

Chapter 7

Expanding the coverage of social protection and health services for better migration and development outcomes

Social protection and health coverage play an increasingly important role in development policy, including the Sustainable Development Goals. This chapter considers the impact of migration on such services, whether increasing demand or supporting their provision. It first looks at how new entrants into the country, such as immigrants and return migrants, use and contribute to the system. It then analyses whether remittances are used for social and health expenditures, highlighting differences in urban and rural localities. The chapter also investigates how social protection and health policies might affect decisions to migrate and remit, based on individual and household coverage of such policies.

Social protection is concerned with preventing, managing, and overcoming situations that adversely affect people's well-being (UNRISD, 2010). From a policy perspective, they are enacted through labour interventions, social insurance and social assistance (i.e. transfers).¹ Good social protection and health coverage are essential to society as they promote social cohesion, ensure happier lives and improve productivity, yet more than 70% of the world population lacks proper social protection (ILO, 2014) and at least 400 million people worldwide do not have access to essential health services (WHO and World Bank, 2015).

The international community has committed to improving on this front. The International Labor Organization's (ILO) 2012 Social Protection Floors Recommendation (Recommendation Number 202) aims to get countries to guarantee access to essential health care and basic income security, nutrition and education for children, older persons and those of active age but unable to earn a sufficient income (ILO, 2012). In addition, two landmark commitments were made by leaders from governments and United Nations organisations, city chiefs, and health experts from around the world at the 9th Global Conference on Health Promotion in November 2016, on bold political choices concerning health: The Shanghai Declaration on Health Promotion and The Shanghai Healthy Cities Mayors' Consensus (WHO, 2016). Social protection and health concerns are set to play an increasingly important role in development policy with the adoption of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs), most prominently:

- **SDG 1**, which aims at ending poverty and explicitly calls for the implementation of nationally appropriate social protection systems, particularly where the poor are concentrated: micro and small enterprises and the informal sector.
- **SDG 3**, which aims to ensure healthy lives and promote well-being for all at all ages, and universal health coverage.
- **SDG 8**, which aims at decent work – opportunities to find work that provides social protection for families.
- **SDG 10**, which aims at adopting social protection policies, and progressively achieving greater equality.

As social protection gains in importance in many countries, so does its potential to interact with migration outcomes in many ways. The United Nations' New York Declaration for Refugees and Migrants for instance, adopted in September 2016 by the United Nations General Assembly, commits member states to taking measures to improve the integration of immigrants through access to education and health care, amongst other things (UN, 2016). Migrants can be users of services, but they can also contribute to them. Households may use remittances to finance social expenditures, thus expanding the private sector and even providing an incentive for governments to spend less on social protection. On the other hand, social protection policies can determine whether people stay or leave the country, whether remittances are sent and whether integration is successful. This chapter considers how migration affects the social protection sector and whether policies in the sector affect migration.

The chapter is divided into four sections. The first section provides a contextual overview of the social protection and health sectors in six of the IPPMD project countries and the data collected in 2014-15. The second section discusses the impact of the four dimensions of migration – emigration, remittances, return migration and immigration – on social protection and health. The third section explores the impact that social protection and health policies may have on the decisions to migrate, whether to send remittances, whether to return, and the chances of successful integration in the host country. The chapter concludes with a series of policy recommendations.

Table 7.1. **Migration and social protection and health: Key findings**

How does migration affect social protection and health?	How do social protection and health policies affect migration?
<ul style="list-style-type: none"> Return migrants and immigrants are less likely to benefit from government transfers than non-migrants. 	<ul style="list-style-type: none"> Public investment in social protection tend to curb emigration.
<ul style="list-style-type: none"> Immigrants are less likely to pay taxes because of their concentration in the informal sector. 	<ul style="list-style-type: none"> Increased social protection coverage reduces the probability of receiving remittances.
<ul style="list-style-type: none"> Remittances are not often used for social expenditures generally, but are used for specific expenditures on and use of health facilities. 	<ul style="list-style-type: none"> Having better access to social protection reduces the likelihood of immigrants returning to their home countries.
	<ul style="list-style-type: none"> Access to social protection and health services foster the integration of immigrants.

Note: These findings do not apply to all countries. More country-specific findings can be found in the IPPMD country reports.

Overview of social protection and health in the ten partner countries

The IPPMD project collected data on social services use, coverage and expenditures; types of labour contracts; and employment benefits, for six countries, Armenia, Costa Rica, Côte d'Ivoire, the Dominican Republic, Georgia and Morocco.² However, data on immigrants were not collected in Georgia, and the number of immigrants sampled was small in Armenia (127 immigrants in 75 households) and Morocco (52 immigrants in 39 households). Therefore, analyses of immigrants focus solely on Costa Rica, Côte d'Ivoire and the Dominican Republic. All sampled households were surveyed, including rural and urban ones, and those with and without all types of migrants (current emigrants, return migrants and immigrants; Chapter 2). Some questions were asked at the household level, including on social expenditures, government transfers and distance to the nearest health clinic. Others, such as on the use of services, the type of labour contracts and the benefits included, were asked to individuals over the age of 14.

This chapter compares various groups of households or individuals depending on their migration background: households receiving remittances (from any source, not just former members) are compared to households not receiving remittances. Individual return migrants are compared to individuals that have no migration background at all. Immigrants are compared to native-born individuals, including return migrants (Chapter 2).

The presence and importance of social protection varies quite widely across countries, and strategies also vary in their objectives. A universal social protection system is costly and can often seem out of reach for developing countries. However, there is a global trend towards extending both health and social protection coverage (Honorati et al., 2015; WHO and World Bank, 2015). All IPPMD countries share the aim of expanding their social protection coverage (Box 7.1).

