of persons residing in a third country: circular migration could create an opportunity for persons residing in a third country to come to the EU temporarily for work, study, training or a combination of these, on the condition that, at the end of the period for which they were granted entry, they must re-establish their main residence and their main activity in their country of origin.

[14] Available at: http://europa.eu/rapid/press-release_MEMO-07-197_en.htm

An important weakness of these definitions though, is that the iterative aspect of circular migration is lost. This is important because this is one of the dimensions which clearly distinguishes circular migration from temporary migration.
In the remainder of this report, we will use the term 'circular migration' and only apply further subdivisions where relevant and where these can be distinguished. Moreover, we use the definition of the EC, but acknowledge that other forms of circular migration are also present in the report.

2.1 The 'triple win' situation in circular migration

Circular migration is considered one of the most promising solutions to address brain drain and the inequitable distribution of health workers among countries (Castles & Ozul, 2014). The WHO Code, for example, encourages Member States to "facilitate circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries" (WHO Code, Article 3.8). In the context of the JAHWF, the positive aspects of circular migration were emphasised by describing it "as when a health worker moves to another country to obtain training or gain experience and then returns to his/her home country with improved knowledge and skills".[15] In recent years, circular migration has been promoted as a so-called 'triple win' solution, bringing benefits to destination countries, source countries and migrant workers. Yet this idea has also been contested (Wickramasekara, 2011). Table 4 provides a summary of the most commonly cited advantages and disadvantages in the debate on circular migration of health professionals.

Table 4. Commonly cited advantages and disadvantages in the debate on circular migration of health professionals

	Destination country	Source country	Migrant worker
Advantages	• Health worker shortages handled in a flexible and timely way • Savings in training of health professionals • Part of a development friendly national migration policy • Limited integration costs • Can meet health worker shortages in rural and remote areas • Enhanced links with origin country	• Benefit from inflow of remittances • Brain drain human capital loss not as great • Health workers return with greater skills and enhanced networks and ideas • Contribution to health of the nation • Enhanced links with destination country	• Enhances income, skills and experience • Able to contribute to health of homeland population • Children can gain experience of growing up in both countries • Easier return to a workplace and family in the home country • Retain traditional and family associations
Disadvantages	• Workers not available on a permanent basis • Complications of organisation health system at destination • Governance challenges	• Loss of skills for part of the time • Difficulty of organising health system with personnel only in the country for a limited time • Governance challenges	• Disruption and costs of moving • Social cost of separation from family for part of the time • Difficulties of adjusting to two work contexts

[15] See: http://healthworkforce.eu/wp-content/uploads/2015/10/150609_wp4_who_applicabilty_report.pdf

	• Difficulties for immigration policy		• Restricted rights and entitlements (e.g. pension benefits, health insurance)

Source: composed of Hugo, 2014; Bulthuis, 2015; Praxmarer, 2014

Doubts and concerns about the concept of triple win are generally focused on the perceived benefits for migrant workers and, to a lesser extent, the source country (Wickramasekara, 2011). These concerns were echoed in the Joint Action on Health Workforce Planning and Forecasting. During the *Global Mobility & Triple Win Migration Session*[16] of the first JAHWF Conference, Heino Güllemann from *Terre des hommes Germany*[17] argued that the concept of 'triple win' needs improvement for migrant health workers to actually 'win' from migration. In the same session, Grit Braeseke from the European Institute for Healthcare Research and Social Economy emphasised that Triple Win Migration is just one instrument among many to create a sustainable health workforce. In a similar vein, the *WP4 Report on applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel within a European context*[18] notes as one of its main conclusions that "solutions to benefit all actors affected by international recruitment - source country, receiving country and the migrant professional - have to be elaborated, with a special focus on also benefiting the source country". Most importantly, participants of the second WP4 Workshop on the applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel[19] gave 'top importance' to the statement below:

> *Circular migration has to be fostered within the EU in a way that benefits source countries, destination countries, and individual health professionals themselves. Bilateral cooperation tailored to different types/profiles of health professionals could be developed.*
> (Statement identified as 'top important' during JAHWF WP4 Workshop, June 2014)

[16] Moderated by Linda Mans, Wemos Foundation. See: http://www.healthworkers4all.eu/eu/project/2014bratislava/
[17] See: http://www.terredeshommes.org/staff/tdh-germany/
[18] Available at: http://healthworkforce.eu/wp-content/uploads/2015/10/150609_wp4_who_applicabilty_report.pdf
[19] See: http://healthworkforce.eu/events/16-to-18062014-lisboa/#monday

3. WHO Global Code of Practice on the International Recruitment of Health Personnel in relation to circular migration

Circular migration is mentioned in the WHO Global Code of Practice on the International Recruitment of Health Personnel, itself an instrument aimed at establishing and promoting voluntary principles and practices for the ethical international recruitment of health personnel and at facilitating the strengthening of health systems. The Code was designed by Member States to serve as a continuous and dynamic framework for global dialogue and cooperation. This section shortly describes the WHO Code of Practice in relation to circular migration.

First of all, the WHO Global Code contains two direct references to circular migration in articles 3.8 and 8.7:

> *Member States should facilitate circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries.*
> (WHO Global Code of Practice, art. 3.8)
>
> *Member States are encouraged to observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel, and assess the scope and impact of circular migration.*
> (WHO Global Code of Practice, art. 8.7)

In both articles, the joint benefits for source and destination countries that should be aimed for are highlighted. Yet naturally, many of the articles in the WHO Global Code are of relevance for circular migration, even if they do not directly refer to it. The Joint Action on Health Workforce Planning and Forecasting has repeatedly drawn attention to the importance of the WHO Code and the close relationship between migration, health workforce planning and the relevance of the WHO code[20]. For example, during the *Global Mobility & Triple Win Migration Session*[21] of the first JAHWF Conference, one of the presentations on a cooperative framework for circular migration mentioned article 5.1 of the WHO Code – "health systems of both source and destination countries should derive benefits from the international migration of health personnel" - as the basis for the approach that the project had taken[22].

Hence, while the WHO Code may not say a lot directly about circular migration, its various articles are of relevance to the topic and can be taken as a starting point for developing circular migration initiatives, as was also brought to light by the JAHWF. Especially the equivalent benefits for both source and destination countries are crucial in this aspect.

[20] A complete overview of JAHWF communications on the WHO Code can be found in the WP4 Report on applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel within a European context.

