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Identifying the role of the sending state in the emigration of health professionals: a review of the empirical literature

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There is a growing research interest in how sending states manage the emigration of health professionals. While the 'push' and 'pull' factors depict sending states as passive actors in this process, emergent studies are revealing them to be active actors with an articulated policy agenda. Using a variety of examples from the empirical literature, this paper identifies the multiple roles that sending states play in the emigration of doctors and nurses. The current findings contribute to the international migration literature in three ways. Firstly, this paper emphasizes that sending states are active actors in the health professional migration. Secondly, it shows that sending states adopt one of the three strategies: (1) introduce restrictive measures to delay the mobility of health professionals; (2) respond to market demands by producing and promoting emigration; and (3) implement a combination of these two strategies. Lastly, this paper highlights how sending states institutionalize gendered emigration through a bilateral cooperation in nurse migration. Missing from the extant literature are studies on competing beliefs, motivations, and technical information informing the strategies of sending states. This paper concludes by presenting a research agenda to further examine how and why sending states are active actors in the health professional migration.

Keywords: doctors; health professional migration; nurses; sending countries; state

Introduction

The question of why people move has been central to studies of migration. Reflecting this strong interest is a variety of studies that tells us that people move in search of 'greener pastures' professional advancement, reunification with families and relatives, freedom and security, among others. These studies are rooted in a diverse set of literature and theoretical universe.

For instance, migration is historically theorized using the traditional 'push' and 'pull' factors that extend to, among others, economic, political, social and environmental perspectives; although, recent scholars consider them as too simplistic (e.g. O'Reilly, 2013). In the neoclassical economic theory, economists view this movement as an effect of the differences in the cost of labor between the origin (used interchangeably with sending) and destination countries from the macro-level aspect, and depicts the rational decision of individual migrants to emigrate in the micro-level (e.g. Harris & Todaro, 1970; Todaro, 1980). Network theory attributes this mobility to the presence of family ties and social networks (e.g. Massey et al., 1993). These are the only few theories that

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explain the widespread movement of individuals across time and space, but, generally, migration theories[1] portray individual migrants, families, social networks, recruitment agencies and individual brokers as central actors in the migration process.

What is missing in these views is the contribution of the state as one of the key actors in the overall structure of migration. Massey (1999) and Zolberg (1999) recognize this deficiency, so they encourage migration scholars to integrate the state as one of the significant actors that influence international migration. While a number of scholars have begun to analyze the role of the state from the perspective of destination countries (e.g. Freeman, 2006; Guiraudon & Joppke, 2001; Hugo, 2012; Joppke, 1999; Mahmud, 2015; Schain, 2008), the question of how the sending state impacts migration remains under studied (e.g. Massey, 1999). This review contributes to the development of the literature in this field by examining how sending states intervene in the outward movement of their nationals using the case of health professional migration.

Classically, when referring to states, scholars differentiate between the destination and origin countries.[2] These countries, herein referred to as 'states', play a role in the migration process given their regulatory authority in border control and migration management. Massey (1999, p. 50) emphasizes that '[e]ven though governments may not be able to control fully the powerful forces promoting or sustaining migration, state policies clearly have an influence in determining the size and composition of the flow.' States may opt to open their borders to the highly skilled and talented workers instead of the low skilled and seasonal workers, which depends on the demand of domestic labor markets. For instance, in destination countries, Schain (2008) explains that the immigration policies of the United States (US), France and the United Kingdom (UK) respond to the changes in the demand of labor markets by restricting and (re-) opening their borders to labor immigrants. For sending states, the literature often portrays these countries as passive actors (e.g. Massey, 1999, p. 51), but recent studies highlight their active intervention in migration (e.g. Acacio, 2008; Fitzgerald, 2008; Hamada, 2012; Levitt & Dehesa, 2003; Üstübici, 2015).

Health professional migration is the most likely case in which we are to see more active state intervention from sending states. The World Health Organization (WHO) estimated that there is a global workforce shortage of 7.2 million in 2013 and will increase to as much as 12.9 million in 2035 (Global Health Workforce Alliance & World Health Organization, 2013). In 2010/2011, there were 54 developing countries (a reduction from 57 countries in 2006) that were facing critical shortages of health professionals, with a total deficit of 2.8 million doctors and nurses (OECD, 2015, p. 133). From this development, we could trace the dynamic role of sending states particularly on how they strategize and implement migration management policies that could strike a balance between the need to keep them as an important resource in the health sector and the inherent right of their health professionals to move.