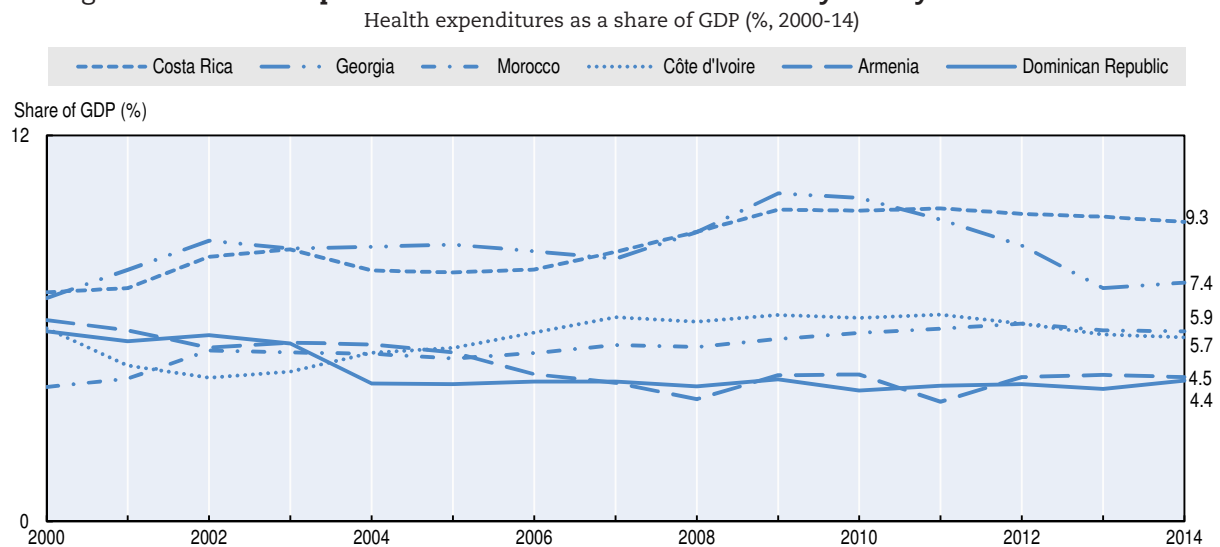
Box 7.1. Social protection in the IPPMD countries' national development strategies

In addition to having a prominent place in the SDGs, social protection is also a main feature in national development strategies.

- In Armenia's 2014-25 Perspective Development Strategic Programme, the improvement of the social protection system is one of its four key priorities.
- In Costa Rica's 2015-18 National Development Plan, the first three key strategic sectors discussed are 1) labour and social security; 2) human development and social cohesion; and 3) health, nutrition and sport.
- Côte d'Ivoire's 2016-20 National Development Plan outlines strengthening social protection systems as a key part of the fight against vulnerability and as a major challenge for the country.
- The Dominican Republic's 2010-30 National Development Strategy describes the gap in the provision of health services and the insufficient growth in decent employment as major shortcomings. One of the strategy's four axes is to guarantee health and comprehensive social security for everyone within a framework of territorial cohesion.
- In Georgia's 2014-20 national development strategy (Georgia 2020), improving the social assistance system is a sub-pillar of the main strategy on the development of human resources.
- While no overarching national strategy provides direction for the social sector in Morocco, the 2012-16 sectoral health strategy comprises seven axes, one of which is improvement in access to health services, health outcomes for vulnerable populations and resources for health. Morocco's 2015-25 national employment strategy also has a pillar dedicated to enhancing human capital, with an objective of expanding social protection coverage.

The IPPMD countries provide a broad array of social protection coverage. Figure 7.1 provides a picture of health expenditures as a percentage of gross domestic product (GDP) in the IPPMD countries, from 2000 to 2014.

Figure 7.1. **Health expenditures in the IPPMD countries vary widely as a share of GDP**



Note: Health expenditure includes both public and private health expenditures. Only IPPMD partner countries covered in this chapter are shown.

Source: World Bank, *World Development Indicators*, <http://data.worldbank.org/products/wdi>.

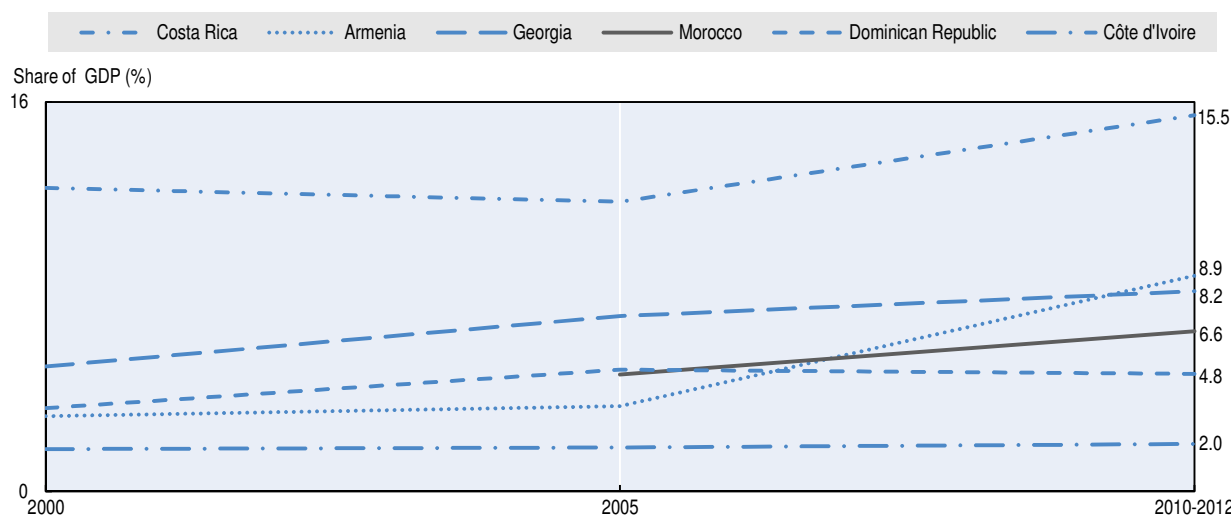
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Costa Rica and Georgia spend relatively large shares of their GDP on health provision. Spending on health has fluctuated in some countries, but less so in others. Georgia spent roughly the same share of GDP in 2014 (7.4%) as it did in 2000 (6.9%), but expenditures had reached 10% in 2009-10. In Costa Rica, health expenditures in 2000 amounted to 7.1%, and they increased to 9.3% by 2014, a 2.2 percentage point increase and an increase of about 31% over the period. No country had a higher relative percentage increase than Morocco, where the share of health expenditures grew 1.7 percentage points, from 4.2% in 2000 to 5.9% in 2014 (a 41% increase). On the other hand, in Armenia and the Dominican Republic the share of GDP spent on health fell substantially between 2000 and 2014, by 28% and 26% respectively.

The shares shown in Figure 7.1 are for total expenditures (including private ones), but the role of government ranges widely across countries. In Costa Rica, 73% of health expenditures were from public sources in 2014. Public expenditures were also relatively high in the Dominican Republic (67% of total expenditures), while in contrast, they were below 50% of total health expenditures in Georgia (21%), Côte d'Ivoire (29%), Morocco (34%) and Armenia (42%) (World Bank, 2016a).

Looking at social expenditures, Costa Rica is by a wide margin the country spending the most at 15.5% of GDP in 2010, while Côte d'Ivoire spends the least at around 2% in 2011 (Figure 7.2). The growth rates also varied between countries. Expenditures over the 2000 to 2012 period grew fastest in Armenia at 161%, whereas they barely changed in Côte d'Ivoire from 2000 to 2011.