[21] Moderated by Linda Mans, Wemos Foundation. See: http://www.healthworkers4all.eu/eu/project/2014bratislava/

[22] See: http://www.healthworkers4all.eu/fileadmin/docs/eu/events/2014Bratislava/Triple_win_-_PPT_Grit_Braeseke.pdf

3.1 EPSU-HOSPEEM Code of Conduct on Ethical Recruitment

The European Hospital and Healthcare Employers' Association (HOSPEEM) and European Federation of Public Service Unions (EPSU), cooperating in the Hospital Social Dialogue Committee, adopted their own EPSU-HOSPEEM Code of Conduct Ethical Cross-border Recruitment and Retention on 7 April 2008[23]. It focuses only on intra-EU mobility, but has many similarities to the WHO Code of Practice.

The EPSU-HOSPEEM Code contains beneficial solutions for both source and receiving countries. While no direct reference is made to circular migration, EPSU and HOSPEEM declared that they "want to encourage, and as far as possible contribute to, the development and implementation of policies at local, national and European level with the purpose to enhance workforce retention and promote accessible and high-quality health care in developed and developing countries. (..) The European social partners in the hospital sector acknowledge the possible mutual benefits of migration for workers and employers in sending and receiving countries, deriving from the exchange of practices, knowledge and experience".

Hence, as applies to the WHO Code, while no direct reference is made to circular migration, the various articles of the EPSU-HOSPEEM code are certainly of relevance to the topic and should be taken into account when developing circular migration initiatives, especially in the hospital sector.

[23] Available at: www.epsu.org/IMG/pdf/EPSU-HOSPEEM_Code_of_conduct_07-04-08_with_signatures-2.pdf

4. Overview of circular migration of the health workforce

There is an absence of empirical data and research on circular migration of health workers. While much is claimed, little is known about circular migration in any field, including health (Castles & Ozul, 2014). There is a lack of data, research and knowledge regarding its prevalence as well as its health workforce impacts in sending and receiving countries (Hawthorne, 2014). Hence, we cannot provide any data on circular migration of the health workforce.

Additionally, there generally is a poor understanding of the reasons why some migrants spontaneously return and become circular migrants, and others do not. While there are indications that, for example, Romanian nurses leave their country with the intention to work abroad for a few years and then return, many of them ultimately remain in the destination country, often because they get married there. To address this lack of knowledge, the TEMPER[24] project started in 2014 to provide a comprehensive assessment of the pros and cons of recent initiatives to promote circular migration while one of its main aims is to identify the main drivers of return and circulation decisions of migrants.

The health workforce migration data that were presented in section 1.2.1 of this report, show that there is a growing share of foreign-born doctors and nurses in OECD countries and that this emigration has an increasingly negative impact on health systems in countries of origin. Quantitative and qualitative research on the prevalence and impact of circular migration would be helpful in identifying approaches to generate more positive effects for healthcare systems. With regards to these trends, the following research topics are proposed to be addressed in future data collection procedures and/or research:

- What percentage of health worker migration can be labelled as 'circular migration' according to the definition of the European Commission? Also, a split-up according to type of health professional would be desirable. Naturally, this can only be done retrospectively.
- What are the advantages and disadvantages of circular migration for:
    - Destination countries. Possible indicators to be collected are:
        - Integration costs of the health worker
        - Training costs of the health worker (including language training)
        - Average stay of health worker
    - Source countries. Possible indicators to be collected are:
        - Average inflow of remittances
        - Governance challenges
        - Knowledge transfer and impact on healthcare services offered
    - Migrant health workers. Possible indicators to be collected are:
        - Changes in income, net win/loss of circular migration on yearly basis
        - Social and cultural impact of circular migration
        - Professional development, e.g. promotions, specialisation
        - Reasons for (circular) migration

[24] TEMPER: Temporary versus Permanent Migration. Funded by the European Union's Seventh Framework Programme for research, technological development and demonstration. See: http://www.temperproject.eu/

5. Cooperation on circular migration of the health workforce in the EU

Even though little is known about the impact and effects of cooperation forms in circular migration of the health workforce on source countries, destination countries and health workers (Money & Kuo Lin, 2014), because of a lack of data and also because many are still in their infancy, it is possible to draft an overview of the formal and informal cooperation practices which take place across Europe.

5.1 Formal mechanisms and structures for circular migration in the EU

The focus of this section will be on formal cooperation structures for circular migration which are currently available in the EU for migrants from EU and non-EU countries. The focus will be on those migration policies that are relevant in light of circular migration. Hence, no attention will be given to horizontal general migration legislation and policies. An extensive overview of the diversity in formal agreements and mechanisms that are generally used in cooperation on labour migration can be found in Attachment I.

- **EU Blue Cards**[25] are issued by EU Member States to third-country nationals. The Blue Card is designed particularly to attract highly qualified third-country nationals to jobs in occupations where there is a shortage of qualified personnel or where a shortage is likely to arise in future. The holder of an EU Blue Card is entitled to take up residence in the EU for the purpose of taking up paid employment. The Blue Card addresses ethical recruitment in *"sectors suffering from a lack of personnel, by protecting human resources in the developing countries which are signatories to this agreement"* (Directive 2009/50/EC Art 3/3). The Directive allows Member States to reject applications in order to ensure ethical recruitment from countries suffering from a lack of qualified workers, for example in the health sector (Praxmarer, 2014). Yet it should be noted that the Progress Report prepared by the Commission in May 2014[26] provides a rather disappointing picture about the application of the Directive: only some 15,000 Blue Cards have been issued during 2012 and 2013, out of which 14,000 were by Germany alone. For 2014, 13,724 Blue Card where issued (12,108 in Germany). These relative low numbers are partly due to rather restrictive admission conditions (e.g. high salary threshold), low level of harmonisation and the continued existence of diverse parallel national schemes for attracting highly skilled TCNs (around 25.000 permits issued in 2014). Furthermore, of the countries that reported on their application of the Directive, only 8% provided a breakdown by profession. However, evidence for Germany points to around 20% of Blue Card holders working in 'human medicine' sector[27].
- **Bilateral agreements** are agreements between two states which describe in detail the specific responsibilities of, and actions to be taken by each of the parties, with a view to

[25] Directive 2009/50/EC: http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=URISERV:l14573&from=EN

[26] Available at: http://ec.europa.eu/dgs/home-affairs/e-library/documents/policies/immigration/work/docs/communication_on_the_blue_card_directive_en.pdf

[27] See Wanderungsmonitor 2014. Erwerbsmigration nach Deutschland. Available at: http://www.bamf.de/SharedDocs/Anlagen/DE/Publikationen/Broschueren/wanderungsmonitoring-2014.pdf;jsessionid=A391556D027C472ABFF25AD2A5529EB1.1_cid359?__blob=publicationFile

accomplishing their goals. They create legally binding rights and obligations. Some EU Member States have already cooperated for many years on a bilateral or regional level to ensure the sustainability of migration and support circular migration. It is possible to identify four broad types of bilateral agreements (Matrix Insight, 2012):

- Agreements that aim to limit or exclude recruitment from countries with health workforce shortages.
- Agreements that aim to facilitate health professional mobility by establishing systems for mutual recognition of diplomas.
- Agreements that aim to foster international recruitment of health professionals (most often nurses).
- Agreements between professional bodies (often concerning training of health professionals).