The framework of 'push' and 'pull' factors of migration represents the countries of origin as passive actors, powerless in managing the outward mobility of their health professionals due to more attractive economic, political and social conditions in destination countries. They are often generally depicted as 'losers' in the migration process. However, a review of the existing literature in health professional migration reveals a more complex picture. For example, in the case of Zimbabwe, Chibango (2013) points to the proactive role of the government in terms of addressing the 'brain drain' or the gradual loss of skilled professionals due to emigration through a combination of retention policies and delaying emigration mechanisms. In his review of the opposing debates on 'brain drain', Skeldon (2009) suggests that sending states could intervene in two ways:

a health training system for the international market and another one for the domestic market. Meanwhile, there are also several studies that describe sending states that orchestrate or promote emigration, for example India (Yeates, 2009a, 2009b) and the Philippines (Choy, 2003; Rodriguez, 2010; Yeates, 2009a, 2009b). These studies point to the need of a holistic review of sending states' strategies, which concern with the emigration of their professionals. Consolidating these insights will allow us to begin integrating the role of sending states into debates about migrant-level factors and regulatory dynamics behind the contemporary migration.

This paper aims to identify the multiple roles that sending states play in the emigration of doctors and nurses using a variety of empirical examples of sending state practices. In so doing, this paper contributes to the international migration literature in three ways. Firstly, it emphasizes that sending states are active actors in the health professional migration. Secondly, it shows that sending states adopt one of the three strategies: (1) introduce restrictive measures to delay the mobility of their health professionals; (2) respond to market demands by producing and promoting health professional emigration; and (3) implement a combination of these strategies. Lastly, this paper highlights how sending states institutionalize gendered emigration through the visible pattern of a bilateral cooperation in nurse migration. By contrast, organized mobility of doctors through a bilateral cooperation is rare.

Missing from the existing literature under review, however, are studies on competing beliefs, motivations, and the technical information (e.g. data, policy studies) informing the strategies of sending states. As a future research agenda, we could analyze these areas by studying the design of implemented policies and processes that lead to the sending state's participation in a bilateral cooperation. These perspectives would reveal the interaction of different policy actors within the sending states in the design and negotiation processes, which are essential in understanding how and why these countries orchestrate and/or restrict emigration. Further, the Global Nursing Care Chain (GNCC) concept, which explains how developing countries provide the necessary skilled care labor in terms of nurses to the rich and destination countries (see Yeates, 2009b) in combination with the framework of public policy and international relations will help in understanding the gendering of health professionals through a bilateral cooperation. These future research agendas aim to integrate policy sciences and international relations with migration studies to further examine how and why sending states are active actors in the emigration of their health professionals.

This paper is organized as follows. The next section describes the methodology used and followed by a brief review of different drivers of health professional migration to help us locate the strategies of sending states in the health professional emigration. The succeeding section discusses the restrictive policies implemented by sending states to delay the outward mobility of health professionals before describing those that produce and promote health professional migration. Finally, the paper ends with the discussion of the key findings and presents a research agenda for future studies.

Method

The author conducted a review of peer-reviewed journal articles studying the role of the sending state in the migration of health professionals. In determining the relevant articles for this review, the author established the following inclusion criteria – (1) studies published from 2004-June 2015; (2) cases of doctors and nurses; (3) studies that used empirical data such as surveys, interviews and direct observations. This paper excludes

studies that did not have reference to the intervention of sending states such as experiences, deskilling or non-recognition of professional skills of health professionals in destination countries, qualitative and quantitative studies on the effects of health professional migration to sending countries and theoretical studies on social justice and individual rights of migrants.

The author started a literature search for journal articles published in 2004 to reflect how scholars have documented and examined the strategies of sending states in addressing the active recruitment practices of destination countries that caused the massive emigration of health professionals beginning the year 2000.[3] The interval of 4 years (2000 and 2004) is a sufficient time to trace how migration scholars examine this phenomenon and capitalize this issue to study the role of sending countries in response to the call of Massey (1999) and Zolberg (1999) to integrate the sending state as an important actor that shapes international migration. This current review is limited to doctors and nurses, because they have the highest incidence of emigration in medical professions.

This paper is particularly interested in the intersection of social science and medical and nursing disciplines in studying the emigration of doctors and nurses. The author utilized the Medline/PubMed as a search engine to initially locate the relevant literature, which scholars often used in health-related migration literature reviews (e.g. Dywili, Bonner, & O'brien, 2013; Likupe, 2013; Willis-Shattuck et al., 2008). Furthermore, this paper also used the Web of Science, Scopus and Google Scholar to increase the number of search results and include other relevant literature. For the literature search, the author used the following keywords such as *health professional migration, nurse migration, doctor migration, physician migration and health worker migration*. After applying the first two inclusion criteria, the literature search identified 95 journal articles.