Figure 7.2. **Social expenditures in the IPPMD countries vary widely as a share of GDP**
Social expenditures as a share of GDP (%), 2000-2010/12



Note: Data availability varies by country. For Morocco, the starting point is 2005, while for all other countries it is 2000. For Costa Rica, the Dominican Republic and Morocco, the ending point is 2010, while for Côte d'Ivoire it is 2011 and for Armenia and Georgia it is 2012.
Source: ILO, ILOSTAT Database, www.ilo.org/ilostat.

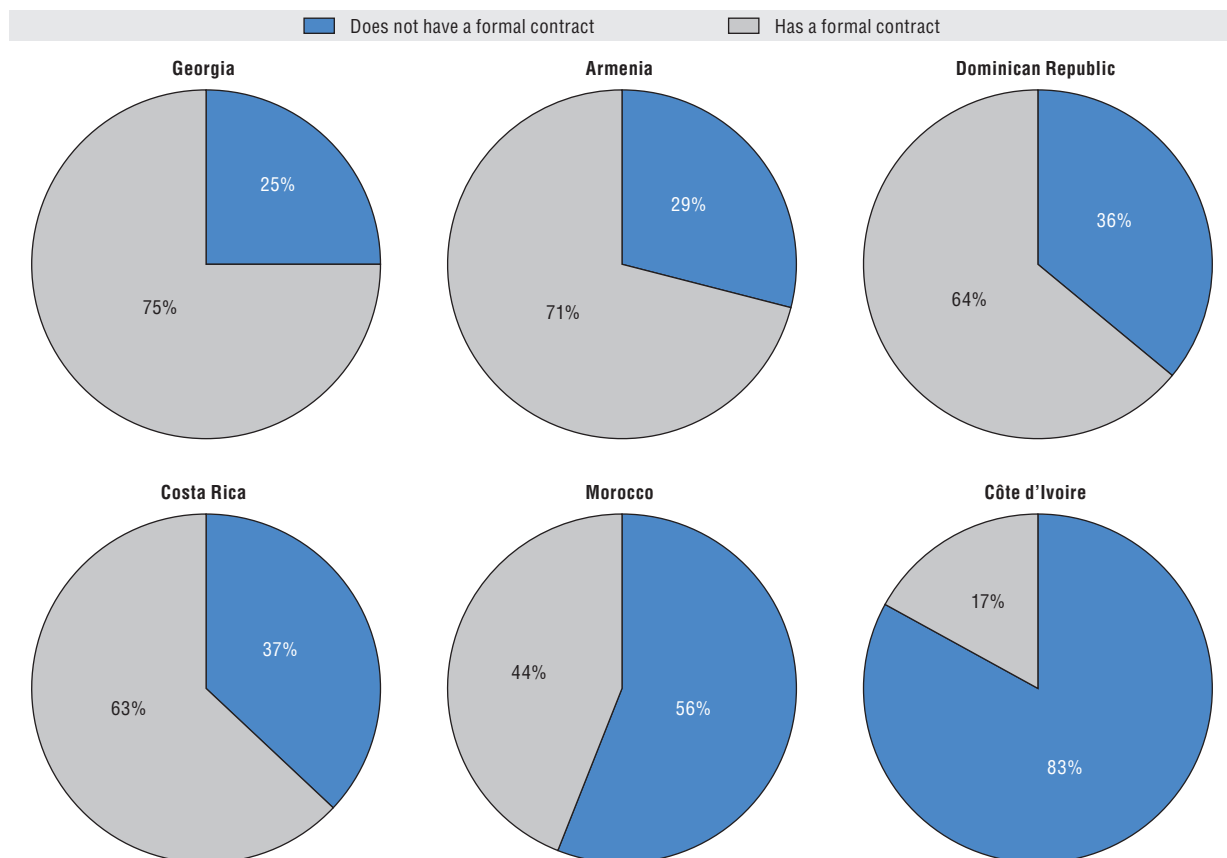
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There is a diversity in how countries spend on social protection. According to the World Bank's ASPIRE Database, which looks specifically at expenditures on social assistance transfers, in Georgia, expenditures are mostly for social pensions, in Armenia for cash transfers, in the Dominican Republic a mix of in-kind transfers, school meals and fee waivers, while in Costa Rica, it is mostly attributable to conditional cash transfers. For social contributions in Costa Rica, compulsory payments made to the government make up a relatively large share of the country's total revenue (World Bank, 2016b).

Having a formal labour contract is an important determinant of social protection – not only for workers, but also their families. They minimise the likelihood of working under precarious conditions and increase the probability of obtaining work-related benefits and insurance. Many of the benefits covered in formal labour contracts also extend to immediate family members. Formal labour contracts often ensure that workers use legal systems if problems arise between the worker and the employer (OECD, 2009). It is a general reflection of the level of social protection coverage in a country. Figure 7.3 presents an overview of the IPPMD findings on labour contracts.³ The percentage of workers without formal contracts varies widely across the countries, from 25% in Georgia to 83% in Côte d’Ivoire. It is important to note that the percentage in the IPPMD data is lower than the official figures for Costa Rica (44%) and the Dominican Republic (49%), and higher than the official figures for Armenia (20%) and Côte d’Ivoire (70%) (ILO, 2013).⁴ This may reflect the difficulty of accurately sampling informal urban workers in Costa Rica and the Dominican Republic. It may also reflect the level of informal employment in the regions that were sampled in those two countries, as coverage was not national. The official figures for Côte d’Ivoire certainly report people employed in the informal sector but omit those informally employed outside of the informal sector,⁵ which would increase the official figure and make it closer to that found in the IPPMD data.

Figure 7.3. **Rates of informal work vary enormously among IPPMD countries**

Share of non-agricultural workers without formal labour contracts (%)



Note: Individuals employed in the agricultural sector are not included. Agricultural occupations are defined by agricultural, forestry and fishery workers (ISCO category 6), as well as those working in elementary occupations in those fields (ISCO category 92), except for Morocco where elementary occupations are not included as agricultural occupations as they cannot be identified from the data.

Source: Authors' own work based on IPPMD data.

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How does migration affect social protection and health?

One of the major effects migration has on social protection and health comes down to whether migration is allowing individuals to contribute more to the system than they are taking out, and whether remittances are being used to pay for services in the sector. The question can be explored by breaking it down as follows:

1. Entrants into the country can be users of services. These consist of:
 - a. immigrants – who may have limited *de jure* and *de facto* access to the services for a number of reasons
 - b. return migrants – who often have previous knowledge of the system and generally easier access.
2. Entrants can also contribute towards replenishing the system:
 - a. emigrant workers⁶ may leave the sector while immigrant and return migrant workers may fill the vacancies
 - b. immigrants and return migrants can help finance the services by paying taxes and through deductions from labour income.
3. Remittances may be used to cope with shocks, which may spur more supply from the private sector, and in extreme cases provide an incentive for governments to spend less on social programmes.

This section explores some of these issues, drawing on the empirical analysis of the IPPMD dataset.