- **Multilateral agreements** are a common instrument to manage migration between more than two countries. These include an EU framework called **mobility partnerships.** Mobility partnerships use 'soft law'-based[28] country agreements to share the responsibility and management of circular migration. After a memorandum of understanding is signed – an agreement between EU Member States and interested third-party states – non-EU citizens may be granted better access to work opportunities in participating EU Member States[29].
- A **Memorandum of Understanding** is a less formal international instrument and usually non-binding. It typically entails general principles of cooperation describing broad concepts of mutual understanding, goals and plans shared by the parties.

5.1.1 Overview of formal mechanisms and structures on circular migration of the HWF currently in place among EU Member States

As noted before, there is an absence of research on circular migration of health workers (Castles & Ozul, 2014). To draft an overview of the formal mechanisms and structures on circular migration of the health workforce which are in place among EU Member States, we drew heavily on the work that was conducted by the European Migration Network (2014) and Praxmarer (2014), who did a great job in collecting and synthesizing the available information. A summary based on their work is provided below, while Appendix II provides a complete overview of current agreements related to circular mobility of the health workforce across the 28 EU Member States. Please note that this work was completed in the beginning of 2014, so some of the information provided may be outdated.

What becomes clear from the overview of formal circular migration agreements, based on the analyses by the European Migration Network (2014) and Praxmarer (2014), is that immigration policies are still the traditional mechanism for managing international migration flows and these policies differ among European Member States according to national policies and priorities. Mobility partnerships, specifically focused on circular migration, are rarely used up to now.
Bilateral agreements appear to be the most commonly adopted tool to address health workforce migration. Yet at the same time, the PROMeTHEUS study (Health PROfessional Mobility in THe

[28] Meaning they lack a legally binding or enforceable nature upon participating Member States.
[29] See: http://www.governancereport.org/home/governance-innovations/featured-innovations-2014/mobility-partnerships-european-union/

European Union Study[30]) concluded that the largest labour movement between countries takes place outside the channel of bilateral agreements (for example through recruitment agencies, family links and social networks). Moreover, agreements on health workforce migration often focus on facilitating mobility for recruitment rather than managing migration of health migrants from sending to receiving countries. Also, countries often report on 'agreements' they have in place, without specifying the nature of these agreements. This makes it difficult to determine what the legally binding aspects of these agreements are and hence what their potential impact on source and destination countries could be. The picture which emerges from this overview is consistent with the discussions in the Joint Action, which concluded that there is not much experience at Member State level with cooperation agreements on circular migration if the HWF within the EU, and that EU-level action could be taken to address this[31].

Specific tools on circular migration of the health workforce

A small number of EU Member States have adopted specific tools to promote temporary and circular migration and to improve positive impacts and minimise negative impacts on third countries (European Migration Network, 2014). These range from provision of training and internship opportunities for healthcare professionals (BE, FR); implementation of specific projects (DE, IT, HU, NL, SE), schemes for volunteering for health professionals in developing countries (UK) and specific agreements which include provisions to support circular migration (PT). A more detailed summary of these tools is provided below (integral taken from the Summary of the EMN Ad –Hoc Query No. 524, see European Migration Network, 2014).

Training and internship opportunities for healthcare professionals

- In Belgium, the Federal Public Service for Health facilitates the granting of authorisation to exercise a profession so that internships of foreign doctors are not limited to observation internships, and under specific circumstances, dispensation may be granted to allow foreign doctors to acquire further clinical training.
- In France, the measure "diploma of specialised medical training and diploma of specialised medical in-depth training" allows third country national doctors and pharmacists to access classes and practical training internships in France in order to specialise and complete a practical internship in a public healthcare facility within the framework of an international cooperation initiative with countries of origin. In addition, cooperation agreements with Saudi Arabia, the United Arab Emirates, Bahrain, the Sultanate of Oman, Kuwait and Qatar allow doctors, specialising or already specialised in their countries, to register to a study in the field of their choice in France, and in some cases, can be hired as practitioners during their last year of training.
- The Netherlands has signed a Memorandum of Understanding with the Republic of Suriname in 2012 on registration of physicians in the Netherlands, which allows Surinam physicians to practice in the Netherlands only during the time of a training course.

[30] See: http://www.euro.who.int/en/about-us/partners/observatory/activities/research-studies-and-projects/prometheus

[31] See: WP4 Report on applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel within a European context.

Implementation of projects

- In Germany, the implementation of cooperation agreements between the Federal Employment Agency and the public employment services in Serbia, Bosnia-Herzegovina, the Philippines and Tunisia takes place within the framework of the 'Triple Win Project'.
- In Hungary, the SIMIGRA project was implemented which supports the integration of foreign professionals in line with the provisions of the WHO Global Code.
- In the Netherlands, a project was undertaken aimed at strengthening the healthcare sector in Morocco through the temporary assignment of Moroccan migrants living in the Netherlands.
- In Sweden, the Swedish International Development Cooperation Agency launched a joint project with IOM and UNDP to support experts of the Somali diaspora to return temporarily (1 year) and contribute to development in Somalia in three sectors, including healthcare.

Schemes for volunteering of health professionals in developing countries

- The United Kingdom supports the goal of increasing overseas volunteering by health professionals to contribute effectively to global health development and to bolster the skills of the UK health workforce once the volunteer returns. The UK supports:
    - The Medical Training Initiative (a two-year training scheme delivered through Tier 5 of the Points-Based System)
    - The Department for International Development-led Health Partnership Scheme.

Specific agreements which make provisions for circular migration

- Portugal has concluded several bilateral and multilateral agreements with the aim of fulfilling the labour demand for doctors in the National Health Service which define guidelines to facilitate circular and temporary migration.

A final important conclusion that can be drawn based on the overview of formal circular migration agreements for the health workforce in place, whatever form they may have, is that there is a lack of knowledge about the extent to which they are used by migrants, what their effects are on (circular) migration – for countries of origin and destination and the migration worker – and the advantages and disadvantages of each of these agreements.

5.2 Informal cooperation on circular migration of the health workforce in the EU

Where circular migration of the health workforce is concerned, many initiatives and collaborations take place outside the realm of formal legislative and policy mechanisms and structures. These mainly take the form of temporary projects, often funded by national governments or international bodies related to the health workforce or migration, and often involve NGOs to help execute them. Unfortunately, there is no overview or repository available on all projects and collaborations on circular migration taking place, which limits the possibilities of inter-project and inter-country learning. Given the limited scope of the report, we can only present a snapshot of relevant projects and collaborations below. The three projects and collaborations were mostly selected as they were presented during the JAHWF activities related to circular migration of the HWF and give an insight in the various forms that these informal collaborations can take, all providing their own specific bit to the knowledge base around circular migration of the health workforce.