To locate references on the role of sending states, this author checked carefully titles of articles to see if these captured the name of a sending country. Alternatively, the author examined the abstract if the title of articles did not explicitly reveal the name of the country of origin utilizing the following key phrases – 'sending countries', 'source countries', 'country of origin' and the following subordinate phrases- 'strategies, 'responses', 'policies', 'promotion', 'managing' and 'regulate'. After this step, there were 53 journal articles left for review.

From these reviewed articles, this paper includes empirical studies only that covered the role of sending states. It excludes articles that are theoretical, literature reviews and studies that gave no account of method or data gathering procedures or studies that are based on other empirical studies. This selection criteria filtered the existing pool of literature into those studies that examine the role of the sending state using actual data and observations and those that do not. These empirical studies depict the actual practices of sending states, which are sometimes different from their written policies. Finally, there were 35 journal articles reviewed and included in this paper.

In the next section, using the existing literature, this paper will discuss the drivers of health professional migration. Determining these factors will allow us to better understand how sending states intervene in the outward movement of their health professionals.

Drivers of health professional migration

This section reviews the different drivers or factors that motivate the emigration of health professionals. These are the push and pull factors and the culture of migration among sending countries. The push and pull factors generally refer to the conditions or

circumstances present in the countries of origin (push) and destination (pull) that encourage individuals to emigrate. The culture of migration evolves from the influence of migrants to non-migrants in their decision to emigrate within the frame of a social network that eventually develops into a cumulative causation of migration over time (Kandel & Massey, 2002, p. 983).[4] Understanding different drivers or factors of health professional migration will enable us to locate different strategies of sending states in response to the outward movement of their health professionals.

The economic push and pull factors largely influence the migratory movement of doctors and nurses. Low wages from the countries of origin (push) and high pay with other attractive financial benefits in destination countries (pull) motivate these health professionals to work abroad. Indeed, empirical studies on Pacific Island Countries (PICs) (Brown & Connell, 2004), selected African countries (Chikanda, 2005; Kalipeni, Semu, & Mbilizi, 2012) and India (Mullan, 2006; Thomas, 2006) reveal that financial incentives motivate health professionals to emigrate. In a much broader and macro-level analysis, the economic condition of developing countries [measured using gross domestic product (GDP) or income per capita as indicators] contributes to explaining the massive emigration of doctors (Okeke, 2013) and nurses (Ross, Polsky, & Sochalski, 2005). For instance, in Sub-Saharan Africa countries, Okeke (2013) indicates that a temporary decline of one percentage point in GDP per capita increases the migration of physicians in the following year by 0.3%. For nurses, Ross et al. (2005, p. 257) estimate that low income countries account for 209% of international nurse registration in the UK when compared to high income countries. Beyond the generic economic motivations and looking at the specific motivations for each profession, the movement of doctors and nurses extends these factors to kinship, family ties, and gender specific issues. Put simply, their motivation to move resemble the broader sets of motivations that encourage other migrants to emigrate.

For doctors, kinship, family, and professional ties are the dominant pull factors that triggered migratory movement (Brown & Connell, 2004; Groutsis & Arnold, 2012; Healy & Oikelome, 2007), which clearly support the presence of social networks in destination countries that influence emigration decisions. In a small Pacific Island like Nieu, Connell (2007b) identifies two other important push factors that initiates the emigration of doctors – feeling of boredom and lack of career growth. Curtailed by this geographical location, the feeling of isolation from the rest of the world triggers a migratory movement from doctors despite the existing shortage of this skill in their home countries. Conversely, in the case of India, higher education is the ultimate driver of doctors' emigration (Tharakan et al., 2012). Mullan (2006, p. 386) explains that doctors from India immigrate to developed countries at the early stage to acquire advanced medical degrees and intend to remain in these countries for a more rewarding career.

In terms of nurses, financial incentives and the quality of working conditions (Zander, Blümel, & Busse, 2013) influence their decision to work abroad. Aside from these motivations, however, the current literature focuses alternatively on gender-related factors such as women empowerment and independence. For example, in India, some anthropological studies on the migration of nurses reveal that women, from rural-middle class, pursue a nursing profession in order to 'see the world', to 'travel' and improve their status as prospective brides of men from good families (Percot, 2006; Percot & Rajan, 2007; Walton-Roberts, 2012). From a gender perspective, women who studied nursing and emigrate increase their value in the matrimonial market when they are able to work abroad, because of higher earnings and the assurance of bringing their future husbands to work with them abroad (Percot, 2006; Percot & Rajan, 2007; Walton-Roberts, 2012).