Immigrants and return migrants use social services less than other individuals

There is a common belief in many countries that immigrants are net beneficiaries of social services, and thus have a negative fiscal impact. If many entrants, whether immigrants or return migrants, use social facilities, an increase in either group may increase the pressure on the system. Evidence on the net fiscal impact of immigration focusing on OECD countries finds that on average the impact is either very small relative to GDP or zero. The variation across countries can be largely accounted for by whether immigrants are working and if they entered for labour, family or humanitarian reasons; labour migrants tend to contribute the most (OECD, 2013).

The IPPMD team collected data on whether households received government transfers for social services; whether individuals had visited a health-related facility and if so, how often in the past 12 months.⁷ In the three IPPMD countries where immigration is studied – Costa Rica, Côte d’Ivoire and the Dominican Republic – immigrant households tend to be less likely than households without immigrants to receive social transfers from the government (Figure 7.4).

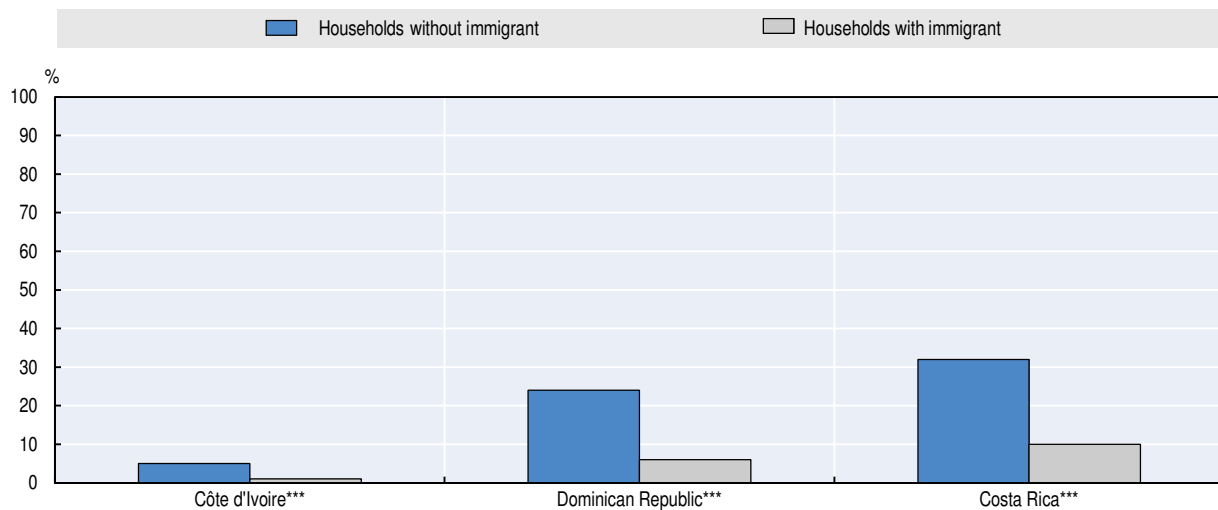
Moreover, regression analysis controlling for the household’s size, wealth, and a rural and geographic regional dummy variable confirms the negative link between being an immigrant household and receiving social protection for Costa Rica, Côte d’Ivoire and the Dominican Republic (Table 7.2). The data also show, moreover, that whether the household resides in a rural or urban region does not determine this result.

Return migrants have more knowledge of the country, and therefore may use the system differently than immigrants, and more like others living in the country. They may return to retire, claiming a pension from their previous employment in the country. However, here too, the results for Armenia and Georgia suggest that return migrants are less likely to receive governmental

transfers than other native-born individuals (Table 7.2). Both countries have actively called for emigrants to return to the country, following the years of unsteady growth in the countries. With better employment and living standard prospects, it could be that prime age and educated emigrants are returning to the country, characteristics of individuals that typically necessitate fewer social transfers. In Armenia, circular migrants that work part of the year in Russia may not stay long enough in Armenia to qualify for such transfers. While the results were valid for both rural and urban regions in Armenia, in Georgia return migrants are less likely to access government transfers than other native-born individuals exclusively in rural areas.

Figure 7.4. Households with immigrants are less likely than households without immigrants to receive government transfers

Share of households receiving government transfers (%), by whether they have an immigrant



Note: Governmental transfers include pension payments and any other social payment received from the government (including for health). Statistical significance calculated using a chi-squared test is indicated as follows: ***, 99%, **, 95%, *, 90%. Countries are ordered according to the ratio of households without immigrant over immigrant ones.

Source: Authors' own work based on IPPMD data.

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Table 7.2. The links between migrant status and government transfers

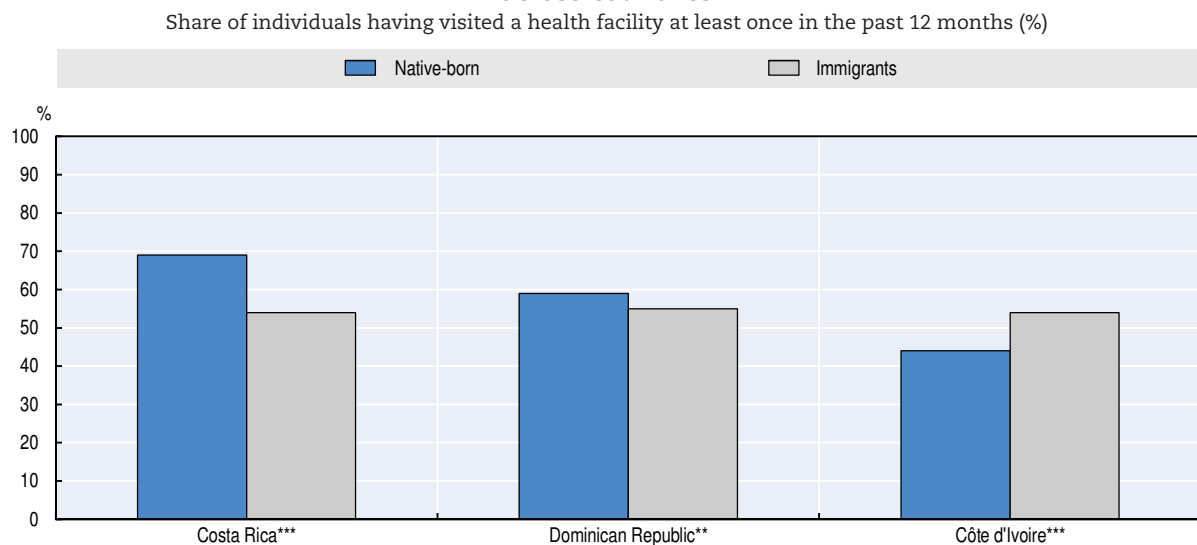
Dependent variable: Household received government transfers		
Variables of interest: Household has an immigrant and household has a return migrant		
Type of model: Probit		
Sample: All households		
Variable of interest:	Household has an immigrant	Household has a return migrant
Armenia	n/a	↓
Costa Rica	↓	
Côte d'Ivoire	↓	
Dominican Republic	↓	
Georgia	n/a	↓
Morocco	n/a	n/a