5.2.1. Snapshot of informal cooperation on circular migration of the HWF currently taking place across EU Member States

Health Workers for All

The project '*Health workers for all and all for health workers*' (HW4All, 2013-2016) is a European civil society initiative that contributes to a sustainable health workforce worldwide.[32] The project is funded by the European Union and coordinated by Wemos, a collaborating partner of the JAHWF. Through advocacy and campaigning in Europe, HW4All (involving organisations from eight EU-countries) contributes to a sustainable health workforce worldwide. The project focuses on the WHO Code implementation and is strongly aware that Europe needs to be part of a solution to the global health workforce problems rather than a source of the problem itself. It develops and shares tools for policy analysis and (inter)action to increase knowledge and understanding of human resources for health from a global health perspective. It has for example produced a report on 'The Health Worker Crisis: an analysis of the issues and main international responses' which gives an overview of the impact of the brain drain on health care provisions in source countries and current international strategies to mitigate these effects[33].

MIDA Ghana Health project

The Migration for development in Africa (MIDA) initiative links the skills and expertise in the diaspora to the development of home countries. The MIDA Ghana Health project aims to build a bridge between available resources of the Ghanaian diaspora and needs, opportunities and policies in the health sector in Ghana. The main purpose of the project is to facilitate the temporary return to Ghana of Ghanaian health professionals from the diaspora residing in the Netherlands, United Kingdom, Germany and other EU countries for the benefit of local health institutions. The MIDA Ghana Health project is funded by the Dutch government through the Embassy of the Kingdom of the Netherlands in Accra[34].

The MIDA Ghana Health project is demand driven and based on identified needs in Ghana. The results have been positive. Hospitals in Ghana reported on diaspora experts carrying out complex operations and training local staff. The commitment and transfer of knowledge has had a great impact on the hospitals and quality of patient care improved. The circular migrants are positive as well. They often use (all of their) vacation time in destination countries to offer workshops, training and perform medical procedures in Ghana. It makes them happy to be able to do this and see the improvements in Ghana. From 2005-2008, there were 67 assignments as part of the MIDA Ghana Health project, between 2008 and 2012 there were 215 assignments and 15 internships completed (IOM, 2012).

The Triple Win Migration© - approach

In 2008, the German institute IEGUS (Institut für Europäische Gesundheits- und Sozialwirtschaft GmbH) started focusing on the skills shortage and migration approaches for nursing personnel. Its initial approach was on circular migration, but this was ultimately developed into a 'Training and Development partnership' - thereby creating synergies between migration and development, called

[32] See: http://www.healthworkers4all.eu
[33] Health Poverty Action: www.healthworkers4all.eu/fileadmin/docs/gb/Report_HW4ALL_Website_version.pdf
[34] See: https://diaspora.iom.int/mida-ghana-health-project

Triple Win-Migration©[35]. The focus of the Triple Win-Migration© partnership is on non-EU Member States and the German long-term care sector. The WHO Code of Global Practice is one of the guiding principles for Triple Win Migration© and it is based on the vision that: (1) source countries will win knowledge (skilled workforce); (2) Germany will win labour and gains from cultural diversity; and (3) migrants will win job opportunities (in both destination and source countries) and skills.
Within this cooperative framework, foreign nurses (among others from India and Vietnam) are recruited and trained in their country of origin according to their language skills. The project Triple Win-Migration© management provides them with support in connection to their transfer to Germany (e.g. recognition of qualifications, residence and work permit). It also provides them with an intercultural training. The foreign nurses have the opportunity to work in German healthcare facilities and are (further) educated in geriatric and elderly care. They are actively supported to utilise this gained work experience for the benefit of their home country.

Better managing the mobility of health professionals in the Republic of Moldova
From 2011-2015, the project '*Better managing the mobility of health professionals in the Republic of Moldova*'[36] has worked to promote legal and circular migration, diminish the negative effects of brain drain and brain waste on the Republic of Moldova, and facilitate the reintegration of health professionals returning to the national health system. The project succeeded in identifying a number of issues concerning the migration and mobility of health workers and in developing mechanisms for the motivation and retention of health personnel at national level. Key achievements of the project include:

- The completion of a series of studies regarding the migration of health professionals that has generated evidence to inform decision- and policy-making;
- The launch of a database that compiles data on health professionals' employment and mobility, job vacancies and turnover, and continuing professional education in order to more efficiently manage HRH;
- A training course on HRH management and governance by the School of Public Health;
- The development of an e-learning platform for migrant health professionals who intend to return to the Republic of Moldova;
- The adjustment of post-university and nursing curricula to meet European and international standards for professional education; and
- The development of a model bilateral agreement and support throughout the negotiation and signing of a memorandum of understanding between the Republic of Moldova and the Federal Republic of Germany.

As part of the project, a video on '*Mobility of health professionals in the Republic of Moldova - context, challenges, results and lessons learned*'[37] was produced to present the project to a larger audience.

[35] See: http://www.healthworkers4all.eu/fileadmin/docs/eu/events/2014Bratislava/Triple_win_-_PPT_Grit_Braeseke.pdf
[36] See: http://www.un.md/viewnews/203/
[37] Watch the video here: https://www.youtube.com/watch?v=eQ2lG6PwXZw&feature=youtu.be

Return to Care

Return to Care[38] is an inter-university charitable foundation of the Catholic University of Leuven, the Free University of Brussels and the University of Liège (Belgium). The universities that have created the foundation believe that they should act to reduce the shortage in and the exodus of doctors from the South (i.e. countries in the South of Africa). Each year, after a selection process, the Foundation accepts a number of doctors from Southern institutions (hospitals, medical schools) who complete training in the institutions of the three Belgian universities. The Belgian universities aim to help these physicians become actors of progress that meet the needs of the institutions, schools or hospitals in the South.

[38] See: http://www.returntocare.be/

6. Education and training in relation to circular migration of the health workforce

There are distinct yet related ways in which education and training can be part of circular migration of the health workforce. Both will be shortly touched upon in this report:

- Education and training as the sole purpose of the circular movement of health workers or students. Or as described in the 2008 Green Paper On the European Workforce for Health[39], the situation where health workers or students move to another country for training and/or to gain experience, and then return to their home countries with additional knowledge and skills. Paragraph 6.1 provides an example of this.
- Education and training as part of circular migration which has employment as main purpose. This refers to the way in which education, training, qualifications, skills and diploma's, and their recognition in the country of destination, affect the circular migration of health workers who migrate for employment purposes. Paragraph 6.2 discusses these issues.