Beyond the push and pull factors, the culture of migration is a significant factor for the emigration of nurses in the Philippines (Barber, 2013; Ronquillo, Boschma, Wong, & Quiney, 2011). The migration culture in nurse's emigration evolved from the 'Westernized' nursing education during the US colonial period (Barber, 2013; Ronquillo et al., 2011, p. 266) and increased the visibility of emigration through the first wave of mass mobility in the US as early as the 1960s through the 1965 US Immigration Act (see Choy, 2003). Ronquillo et al. (2011, p. 267) emphasize that family pressure contributes to cultivating the culture of migration through the influence of successful family members who are migrant nurses. In the same vein, the migration culture of nurses from the Indian state of Kerala that evolves from the population of Christian minority is responsible for the upsurge of nurse emigration across the region and other religious and ethnic groups (Percot, 2006; Percot & Rajan, 2007). Meanwhile, Connell (2014) explains that culture, geography, history and the earlier experiences of emigrants stimulate the decision of health professionals in nine PICs to emigrate.

In understanding the interplay of these factors allow us to identify how sending states respond to the emigration of health professionals. The succeeding sections review different strategies of sending states in addressing this mobility.

Restricting emigration and the export of health professionals: a contrast of strategy

In the previous section, the different drivers of health professional migration helped situate the discussion on the international mobility of health professionals in the broader context of migration. In this section, we will review empirical studies on strategies of sending states to illustrate how they managed the emigration of health professionals in practice.

How countries of origin restrict the emigration of health professionals

In response to the push and pull factors, some sending states like Zimbabwe, Ghana, South Africa and India implement a retention policy that would prevent health professionals from emigrating. These countries impose service bonds to nursing and medical students funded by government funds after graduation or before registration. Under this scheme, these students have to complete mandatory community service that would further delay their imminent emigration plans (Chikanda, 2005; Hagopian et al., 2005).

In Zimbabwe, a majority of the total registered nurses had graduated from government-run nursing training schools. Since 1997, the government has required students to perform a community service for three years (Chikanda, 2005, p. 172) in public hospitals and health facilities. Similarly, in India, the government-run medical schools in some states implemented the service bonds for medical students to serve health facilities in rural areas, but the system lacks a strict enforcement (Mullan, 2006, p. 385). Despite the growth of private medical schools in India, the publicly-owned medical training institutes have a considerable share in the total supply of physicians. Explicitly, the urban physician-to-population ratio is six times the number of physicians in rural areas (Mullan, 2006, p. 383) and the imposition of bond periods to Indian medical students could close this gap. For Ghana, Hagopian et al. (2005, p. 1757) reveal that the enforcement of a five-year service bond to medical students is also problematic, citing the difficulty of tracking the debtors and rapid fluctuations of the value of the bond as key issues. In South Africa, where all medical schools are under the public university

system, likewise, implements the obligatory community service for newly graduated medical students to mitigate the adverse effects of doctors' emigration (Hammett, 2014, p. 42).

While empirical studies view these initiatives as a regulatory function of sending states, a wide body of knowledge continuously produces policy recommendations for sending states to directly respond to the push and pull factors of health professional migration. These studies call for a state intervention to improve financial remunerations, incentives and working conditions of health professionals in sending countries (Astor et al., 2005; Brown & Connell, 2004; Lorenzo, Galvez-Tan, Icamina, & Javier, 2007; Perrin, Hagopian, Sales, & Huang, 2007; Zander et al., 2013). Specifically, these policy proposals included several reforms to augment the current pay structure and hasten the career promotion (Okeke, 2014), to enhance access to advanced technology (Astor et al., 2005), to create quality working environment (Thomas, 2006), and to increase domestic post-graduate educational opportunities, specifically for doctors (Hagopian et al., 2005, p. 1756). These proposals directly concern the health professionals, who are working in public hospitals and other health facilities in countries where health services are a public enterprise, for example in the African region (Chikanda, 2005; Hagopian et al., 2005) and PICs (Connell, 2007a). Although these recommendations are widely discussed in the empirical literature, to my knowledge, there is a lack of documentation to verify if sending states actually adopting and implementing these policies, based on the prior literature review conducted.