Note: Arrows reflect the sign of the relation between the dependent variable and the main independent variable of interest and are presented only when the significance level is at 90% or higher. The analysis of return migrants does not include households with any other link with migration (emigration, remittances or immigration). Results denoted "n/a" refer to countries for which data were not collected.⁸

Turning to health services, the data suggest that individual immigrants are not necessarily more likely to use a health facility than native-born individuals (Figure 7.5). In fact, in Costa Rica and the Dominican Republic they are less likely to do so, although

regression analysis shows that the results for the Dominican Republic are not robust when other determinants are considered such as gender, age, household size and rural setting (Table 7.3). In Côte d'Ivoire, immigrants are more likely to use health services than native-born individuals. In general, and across all countries, women, older individuals, and those living in smaller and rural households are more likely to have used a health facility in the past 12 months. In fact, running separate regressions for each gender and whether the individual lives in a rural or urban region shows that the difference in use between immigrants and native-born individuals in Côte d'Ivoire is true for women, but not for men. Whether the individual lives in an urban or rural area does not explain this difference.

Figure 7.5. **Immigrant versus native-born individuals' use of health services varies across countries**



Note: Statistical significance calculated using a chi-squared test is indicated as follows: ***: 99%, **: 95%, *: 90%. Countries are ordered according to the ratio between native-born individuals and immigrants.

Source: Authors' own work based on IPPMD data.

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Table 7.3. **The links between migrant status and use of health facilities**

Variable of interest:	Immigrant	Return migrant
Armenia	n/a	
Costa Rica	↓	
Côte d'Ivoire	↑	
Dominican Republic		
Georgia	n/a	↑
Morocco	n/a	

Note: The arrows indicate a statistically positive (upwards arrow) or negative (downwards arrow) relation between the dependent variable and the main independent variable of interest. Countries with "n/a" refer to the fact that the data were not collected in that country or that sample sizes are too small to analyse. The analysis on return migrants does not include immigrants or individuals living in households receiving remittances.⁹

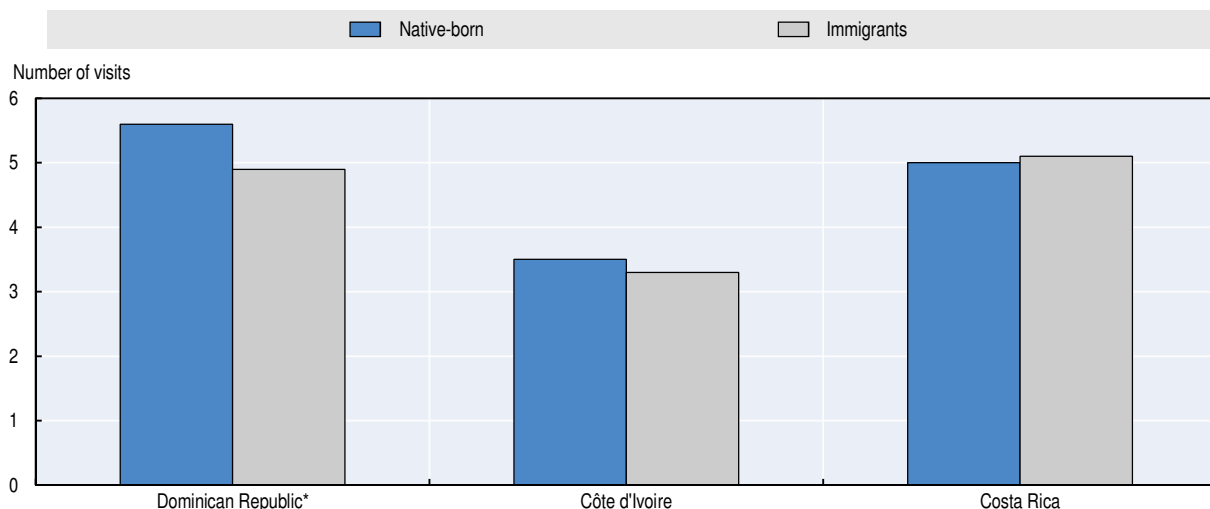
Return migrants use health services like others. The one exception is in Georgia, where they are more likely to use them. Georgia is also the only country where the use of health services is more common in urban areas. Return migrants settling in urban areas may therefore choose to do so in cities because health services are better and improving compared to those in rural areas.

The frequency with which groups use health services is another part of the picture. On average, among individuals who had visited a health facility at all in the past 12 months, the average number of individual visits varied across countries: 4.4 in Armenia, 5 in Costa Rica, 3.4 in Côte d'Ivoire, 5.5 in the Dominican Republic, 4.9 in Georgia and 1.1 in Morocco.

Immigration status made no statistically significant difference to the number of times individuals visited health facilities in the past 12 months (Figure 7.6). Among those who had used health facilities at least once, immigrants visited on average the same amount of times as native-born individuals, and even slightly less in the Dominican Republic. The picture is similar for return migrants in Armenia, Côte d'Ivoire, Costa Rica, the Dominican Republic, Georgia and Morocco (not shown). An ordinary least squares (OLS) regression analysis, controlling for age, gender, education level, whether the individual lives in a rural or urban area and a regional control variable confirms (results not shown) that the differences between immigrants or return migrants and others living in the country are not statistically significant.

Figure 7.6. **There is little difference between how often immigrants and native-born individuals use health services**

Average number of visits to health services in the past 12 months



Note: Statistical significance calculated using a t-test is indicated as follows: ***: 99%, **: 95%, *: 90%. Countries are ordered according to the ratio between the average number of visits by native-born individuals over immigrants.

Source: Authors' own work based on IPPMD data.

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There is therefore no evidence that immigrants or return migrants put pressure on the system, at least in terms of government transfers and use of health services. However, much of the difference between immigrants and native-born individuals has to do with the needs of the immigrant population. Immigrants often arrive in their prime, to work. Their need for social transfers is thus often at a minimum. Moreover, the IPPMD data suggest that

social benefits are not a reason to immigrate to or to specifically choose the host country. Finally, immigrants may remain unregistered with any governmental authority, limiting the possibility to access such services.