6.1 Education and training as purpose of circular migration: the Irish International Medical Graduate Training Initiative (2011-2014)

The International Medical Graduate (IMG) Training Initiative[40] is a successful example of an initiative in which education and training are the sole purpose of the circular movement. The IMG Initiative enables suitably qualified overseas postgraduate medical trainees to undertake a fixed period of active training in clinical services in Ireland. The Initiative is underpinned by WHO Global Code and the principle of reciprocity and was presented during the 'Global mobility and triple win migration' Workshop of the Joint Action on Health Workforce Planning and Forecasting[41].

The purpose of the IMG Training Initiative is to enable overseas trainees to gain access to clinical experiences and training that they cannot get in their own country, with a view to enhancing and improving the individual's medical training and learning and, in the medium to long term, the health services in their own countries. The period of clinical training that will be provided under the IMG Training Initiative is ordinarily 24 months, after which the overseas doctors are expected to return to their countries of origin.

The Initiative is aimed primarily at doctors from countries with less developed health sectors and is not intended to lead to settlement in Ireland. The expectation was that 100 trainees would be offered posts under the Initiative following joint selection process. An example of an IMG Training Initiative which has been developed and implemented is the HSE – College of Physicians and Surgeons of Pakistan IMG Training Initiative 2013.

Ireland has been awarded the Health Worker Migration Policy Council Innovation Award in 2013 due to its efforts to implement the principles of the Code (Praxmarer, 2014). The Award celebrates progress made by countries working to address the challenges of health worker migration[42].

[39] See: http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52008DC0725&from=EN
[40] See: http://www.who.int/workforcealliance/bilateral02.pdf
[41] See: http://healthworkforce.eu/wp-content/uploads/2015/09/5dec_slides_jacob.pdf
[42] See: http://www.aspeninstitute.org/policy-work/global-health-development/what-we-do/health-worker-migration-initiative/health-worker--0

Other education, training and internship opportunities provided with the aim of circular migration were already presented in Chapter 5 of this report. Yet it should be noted that, in contrast to the International Medical Graduate Training Initiative, the programs all at least included the possibility of practice in the destination country during the duration of the training.

6.2 Education and training as part of circular migration with employment as main purpose

This section will briefly discuss formal mechanisms in place across Europe for recognition of professional qualifications for migrants from inside the European Union and for migrants from outside the European Union. Subsequently, attention will be paid to the experiences of migrant workers and hospitals concerning education, training and recognition of professional qualifications in a circular migration process.

6.2.1. Recognition of professional qualifications for migrants from inside the European Union

Within the European Union, free movement of workers is laid down in Article 39 EC and further developed in Regulation 1612/68[43]. Directive 2005/36/EC provides for the mutual recognition of professional qualifications in view of establishment in another Member State. The five health professions addressed in the Joint Action (doctors, nurses responsible for general care, dental practitioners, midwives and pharmacists) fall under the system of automatic recognition. Directive 2005/36/EC has been amended by Directive 2013/55/EU[44], which includes the 'common training framework' (CTF) as a legal construct that introduces a new way of automatic professional qualification recognition across EU countries. With a CTF, EU Member States can expand the system of automatic recognition to professions "not covered by another common training framework nor subject to automatic recognition under Chapter III of Title III". In Directive 2013/55/EU, a CTF is described as: "a common set of minimum knowledge, skills and competences necessary for the pursuit of a specific profession". Currently, no CTFs have been established in the EU yet, but several healthcare professions – including hospital pharmacists[45] and specialised nurses[46] – are exploring the possibilities while the European Commission has commissioned a study on the 'Support for the definition of core competences for healthcare assistants' (CC4HCA)[47].
For professions which do not benefit from automatic recognition, some Member States are maintaining multilateral and bilateral agreements for recognition. These agreements have been discussed in section 5.1 of this report.

[43] Regulation (EEC) No 1612/68 of the Council of 15 October 1968 on freedom of movement for workers within the Community.
[44] See: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:354:0132:0170:en:PDF
[45] See: http://www.eahp.eu/practice-and-policy/common-training-framework-0
[46] See: http://www.esno.org/mission-statement.php
[47] See: https://www.nivel.nl/en/cc4hca

6.2.2. Recognition of professional qualifications for migrants from outside the European Union

Directive 2005/36/EC, described above, applies to professional qualifications obtained in an EU country and provides for the mutual recognition of professional qualifications in view of establishment in another Member State. Health workers with non-EU qualifications can also be covered by the Directive, but only in an indirect way. Article 3.3 of Directive 2005/36/EC states: "Evidence of formal qualifications issued by a third country shall be regarded as evidence of formal qualifications if the holder has three years' professional experience in the profession concerned on the territory of the Member State which recognised that evidence of formal qualifications in accordance with Article 2(2), certified by that Member State". Hence, Directive 2005/36/EC does not apply to a Member State receiving an application from a health professional for recognition of a professional qualification for the first time within the European Union ('the first application for recognition'). The Directive only applies as of the second application for recognition, and only if the conditions described in article 3.3 are met.

In general, migrants from third countries face important difficulties in obtaining recognition of their professional qualifications in the European Union and this may hamper circular migration. While the EU Blue Card (Council Directive 2009/50/EC) somewhat simplifies the process for high-skilled non-EU citizens to work and live in the EU (see also section 5.1 of this report), problems around recognition of professional qualifications – a pre-condition for regulated occupations to have access to a Blue Card – are still considerable. This is because the recognition of third-country qualifications remains a national competence and hence applications must always be made to the authorities of the EU country where migrant health workers plan to move to. Between EU Member States and even within a single country, different methods may apply for the validation and the recognition of academic education, vocational education and work experience and different recognition paths may apply according to the country in which the migrant earned qualifications. For a detailed overview, we refer readers to the publication of the International Organization for Migration on the 'Recognition of Qualifications and Competences of Migrants[48].

6.2.3. Experiences of migrant workers and hospitals on education, training and the recognition of professional qualifications for migrants

In this section, we focus specifically on the experiences of the migrant health worker and the organisational level in destination countries - related to education, training and recognition of professional qualifications – as these determine the success of circular migration to a large extent.