The different policy responses reviewed in this section reveal that sending states are not passive policy actors in the migration process. However, the existing literature did not largely cover the relative success of their efforts. Indeed, these countries pursue different avenues to regulate the outflow of their own health professionals. In the main, they implement these strategies as a way to manage the general migration push and pull factors and to lessen the adverse impact of medical 'brain drain'. As we will discuss below, some sending states practice an entirely distinct strategy, whereby, they orchestrate the emigration process through the production and promotion of health professionals for export.

How countries of origin promote the emigration of health professionals

In his review of the medical 'brain drain', Skeldon (2009) concludes that the impact of skilled migration to the development of sending countries remains unclear. However, aside from the dominant pessimistic argument on 'brain drain', he also recognizes the opposing view that the migration of the highly skilled can be beneficial to sending countries through remittances and return migration. His review concentrates on contextualizing the effects of 'brain drain' on the development of sending states rather than specific strategies of the sending state to address this phenomenon; even though, the two are closely linked. Similarly, Yeates (2009a, 2009b) informs us of some of policies of a selected number of major sending states in promoting the export of health professionals, but she limits her discussion on nurses within the GNCC framework. The GNCC is a conceptual framework that explains how sending countries venture in the production and export of women skilled labor (nurses) for the rich and developed countries on top of the care chain (Yeates, 2009b).[5] These two studies highlight the important role of sending states in the migration process, but did not discuss the actual implementation practices of sending countries in promoting the migration of doctors and nurses, especially concerning education and bilateral cooperation.

Investing in the health professional education system for export

The design of the medical and nursing education system is one of the key avenues in which we can see the sending state promoting health professional emigration. For example in training nurses for the international market, Ortiga (2014) argues that the Philippine educational system flexibly adjusts their nursing education curricula to the demand of employers of wealthier host countries. Her interviews with administration officials of universities and colleges offering nursing education revealed that they have to ensure that they produce 'world-class' nurses. Masselink and Lee (2010) categorize these nursing schools, including the review centers for licensure examination, as 'migrant institutions', because these institutions bridge the link between higher education and migration.

This aggressive strategy to increase the employability of Filipino nursing graduate in the international market has some drawbacks. The additional educational loads, especially offering new subject courses overburdened the students (Ortiga, 2014, pp. 68–69). Further, the Philippine educational institutions also struggle to handle the demand for more advanced medical facilities that should be at par with those from developed countries (Ortiga, 2014, pp. 68–69). However, the empirical literature did not explore how sending states' governments respond to these issues in terms of reviewing the existing curriculum and funding considerations to sustain this export promotion strategy.

Similarly, some governments of sending states encourage the establishment of more nursing schools and training centers in order to train more nurses for the global market. In India, the central government had relaxed in 2007 the policy on the requirements of opening private nursing schools to accommodate the domestic and foreign demands for nurses, but placed the quality of nursing education in the country at risk (Walton-Roberts, 2015, p. 378). Conversely, accreditation and training are the current policy challenges for the central government of India (Walton-Roberts, 2015, p. 378). We can view this scheme as a sending state-led effort to promote the emigration of nurses.

In another aspect, sending governments invested in exporting their health professionals are highly responsive to maintaining a good image. For instance, in the reported exam leakage on the Philippine Nursing Licensure Exam in June 2006, Masselink and Lee (2013) describe that government officials immediately responded through an investigation of the case and decided to conduct another examination to the same examinees on subject areas affected by the leakage. The Philippine government officials decided to do so, because they feared that Filipino nurses would lose their credibility and eventually reduce their employability in the international market, specifically in the US (Masselink & Lee, 2013, pp. 93–94). Masselink and Lee (2013) expound that the Philippine government saw the potential loss of the market this incident could have caused through the reduction of remittance earnings for the country.

In terms of medical education, we can indirectly locate the active promotion of health professionals for export in relation to the growth of medical schools in sending states. Mullan (2006, p. 385) reveals that the significant interest of prospective medical students for emigration has influenced the growth of medical schools in India (which during the time of his publication has 242 schools). From a micro perspective, Astor et al. (2005) demonstrate that physicians in India, Philippines, Columbia, Nigeria believe that their medical education equipped them with highly specialized skills that they can utilize in other countries. These authors illustrate that sending states deliberately prepare their medical students for foreign employment through the level of education that is recognized in destination countries, which supports their active role as policy actors in the migration process.

However, Mullan (2006, p. 385) describes the contrast between the growth of Indian medical schools, which is a manifestation of emigration promotion and the imposition of service bonds to medical students of government-run medical schools in some states. Although he did not substantially explain this contrast in strategy, Mullan (2006) signals that India has a large geographical inequality of the stock of physicians on top of the unreliable estimates of the outflow of doctors.