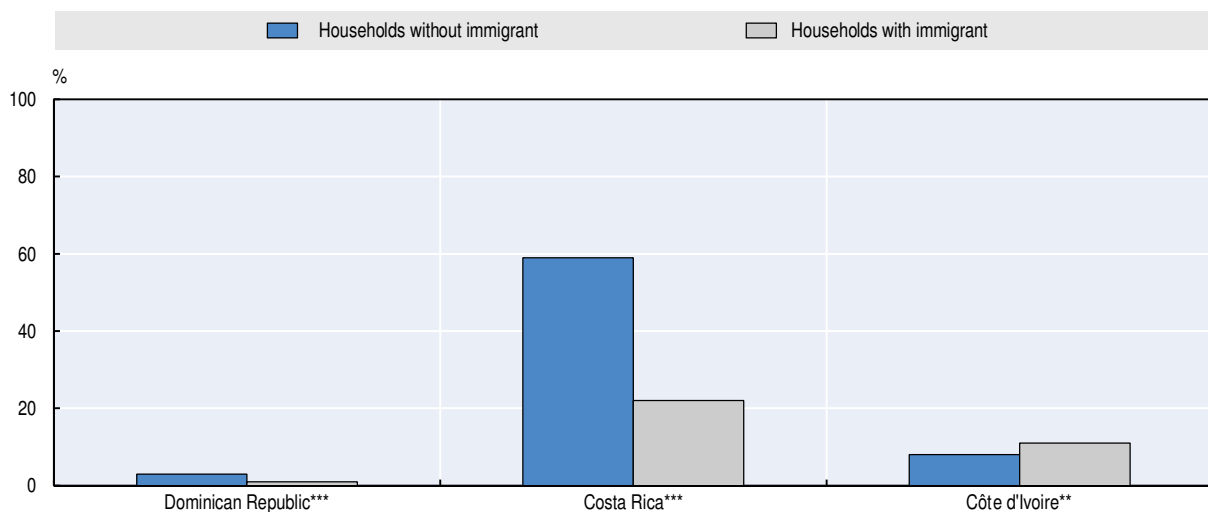
Immigrants are less likely to pay direct taxes, partly because they do not have formal job contracts

Immigrants and return migrants can contribute to the social protection sector by financing it through taxes or payroll deductions, which usually necessitates a formal labour contract. The IPPMD project collected data on whether households paid direct taxes,¹⁰ how much they paid in the past 12 months and whether individual workers had a formal labour contract.¹¹

Compared to households without immigrants, those with immigrants tend to be less likely to pay direct taxes in Costa Rica and in the Dominican Republic, although the response rate in the latter is very low. In contrast, immigrant households in Côte d'Ivoire are more likely to pay taxes (Figure 7.7). A probit regression model confirms these results in both Costa Rica and Côte d'Ivoire (Table 7.4). One likely reason for the positive results in Côte d'Ivoire is that the immigrant population there is long established and relatively well integrated into the country's system. Many work with established companies in the cacao plantations.

Figure 7.7. Households with immigrants in Costa Rica and the Dominican Republic are generally less likely to pay taxes than households without immigrants

Share of households paying taxes (%), by whether they have an immigrant



Note: Sample size of households claiming to have paid taxes is small in the Dominican Republic (53). Statistical significance calculated using a chi-squared test is indicated as follows: ***: 99%, **: 95%, *: 90%. Countries are ordered by the ratio of shares of households without immigrants over immigrant ones.

Source: Authors' own work based on IPPMD data.

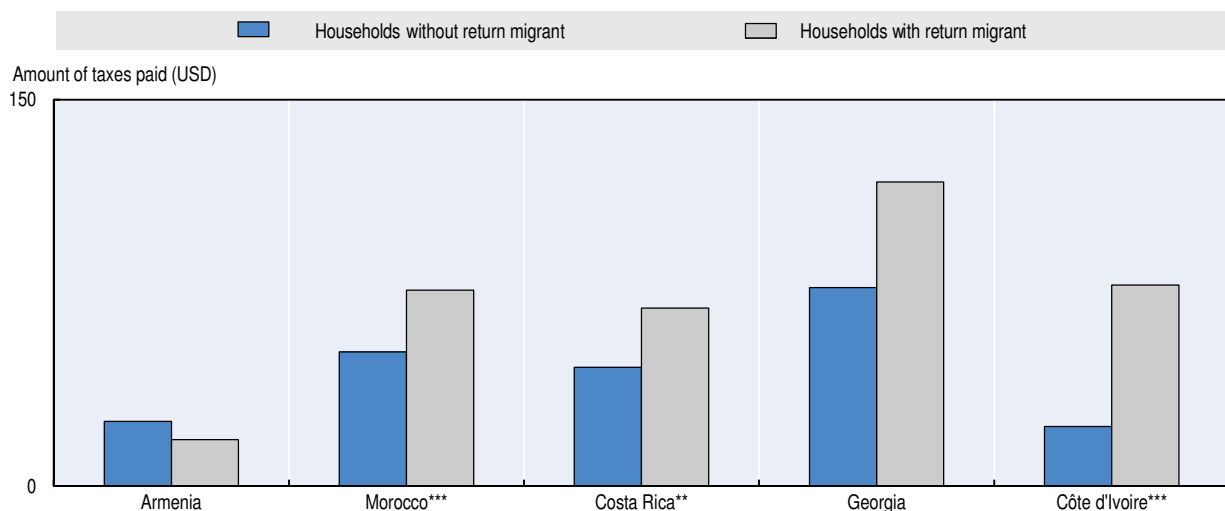
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Households with return migrants tend to be more likely to pay taxes in Armenia but less likely in Morocco, although neither of these differences are confirmed by a probit model (Table 7.4). Instead, regression analysis controlling for household wealth and size shows that households with return migrants are less likely to pay taxes in Costa Rica.

But it is not just about paying taxes – it is also how much one pays. The IPPMD team also collected data on how much tax households paid in the previous 12 months. There is virtually no difference between the amount of taxes paid between households with and without immigrants in most countries, and in fact, households with immigrants pay even more in Costa Rica, according to regression analysis (Table 7.4).

Households with return migrants pay more taxes than households without return migrants in four of the five countries examined, and the trend is confirmed by regression analysis in Costa Rica, Côte d'Ivoire and Morocco (Figure 7.8 and Table 7.4). This suggests that return migrants in these countries have returned to productive jobs, after working and gaining experience abroad. In any case, they help finance the social protection system.

Figure 7.8. **Households with return migrants generally pay more direct taxes than those without**
Average amount of taxes paid in the last 12 months per household member (USD), by whether the household has a return migrant



Note: Exchange rate calculated on 1 July 2014. Statistical significance calculated using a t-test is indicated as follows: ***: 99%, **: 95%, *: 90%. Figure only includes households that pay taxes. Countries are ordered according to the ratio of the shares of households without any return migrant over households with one. The Dominican Republic is not included due to its small sample size. Households without return migrants does not include households with any link with migration, including emigration, remittances and immigration.

Source: Authors' own work based on IPPMD data.