Experiences of the migrant health worker

The report by Bulthuis (2015), written during an internship at the Wemos foundation, a collaborating partner of the Joint Action on HWF Planning and Forecasting, focuses exclusively on health workers' experiences of circular migration. Professional aspects of circular migration were an important part of the research and included personal development on the job, the ability to participate in education or training (while working) and the quality and relevance of the education or training. It was found that circular migrants experienced the possibility for personal and professional development as part of their circular migration as very positive. The opportunity to develop skills in the country of

[48] See: http://publications.iom.int/system/files/pdf/recognition_qualifications_competencesofmigrants.pdf

destination was mentioned several times in this regard and can be considered a pull factor for health workers in circular migration. The migrants described not only the possibility to develop themselves, but all considered the knowledge and experience gained to be very relevant for their work in both source and destination country. However, they also mentioned they would like to make more frequent trips to their country of origin, to increase the impact of their newly obtained knowledge. Owing to the fact that they work in their country of destination, it is impossible to go more often or for longer periods of time. For this reason, the respondents suggested that there should be policies in place to improve the possibilities of the health worker to go to their country of origin more often. Governments could encourage employers to give special leave for people involved in circular migration.

Experiences of hospitals with the migration of health workers

Brand (2012) conducted research on the experiences of Dutch and Belgian hospitals with the migration of health workers, and explored the relations between European circular migration policy and current practices. In the interviews that he conducted, advantages and disadvantages of circular migration were discussed. In general, hospitals were sceptical about the idea of European circular migration. According to the hospitals, the advantages do not outweigh the disadvantages. Some of the most important disadvantages they cited were related to the education and recognition of qualifications of the migrant health workers (Brand, 2012).

Participating hospitals were divided about the comparability and quality of the training of foreign staff. Generally, migrant health workers were considered highly qualified in terms of the technical knowledge they possessed and their performance of procedural tasks. Yet, professional attitude and experience were often rated more critically, probably as a result of the lack of job experience of many migrant health workers. Moreover, procedures surrounding the recognition of qualifications were considered suboptimal and labelled as slow, bureaucratic and ambiguous. This all impeded the migration process of these health workers. Another barrier, often cited, was the insufficient language level of the migrant workers. To solve this problem, some hospitals provided language courses to the migrant workers, but these were not very successful. Language courses offered by professional institutes were too expensive (Brand, 2012).

To improve the situation for both migrant workers and the involved hospitals, respondents mentioned they needed a vision on circular migration for the future, both at hospital level and at EU level. They mentioned their willingness to participate in pilot projects. Moreover, they strongly insisted on setting up language course requirements as part of the circular migration process (Brand, 2012).

These experiences of migrant workers and hospitals with education, training and the recognition of professional qualifications for migrants underline the importance of involving employer and employee representatives in the design of circular migration policies, preferably at organisational and national level. The EPSU/HOSPEEM Code of Conduct on Ethical Recruitment could be an example, as it directs attention to the development and implementation of policies at local level to enhance workforce retention and to promote accessible and high-quality health care.

7. Conclusion

This Report on Circular Migration of the Health Workforce is part of Work Package 7 of the Joint Action on Health Workforce Planning and Forecasting and addresses the concept of circular migration and its perceived 'triple-win' outcomes, its relation to the WHO Global Code of Practice, the formal and informal cooperation structures in place across Europe and the complex relationship of circular migration with education and training.

One of the main conclusions that can be drawn is that there is a severe lack of knowledge and data on circular migration of the health workforce (Castles & Ozul, 2014; Hawthorne, 2014). Moreover, policies specifically focusing on circular migration are in their infancy and nothing can be said about their impact or effects on source countries, destination countries and health workers.

7.1 Preliminary guidance on cooperation in circular migration

In view of the lack of knowledge and evidence on circular migration of the health workforce and the limited scope of this report, we cannot provide countries with clear-cut recommendations or best practices on how to deal with this issue. Based on the overview on circular migration of the health workforce that was provided in this report, the following preliminary guidance on cooperation in circular migration can be presented.

Six guiding principles for cooperation in circular migration of the health workforce:

- Consider circular migration of the health workforce as one option among others
- Circular migration should be based on the principles of the WHO Global Code of Practice and aim for a 'triple win' outcome
- Cooperation structures for circular migration of the health workforce should be chosen primarily based on the health workforce needs of the source country and adapted to the envisioned goal
- Circular migration of health workers is a joint process and should involve all relevant parties
- The importance of language skills and recognition of professional skills needs to be acknowledged and better integrated in circular migration processes
- More data and research on circular migration of the health workforce are urgently needed

Consider circular migration of the health workforce as one option among others

Training sufficiently large numbers of health workers so as to curb dependence on immigration is one of the key principles of WHO's Code of Practice. Hence, countries' chief means of expanding the supply of health workers should be to boost their education and training capacity and their average duration of health practitioners' working lives. Policies to improve wages and working conditions can also act as incentives to come home or not to emigrate. Against that background, recruiting foreign health workers is something of a stop-gap, particularly for the most urgent needs (OECD, 2015). In his key note speech during one of the Joint Action conferences, Martin Seychel, Deputy Director General of Directorate General for Health and Consumers, European Commission, also noted that EU countries need to plan their health workforce needs, better forecast skills needs and collaborate in recruitment and retention strategies as a means to create a sustainable health workforce. In other words, while

professional mobility should and is supported by the EU, an excessive reliance on foreign health professionals should be avoided. Moreover, it has been found that this would also be the preference of the health workers themselves, especially those from developing countries. Circular and return migration are *not* the preferred outcomes for the majority of migrant health professionals from developing countries (Hawthorne, 2014). Hence, circular migration should always be considered as just one option among others and pre-conditions should be created to ensure that circular migration is not economically forced, but motivated by professional development opportunities.

Circular migration should be based on the principles of the WHO Global Code of Practice and aim for a 'triple win' outcome

Where countries engage in circular migration of the health workforce, they should take into account the WHO Global Code of Practice as a starting point for developing circular migration initiatives. Benefits for source and destination countries and migrant health workers – a 'triple win' outcome – are crucial to take into account in this aspect. This was also strongly stated by participants of the Joint Action Workshop on the applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel[49] in the adopted 'top important' statement: "Circular migration has to be fostered within the EU in a way that benefits source countries, destination countries, and individual health professionals themselves". For the hospital sector, the EPSU-HOSPEEM Code of Conduct on Ethical Recruitment may provide additional and specific guidance in this regard.

Cooperation structures for circular migration of the health workforce should be chosen primarily based on the health workforce needs of the source country and adapted to the envisioned goal

Because of the lack of knowledge surrounding circular migration, there is no gold standard in how cooperation between sending and receiving countries should be shaped. In view of the ethical component of circular migration, and to work in line with the WHO Global Code, countries are advised to take the health workforce needs of the source country as point of departure in drafting a cooperation agreement, be this formal or informal. Moreover, cooperation tailored to different types/profiles of health professionals could also be developed, as the needs of for example doctors and nurses, the professions mostly involved in migration, may be quite different in this regard.