Bilateral cooperation

Scholars have recognized the importance of bilateral cooperation in promoting health professional migration on top of the domestic-led initiatives. Recent scholarships provide a descriptive review and analysis of this particular strategy (e.g. Ford & Kawashima, 2013; Yagi, Mackey, Liang, & Gerlt, 2014), but few of them have investigated in supporting this claim with empirical data. This section reviews the empirical data on bilateral cooperation as a policy instrument of sending states in securing a sustainable foreign market for health professionals. This review highlights some of the challenges and risks that sending countries have encountered when cooperating with destination countries and reveals different outcomes in realizing this strategy.

The 2010 WHO Global Code of Practice for the International Recruitment of Health Personnel (herein refer to as the Code) provides the overall framework of the bilateral cooperation in managing migration. Aside from the guidelines for ethical recruitment of health professionals from developing countries, the Code also encourages member-states to enter into bilateral agreements to manage health professional migration. Siyam et al. (2013), disclose that 85 of the 193 member-states have implemented the Code and only several countries have entered into bilateral agreements. These countries are mostly sending countries like the Philippines, Pakistan and Cuba, among others (Siyam et al., 2013, p. 817).

Implemented in 1995, the South Africa-Cuba bilateral agreement is a classic case of South-South development cooperation, which enables the recruitment of the surplus Cuban doctors to South Africa and medical students in the latter to train in Cuba (Hammett, 2007). Hammett (2014, p. 49) believes that this agreement meets the short-term and medium-term goals for both countries without having negative impacts in their health system. Doctors from Cuba benefited through professional experience, remittance, and political merit (Hammett, 2014, p. 45), while the Cuban government strengthened its good international image through a medical internationalism (Hammett, 2014, p. 44). For South Africa, the training of doctors in Cuba guaranteed a stable increase of physicians in rural areas in the long run (Hammett, 2014, pp. 45–46). While this strategy achieved gains for both countries, Hammett (2014, pp. 48–49) argues that the goal of ensuring the right fit of skills development and reintegration programs for South African doctors is a continuing policy and implementation challenges for two countries.

In the Philippines, Dimaya, McEwen, Curry, and Bradley (2012) reveal that the private and public stakeholders in nursing education and practice almost unanimously believed that the participation of the country in bilateral cooperation will stimulate brain circulation through a temporary migration scheme that effectively facilitates knowledge transfers aside from the financial benefits through remittance. Additionally, they disclose that policymakers have expanded the focus of bilateral agreements to requiring the destination country to invest in the human resource development. They also believe that this strategy will replenish the reduction of the stock of nurses due to emigration.

However, some bilateral agreements did not achieve favorable outcomes for sending states. In the Japan-Philippine Economic Partnership Agreement (JPEPA), the Philippines did not realize the intended benefits of this cooperation, because of the low deployment of nurses (Blank, 2011). Hosono (2011) attributes this failure to the inability of nurses to qualify for registration amidst the difficulty of passing the Japanese language proficiency exam. Despite this policy failure, Masselink and Lee (2013) stress that the Philippines deliberately pursued the implementation of JPEPA to attain the economic benefits from the agreement through the continuous flow of remittance from Filipino nurses in Japan.

Finally, although Young (2013) examines the effectiveness of the UK's ethical recruitment policy, he shows some important bilateral agreements of the UK with sending countries in the migration of nurses. For example, he describes the agreement between the UK and sending countries such as India, the Philippines and South Africa in the recruitment of nurses. However, to my knowledge, there are no other related empirical studies that scrutinize how the sending countries used these agreements to promote or restrict the emigration. For instance, Young (2013) mentions about the South African case to illustrate how a sending state engages in a bilateral cooperation to stop their nurses from leaving. Yet, he did not examine how South Africa implements this agreement. Similarly, there is no empirical study to date (based on my review of the literature) that investigates comprehensively how South Africa executes this bilateral agreement in restricting nurse immigration to the UK.

Discussion and direction for future research

There is a general absence in the literature about the role of sending states that specifically examines their actual migration management practices. By reviewing the extant literature published during 2004- June 2015, this paper has identified three distinct strategies that sending states apply to manage the emigration of their professionals. These sending countries (1) introduce restrictive measures to delay the mobility of their health professionals; (2) respond to market demands by producing health professionals and promoting their emigration; and (3) implement a combination of these two strategies. In contrary to the mainstream assumption about the passive role of sending states, these strategies show that sending countries are active policy actors in the migration management process. In this section, we can synthesize the key findings of this paper, determine the remaining gaps and present a future research agenda for addressing remaining issues.