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Table 7.4. **The links between migrant status and household tax payment**

Dependent variable:	Paid taxes		Amount of taxes paid	
Variable of interest:	Immigrant	Return migrant	Immigrant	Return migrant
Armenia	n/a		n/a	
Costa Rica	↓	↓	↑	↑
Côte d'Ivoire	↑			↑
Dominican Republic				
Georgia	n/a		n/a	
Morocco	n/a		n/a	↑

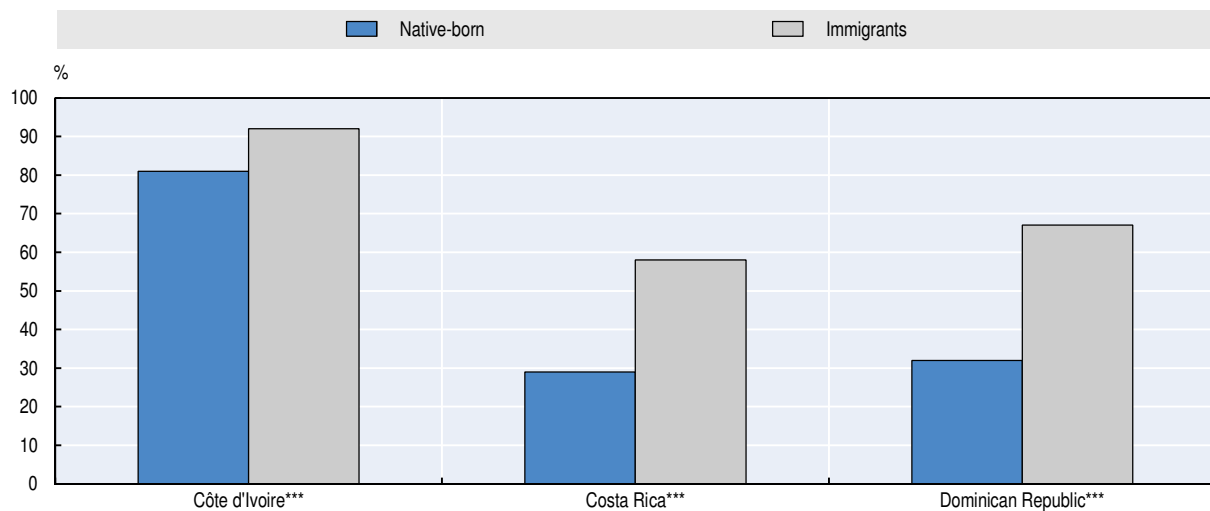
Note: The arrows indicate a statistically significant positive or negative relation between the dependent variable and main independent variable of interest. Countries with "n/a" refer to the fact that the data were not collected in that country or that sample sizes are too small to analyse. The analysis of return migrants does not include households with any other link with migration (emigration, remittances or immigration).¹²

There are a number of reasons why immigrants may tend to be less likely to pay taxes. First, households with immigrants may not stay long enough to be required to pay taxes, since they often work seasonally. Second, and possibly the main reason, is that immigrants are more likely to work outside of the formal sector, and therefore to be outside of the tax collection system. Figure 7.9 compares immigration status with having a formal labour contract for working individuals. Immigrants in Costa Rica, Côte d'Ivoire and the Dominican Republic stand out as being overwhelmingly more likely to be informally employed than native-born individuals. The differences between immigrants and native-born individuals were confirmed through regression analysis in all three countries (Table 7.5). Indeed, this seems to be related to whether the household paid direct taxes. Although all three countries show that having a member with a formal labour contract is correlated with the household paying taxes, the difference in shares of households that paid taxes while having a member with a formal labour contract was much larger in Costa Rica (55% vs. 32%) than in Côte d'Ivoire (12% vs. 9%), which may partly explain why households with immigrants are less likely to pay taxes than households without immigrants in Costa Rica and not in Côte d'Ivoire.

The regression results suggest that this has much to do with workers' individual characteristics, and therefore likely with their occupations. For instance, more highly educated and older workers were more likely to have formal labour contracts. In Costa Rica, formal labour contracts were more common for men and in urban regions, which suggests that informal employment is more prevalent among women and in rural areas, for example domestic work and retail and cottage industry activities.

Figure 7.9. Immigrants are more likely to lack a formal labour contract

Share of non-agricultural workers without a formal labour contract (%)



Note: Agricultural, forestry and fishery sectors are not included (ISCO group 6 and 92). Statistical significance calculated using a chi-squared test is indicated as follows: ***: 99%, **: 95%, *: 90%. Countries are ordered according to the ratio of shares of native-born individuals over immigrants.

Source: Authors' own work based on IPPMD data.

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Non-agricultural return migrant workers were also more likely to lack a formal contract in Armenia and Morocco. In Armenia, this has probably to do with short stays in the home country due to seasonal migration movements (not shown), which can be outside of the

agricultural sector (e.g. the construction sector in Russia). In Morocco, it is correlated with younger and less educated individuals, possibly reflecting the fact that many youth have started returning to Morocco as employment opportunities are on the rise and the push to leave Europe following a general crackdown on irregular migrants. Many may be finding informal jobs in the country, finding it difficult to land a formal job after not having lived there for many years.

Table 7.5. **The links between migrant status and formal employment**

Variable of interest:	Immigrant	Return migrant
Armenia	n/a	↑
Costa Rica	↑	
Côte d'Ivoire	↑	
Dominican Republic	↑	
Georgia	n/a	
Morocco	n/a	↑

Note: The arrows indicate a statistically significant positive or negative relation between the dependent variable and main independent variable of interest. Countries with n/a refer to the fact that data were not collected in that country. The analysis of return migrants does not include households with any other link with migration (emigration, remittances or immigration).¹³

In summary, while immigrants and return migrants do seem to use social services less than native-born individuals (and households), they also seem to contribute less towards them because of their concentration in the informal sector. This may be due to a lack of recognition of their educational qualifications, or a lack of opportunities in the formal sector. Overcoming these barriers could boost human capital in labour shortage sectors and expand the tax base for the state.