To be able to choose the right cooperation form to match the desired goal of circular migration, it would be beneficial for countries to have some examples to learn from and to share knowledge in this regard. Hence, for matters of transparency and to close information gaps, bilateral and multilateral agreements, as well as other formal and informal cooperation structures should be shared and discussed to enable peer learning.

Circular migration of health workers is a joint process and should involve all relevant parties

Based on discussions within the Joint Action, the involvement of all relevant parties in a circular migration process was deemed crucial to turn it into a success. Greater coherence – between ministries within a country and between countries – among migration policies, development co-operation policies and employment, trade and security policies is required for all parties to gain more from circular migration. In destination countries labour rights and social protection of migrant health workers need to be ensured. Therefore, the voices of migrant health workers and labour unions should be present and represented in the social dialogue[50]. Moreover, the results that were presented in this

[49] See: http://healthworkforce.eu/events/16-to-18062014-lisboa/#monday
[50] See: http://www.healthworkers4all.eu/eu/project/2014bratislava/

report on the experiences of migrant workers and hospitals also clearly underline the importance of involving representatives of employers and employees in the design of circular migration policies, preferably at organisational and national level. The EPSU/HOSPEEM Code of Conduct on Ethical Recruitment could be used as an example, as it directs attention to the development and implementation of policies at local level.

The importance of language skills and recognition of professional skills needs to be acknowledged and better integrated into circular migration processes

Our overview on circular mobility of the health workforce made it clear that language skills and recognition of professional skills are crucial aspects of circular migration processes. This became especially clear from the experiences of hospitals with the migration of health workers. Where language skills are inadequate or the recognition procedure for foreign diplomas is unclear, ambiguous and time-consuming, this severely hampers the circular migration process. A sufficient level of language proficiency should be included as a skill requirement in circular migration processes to ensure patient safety. Moreover, the process for recognition of professional skills, especially for migrants from developing countries, should be clarified in close cooperation with the health sector. In all cases, legal clarity and patient safety must govern the process of recognition of professional qualifications and the issuance of a licence to practise. At EU level, the sharing of good practices and mutual recognition procedures between countries may be beneficial in this process.

More data and research on circular migration of the health workforce are urgently needed

There is an urgent need for more data and research on circular migration of the health workforce. While much is asserted, little is known about the issue. Without data and without proper research, it is impossible to assess the magnitude of circular migration of the health workforce, its impact on the sustainability of health systems in source and destination countries, the extent to which it takes place in a managed or spontaneous way, the interaction between intra-EU and non-EU circular migration, and the impact of various formal and informal cooperation structures and policies aimed at facilitating circular migration of the health workforce.

Moreover, while circular migration traditionally assumes physical relocation, in the future this may not be required to facilitate knowledge, economic and social capital transfer, given the multiple virtual options now available. Hence, some research on future scenarios and horizon scanning would also be welcome to inform policy making.

There is a need for EU countries to bring together the various initiatives, formal agreements and cooperation mechanisms on (circular) HWF migration – among others undertaken by regional and national authorities, NGOs, universities and hospitals - in a specific database. This database could for example be put under the responsibility of a Ministry or university. Moreover, while more and high quality quantitative data would give an indication of the magnitude of circular migration of the health workforce, we would also recommend a comprehensive qualitative study which could clarify the reasons for (non-)circular migration, the impact on health workers in terms of knowledge gain (often assumed, but little tested) and on healthcare institutions in both source and destination countries (for example, focusing on the advantages and disadvantages and barriers and facilitators they experience).

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Appendix I. Overview of formal agreements and mechanisms of cooperation on labour migration

Diversity of agreements/mechanisms of cooperation on labour migration
• Bilateral agreements (BAs) • Memorandum of understanding (MOUs) • Framework agreements: broad bilateral cooperation instruments covering a wide range of migration related matters, including labour migration but also irregular migration, readmission, and the nexus between migration and development. • Inter-Agency Understanding (IAU): such as the New Zealand – Pacific Islands States agreements, which are similar to MOUs. • Protocols (Additional or Optional): instruments entered into by the same parties of, and which amend, supplement or clarify a previous agreement. • Agreements for hiring seasonal workers (Canada-Mexico; Germany-Poland) • Cross-border worker agreements • Statements of mutual labour cooperation or informal assurances • Bilateral social security agreements • Anti- trafficking agreements • Trainee schemes: Japan, Republic of Korea (replaced by the Employment Permit System) • Working holiday maker schemes • Multilateral agreements: Mode 4 of General Agreement on Trade in Services: Movement of natural persons

Source: Wickramasekara (2015)

Appendix II. Overview of agreements related to circular mobility of the health workforce across the 28 EU Member States

COUNTRY	AGREEMENTS
Austria	• German Bundesländer Thuringia, Brandenburg, Mecklenburg-Western Pomerania, Saxony, Sachsen-Anhalt bilateral agreement with Austrian physician chamber regarding the recruitment of doctors. • Agreement with Germany for medical graduates to do their specialisation under Austrian system. • Agreements with Danish regions Syddanmark and Seeland.
Belgium	• Belgian law allows foreign-trained non-EEA medical graduates to undertake part of their specialization in Belgium. This is conditional upon a signed declaration of their commitment to return to their country of origin on completion of the assigned training period.
Bulgaria	• MoU 2008 and beyond – South-eastern Europe health network to support the regional health development.
Croatia	• South-Eastern Europe health network • Bilateral agreement Romania to recruit foreign nursing aid.
Cyprus	-
Czech Republic	• Bilateral agreement with Germany regarding recruitment of foreign nursing aid.
Denmark	• Labour mobility partnership with India to manage labour movement of qualified workers under the conditions of a fair recruitment and equal treatment. • Agreement on Common Nordic Labour Market to ensure that migration movements between these countries do not create imbalance in the labour market.
Estonia	• Informal agreement with Finnish medical associations to enable mobility of medical doctors in both directions.
Finland	• Agreement on Common Nordic Labour Market to ensure that migration movements between these countries do not create imbalance in the labour market. • "Attractive Finland" project (2008-2010) provides a framework for the international recruitment of nurses by the City of Helsinki and by the Helsinki Uusimaa Hospital District. It promoted bilateral cooperation and networks for cooperation in the recruitment of foreign employees. • Bilateral agreement with the private recruitment agency Opteam and the Philippines on recruitment of nurses.
France	• Convention d'établissements with Congo: bilateral agreement between France and Congo since 1962. • Convention d'établissements with Morocco, Tunisia, Monaco. • Bilateral agreement with Benin for radiography profession. • Bilateral agreement with Senegal regarding recruitment of nurses and midwives (on the shortage of occupations list).