Synthesizing policy responses of the sending states

The sending state devises and implements bond periods for government scholarship recipients to delay the emigration of their health professionals. They adopted this strategy to address the drivers of health professional migration and serve as a short-term solution to the massive outflow of doctors and nurses. This strategy is one way in which sending states try to play an active role in the migration process. The regulatory function of the sending state could help contain the negative effects of medical 'brain drain' and ensure that an adequate supply of health professionals is present in the domestic health system. Despite the active role of sending states, the empirical literature suggests that these countries did not directly address the economic perspective of the push and pull factors as one of the most dominant drivers of health professional migration. These

studies reveal that the improvement of the pay structure and working conditions of health professionals is still in the policy recommendation level and if realized could channel a long-term solution by maintaining a stable human resource in the health sector. A question still remains: How did the sending states accommodate other policy proposals in formulating the restrictive policy on the emigration of health professionals?

Another strategy of sending states is the production and active promotion of health professional emigration through education. The sending countries with a culture of migration such as India and the Philippines promote the emigration of their health professionals. The sending states' government prepares the international employability of health professionals through a 'world class' medical and nursing education to generate financial remittance that will help revitalize their economy. At the center of some of the sending states' education system are pressures directed toward private educational institutions to handle the higher cost of investment in infrastructure and technology and to ensure that the curricula will not overburden the students. The current literature has yet to capture the different views from other beneficiaries of this policy, which will show if the policymakers have considered and deliberated these demands during the policy-making process.

Further, the literature review uncovers that a sending state implements a combination of enforcing service bonds to students to delay emigration while promoting their emigration through internationally-recognized medical and nursing curricula. In formulating policies, statistical data on the stock vs. outflow of health professionals is a significant aspect to address this policy issue. The presence of conflicting data or unreliable estimates of this flow could contribute to incoherent strategies of sending states. Aside from this issue, what is, however unclear, is the motivation of the sending state in adopting this combination of strategies. This observation raises the following question: How do we account for the difference in sending states' strategies toward the emigration of their health professionals? These remaining questions lead to a future research agenda in examining how sending states formulate their strategies on the emigration of health professionals.

Future research agenda 1 – policy design of policy responses of the sending states

The strategies of the sending state are products of a policy-making process where different policy actors participate and put forward their different interests and positions to tackle health professional migration as a policy issue. The specific provisions of a particular policy or policies could not reveal the policy actors and their motivations behind sending states' strategies unless we look deeper on what transpired during the policy process. Thus, future research must include the motivations and beliefs of policy actors and technical information such as data support and policy studies that they use in putting forward their proposals in addressing this migration process.

Specifically, future research must trace how the actors compete, collaborate and compromise during policy deliberations to fully determine the policy proposals such as which actor dominates and possible reasons for the development of these policies. Some questions that could help in understanding these processes are: Who are the policy actors and what institutions do they represent? What are their key interests and motivations in the emigration of health professionals?

The policy design approach could examine these processes from the perspectives on how the policy actors – state and non-state actors interact (network analysis) and how policy actors deliberate these policies from different stages of the policy process

(stages-heuristic design) inside the sending states. These approaches are concerned with the interaction of different policy actors within the sending state in the design of sending states' strategies and thus, are essential in deepening our understanding on how and why these countries orchestrate and restrict emigration or a combination of these strategies. While the current theoretical approaches in migration studies such as political economy, sociology, anthropology, economics, gender studies or a combination of these fields help in understanding the role of sending states, they could not substantially address these questions. For this reason, future research could complement the theories in these fields by adopting the policy design perspective.

The examination of the policy design of these strategies could also unravel the existing puzzle on why sending states are explicitly promoting the production of nurses in comparison to doctors. As cited in this paper, Masselink and Lee (2013), Ortiga (2014), and Walton-Roberts (2015) examine how sending states such as India and the Philippines promote the emigration of nurses while other scholars did not explicitly discuss this strategy with respect to doctors. Future studies could integrate the GNCCs into the policy network analysis to explain the interaction of international and domestic networks in the migration process of nurses. Network analysis could specifically identify the state and non-state actors within the GNCC and locate their competing motivations and beliefs in the active promotion of nurse export. Likewise, GNCCs could also provide inputs in tracing the absence of explicit export policies for doctors.