COUNTRY	AGREEMENTS
	• Convention medicale transfrontalière regarding doctors from Monaco and Switzerland who work close to the French boarder to carry on their profession in France. • Medical doctors from the countries the Central African Republic, Chad, the Congo, Mali and Togo are allowed to practice in France in case they have a French medical degree. • Franco-Tunisian agreement, where Tunisian students obtaining a French qualification have access to employment in France. • Cooperation agreements with Saudi Arabia, the united Arab Emirates, Bahrain, the Sultanate of Oman, Kuwait and Qatar allow doctors, specialising or already specialised in their countries, to register to a study in the field of their choice in France, and in some cases, can be hired as practitioners during their last year of training.
Germany	• Agreement with Tunisia, Serbia, Philippines and Bosnia-Herzegovina to officially recruit caregivers from third-countries (Triple-Win project, selection of countries based on WHO code). • Triple-Win Project Bosnia-Herzegovina regarding the recruitment of caregivers from Bosnia-Herzegovina based on an agreement with ZAV in Germany and the employment agency in Bosnia-Herzegovina. • Bilateral agreements with on recruitment of foreign nursing aid: Croatia, Ukraine, Poland, Slovenia, Czech Republic, Slovak Republic, Bulgaria, Romania. • Project with Vietnam regarding education and recruitment for retirement homes in Germany. • Agreement with Croatia regarding recruitment of nurses. • Agreement with Austria to enable post-graduate specialisation for doctors. • Goethe-Institute giving language courses for foreign doctors and nurses in cooperation with a German hospital. Since 2012 in Southern Europe e.g. Lisbon. • Project with China regarding the procurement of 150 Chinese nursing specialists for the elderly care sector.
Greece	• Informal agreement with Turkey to recruit Greek doctors to Turkey.
Hungary	• Project to strengthen the Republic of Moldova capacity to manage labour and return migration (2009-2011) • Memorandum of Understanding with India to promote traditional medicines, includes exchange of experts for training. • Bilateral agreements with China, Yemen, Columbia, Palestine, Mongolia and Vietnam to enable students and professors of higher education to come to Hungary. • SIMIGRA project to support the integration of foreign professionals in line with the provision of the WHO code.
Ireland	• Bilateral agreements with non-EU countries regarding recruitment under the WHO Code of international recruitment

COUNTRY	AGREEMENTS
Italy	• Bilateral agreements with Romania regarding the employment of Italian doctors to work in Romania (Regions of Treviso and Timisoara). • Agreement with the Veneto region with training institutions in Romania (Bucharest and Pitesti): foreign nurses are trained to guarantee the language and technical skills needed to work in Italy. • Bilateral agreement with Tunisia regarding recruitment and placement of Tunisian nurses. • Recruitment of home-care nurses from Sri-Lanka in cooperation with the International Organization of Migration and local authorities of Tuscany and the Italian Ministry of Labour. • The Italian NGO "African Medical and Research Foundation" has adhered to the project "Health Workers for All, All for Health Workers", a European civil society initiative funded by the European Commission whose objective is the implementation of the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel which aims to achieve a sustainable health workforce world-wide.
Latvia	-
Lithuania	• Organized recruitment for circular migration by Danish private recruitment agencies. Patterns could be: working temporary in Denmark and return to Lithuania, or work part time in Denmark and part time in Lithuania, or one month in Denmark and one month in Lithuania. • Agreement with Germany to manage the placement of trainees in order to extend their language knowledge and professional skills for health care students. • Agreement with Ukraine regarding "Mutual placement of citizens". • Agreement with Russia dealing with temporary placement of citizens.
Luxem-bourg	• Mobility Partnership with Cape Verde (no focus on health professionals)
Malta	• The International Organization for Migration helps immigrants in Malta to organize the return to their home country with the project "Voluntary Return and Sustainable Reintegration in the Country of Origin". • Re-integration project to strengthen the relation between Malta and African countries.
Nether-lands	• MIDA Ghana Health project to support the health care sector in Ghana through exchange of health professionals. • Memorandum of Understanding with Suriname on registration of physicians in the Netherlands which allows Surinam physicians to practice in the Netherlands only during the time of a training course. • Project to strengthen healthcare in Morocco through temporary assignment of Moroccan immigrants living in the Netherlands.
Poland	• Agreement with the Netherlands (placement of 50 nurses each year) • Agreement with Norway to actively recruit Polish nurses to Norway.
Portugal	• Administrative agreements with Uruguay, Cuba, Colombia, Costa Rica regarding recruitment of doctors under the conditions of the WHO code.

COUNTRY	AGREEMENTS
	• Project of the support to the professionalization of immigrant doctors (PAPMI) regarding the recognition of foreign doctors (2002-2005; 2008 again for 8 months). 2005-2007 same project but regarding integrating nurses from non-EU countries in the Portuguese health care system. • Project for the support of qualified immigrants (PAIQ) regarding recognition of qualifications of third-county nationals.
Romania	• Bilateral agreements with Germany, Switzerland, Hungary, Luxembourg, Spain, France, Portugal, Italy, Croatia, Ukraine and Bulgaria regarding recruitment of health workforce. • Agreement with the Region Friuli -Venezia- Giulia in Italy regarding recruitment of nurses from Romania with training institutions of both countries.
Slovak Republic	• Zuwinbat Project (2008-2012) in the regions Bratislava and Trnava in Slovakia regarding cooperation with the Austrian regions Vienna and Lower Austria to strengthen network between employees, employers and trade unions. • Agreement with Germany to organize recruitment of foreign nursing aid.
Slovenia	• Agreement with Germany to organize recruitment of foreign nursing aid.
Spain	• Bilateral agreements with Colombia and Morocco regarding concepts of migration and human capacity development. No focus on health professionals. • Agreement with UK regarding recruitment of health professionals to UK. • Memorandum of Understanding with Philippines to enable Philippine health professionals to work in Spain.
Sweden	• Agreement on Common Nordic Labour Market to ensure that migration movements between these countries do not create imbalance in the labour market. • Project with IOM and UNDP to support experts of the Somali diaspora to return temporarily and contribute to development in Somalia in three sectors, including healthcare.
UK	• Agreement with South-Africa regarding knowledge exchange, best practice through temporary employment of health care workers. Focus on reciprocal educational exchange of healthcare concepts and personnel. • Memorandum of Understanding with Philippines regarding the recruitment of nurses (expired in 2006, not renewed). • Agreement with India regarding recruitment of nurses, physiotherapists, biomedical scientists and other health care professions that are regulated in both countries. No recruitment from the regions of Andhra Pradesh, Madhya Pradesh, Orissa and West Bengal due to the WHO code. • Agreement with China with recruitment agencies, it is not allowed to recruit from rural areas in China. • Agreement with Spain regarding the recruitment of nurses.

Source: adapted from Praxmarer (2014).

Note: the work by Praxmarer was completed in the beginning of 2014, so some of the information provided may be outdated.