Synthesizing the participation of sending states in bilateral cooperation

The 2010 WHO Code promotes bilateral cooperation among sending and receiving states as an essential strategy to protect the unethical recruitment of health professionals from countries where there is a shortage of these skills. However, some theory on international cooperation, for instance, neoliberalism from the field of international relations assumes that cooperating states gain from cooperation (e.g. Keohane, 1984). From this assumption, we could observe that voluntary codes, such as the WHO, have moved toward mutuality and away from compensation. Likewise, this mutuality is also noticeable in the UK's health professional recruitment code, where the country can recruit nurses only from developing countries with a critical supply of nurses when both countries (UK and sending countries) have signed a bilateral agreement. The recruitment code is UK's response to the negative criticisms of the National Health Service's long history of recruiting internationally educated health professionals (e.g. Raghuram, 2009). Although limited in scope, empirical studies reviewed apparently unveil that bilateral cooperation is a state mechanism to guarantee a market for health professionals.

What is appealing, however, is to consider that sending states employed bilateral cooperation as a strategy to regulate the outward migration of health professionals (e.g. South Africa) and for the active promotion of emigration (e.g. India and the Philippines). A research question could be: Why do some sending states cooperate with other destination countries, and others do not? Siyam et al. (2013) observe that there is a slow movement of forging bilateral cooperation in the health professional migration. Considering the benefits of cooperation, other research questions could explore the following: Why are some states reluctant to engage in this form of cooperation?, and Why is cooperation primarily geared towards the emigration of nurses and rarely with doctors? Future researchers could examine these research questions by tracing processes of bilateral cooperation through the development of bilateral negotiations from the initiation stage until ratification of bilateral agreements.

Future research agenda 2 – the processes in bilateral cooperation

In this paper, most of the empirical studies reviewed are interested in the impact of bilateral agreements (e.g. Hammett, 2007, 2014; Hosono, 2011) and not in the processes before their implementation. Examining the development of bilateral negotiation is important in answering the remaining questions, because it will reveal who the negotiating actors are, their motivations, beliefs and agenda during the stages of negotiation. The public policy field could contribute to address this gap by identifying the negotiating actors in sending states, both state and non-state in the negotiation process. This field of study could also pinpoint these actors' positions and how they negotiate with destination countries. Additionally, some future empirical research could also adopt a multi-level analysis that analyzes the domestic process of negotiation, often occurring at multiple levels and across different policy sectors, and linking these with negotiations at the international levels until these bilateral agreements are ratified. By integrating this theoretical framework with the GNCC concept, we can significantly explain the gendering of health professional migration through bilateral cooperation with respect to the international mobility of nurses. Overall, from these two frameworks, we could justify the cooperation and non-cooperation of sending states in the health professional migration.

The analysis of these two future research agendas could be a significant contribution to the growing emphasis on studying the sending state in health professional migration. These research agendas could provide an in-depth analysis of the interaction of policy actors and negotiating actors in the development of sending states' policies and in bilateral negotiations, respectively as important interventions in addressing this migration issue. While these interventions are also evident in some theoretical and descriptive migration literature, these future research agendas extend to a broader perspective of integrating policy sciences and international politics to the existing frameworks that investigate the role of sending states in the health professional migration.

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Notes

1. Please see Massey et al. (1993) for a critical review and appraisal of the theories of migration across disciplines.
2. Some literature introduces the concept of transit countries (e.g. Collyer, Düvell, & de Haas, 2012). Collyer et al. (2012) refers them to countries that have borders connected to the rich and developed countries of the European Union (e.g. Turkey, Morocco) which belongs to another set of literature that mostly focus on unauthorized migration.
3. See for example the migration trend of foreign-trained nurses in the UK in Buchan (2006) and the global trend of doctors and nurses in OECD (2015).
4. See also Tumbe (2012) for a historical account of migration culture using district-level data within the context of remittance-based migration in India.

5. The GNCC is an expanded framework of global care labor that originates from Hochschild's Global Care Chain (GCC) concept. Hochschild (2000, p. 131) defines GCC as 'a series of personal links between people across the globe based on the paid and unpaid work of caring'. Yeates (2009b, p. 176) interprets this concept as a productive framework that explains 'how processes of outsourcing, commodification and commercialisation of care in the richer countries were drawing women from poorer parts of the world to emigrate to provide a range of social care services for women, men and children'. Hochschild (2000) develops this concept from the perspective of domestic helpers as a form of low skilled labor. Yeates (2009b, p. 176) argues that nursing falls from the professional category of 'care' acquired through formal education and training; hence the birth of GNCC.

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