Remittances are used to finance health expenditures

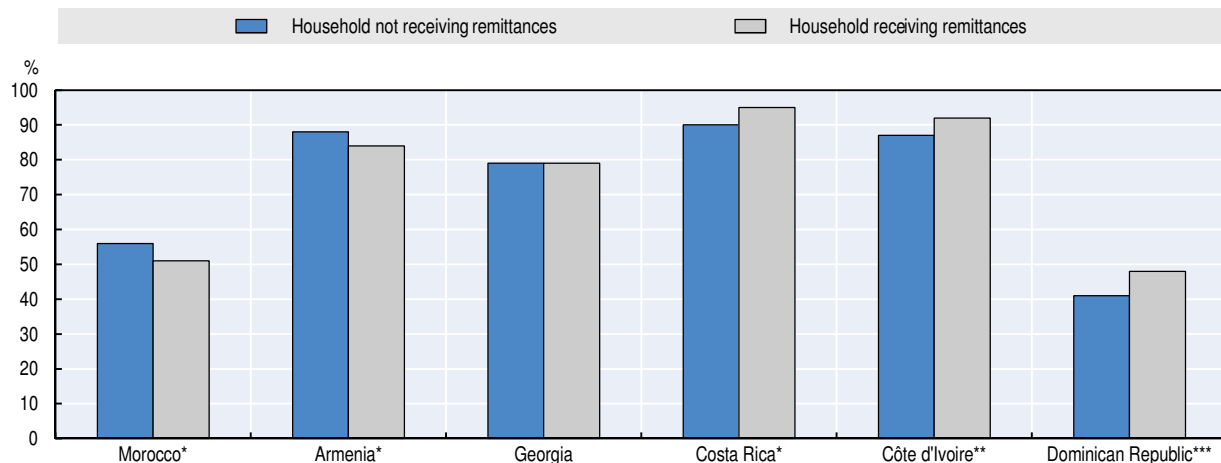
Remittances help overcome credit constraints, and can be invested by the household in social protection and health (Amuedo-Dorantes and Pozo, 2009; Bebczuk and Battistón, 2010; Kalaj, 2010; Kan, 2016). This may make up for poor services in the country (see next section). However, remittances can also lead countries into a development trap, if they come to rely on them rather than develop their own social services. Governments in developing countries with high levels of remittances have been found to spend less on public social protection (Kapur and Singer, 2006). Descriptive statistics presented in Chapter 6 suggest that health treatment is one of the top three activities undertaken by households since a member emigrated in six of the IPPMD countries.

The IPPMD team collected data on three types of social expenditures: pensions, health and insurance.¹⁴ Combined together, remittance-receiving households are more likely to spend on (or save for) at least one of these types of social expenditures in Costa Rica, Côte d'Ivoire and the Dominican Republic, while in Armenia and Morocco, households receiving remittances were statistically significantly less likely to spend on such expenditures (Figure 7.10).

However, regression analysis suggests that when controlling for household size, wealth, whether it is in a rural or urban setting as well as the geographic region, the differences between those receiving remittances or not were only significant in Armenia (lower) and

the Dominican Republic (higher) (Table 7.6). What drives social expenditures across most countries, rather than remittances, is greater household size and wealth and rural or urban setting, the latter effect depending on the country. Larger households may have a greater need for social expenditures, simply because there are more people that may require them, including children and elderly people. Wealthier households may also be predisposed to spend more on social expenditures, first because they may be more likely to engage in migration (positive self-selection) but also because poorer households may have other more fundamental priorities, such as food consumption. In terms of rural and urban setting, social expenditures were correlated with rural households in Costa Rica, Côte d'Ivoire and the Dominican Republic, but with urban ones in Armenia and Morocco. In fact, running a separate regression solely on rural households in the Dominican Republic suggests that remittances are particularly used for social expenditures there; this is not the case in urban regions.¹⁵ This is likely due to the fact that remittances compensate for the lack of social services in rural areas relative to urban ones.

Figure 7.10. **Remittances do not generally increase households' social expenditure**
Share of households with social expenditures in the past 12 months (%), by whether they receive remittances



Note: Social expenditures include household-level expenditures for pension contributions, insurance or health reasons. Statistical significance calculated using a chi-squared test is indicated as follows: ***: 99%, **: 95%, *: 90%. Countries are ordered by the ratio of households not receiving remittances over those that do.

Source: Authors' own work based on IPPMD data.

StatLink  <http://dx.doi.org/10.1787/888933418212>

Breaking down expenditure into health, insurance and pension spending reveals a few differences across countries. According to household-level probit regressions, the positive difference for remittance-receiving households in Costa Rica and Côte d'Ivoire (Figure 7.10) is driven by expenditures on health – 95% of remittance-receiving households in Costa Rica had health expenditures against only 88% of households not receiving remittances, while the numbers were 91% and 85% in Côte d'Ivoire. The negative link found in Armenia in Figure 7.10 can be explained by the fact that only 7% of households receiving remittances in Armenia spent money on pensions, while 11% of households not receiving any did.

Remittances might not play a bigger role in household expenditures on social protection in countries where there is universal coverage of social protection and these services are not particularly difficult for individuals to access. In the case of Morocco, the medical system may be adequate for the demand, and remittances are not needed for this reason.

This reinforces the point that households could be channelling remittances to specific expenditures according to the country's policy context. It may make sense to spend on health in some countries but not in others, due to the quality of services offered or the access to such services. In other countries, it may make more sense to spend on pension contributions, given how limited or non-existent the pension system in the country is. This is precisely the point of the analysis of policies in the next section.

In addition to being directly channelled toward health expenditures (ie. in Côte d'Ivoire and Costa Rica), remittances could also be enabling individuals to use health facilities through expenditure not directly linked to health. For instance, they may cover the cost of getting to a facility or the lost income from spending time at one. Indeed, when probit regressions are run on whether individuals visited a health facility at least once in the past 12 months, this was positively linked to remittances in Armenia and Georgia (Table 7.6). Running separate regressions for both rural and urban regions suggests that in both countries, remittances are used to access health facilities in rural areas, which is not the case when looking specifically at urban regions. Both countries have regions that are isolated, particularly during winter, which may explain the reason since remittances may be used either to finance more expensive services in that region or to travel to another one. In fact, 41% of communities surveyed in Georgia do not have a health centre, according to the community survey. In contrast, remittances seem to be used to access health facilities in urban regions of Morocco.

Table 7.6. **The links between remittances and social expenditure**

Dependent variables: Social expenditures in general and use of health facilities		
Main variable of interest: Household receives remittances		
Type of model: Probit		
Sample: All households and all individuals		
Dependent variable:	Social expenditures in general	Use of health facilities
Sample:	All households	All individuals
Armenia	↓	↑
Costa Rica		
Côte d'Ivoire		
Dominican Republic	↑	
Georgia		↑
Morocco		↑ ¹⁶

Note: The arrows indicate a statistically significant positive or negative relation between the dependent variable and main independent variable of interest.¹⁷

How do social protection and health policies affect migration?

The previous section discussed how migration affects the social protection and health sectors but the effects can also run in the other direction; that is, the policies governing these sectors may affect migration outcomes.

The effect of health and social protection policies will depend on the context of the country

Access to health care and other social services is generally universal in the IPPMD countries. However, in practice, access can vary. In remote areas, it may be limited by geography and the cost of supplying reliable services in certain areas. In Armenia, stakeholder interviews pointed to a lack of access for poor households. Moreover, bureaucratic processes can limit access for return migrants.

Immigrants generally have access to services in the IPPMD countries, as long as they have a legitimate work permit or residential status. For instance, in Costa Rica, universal healthcare is provided to all permanent residents. In the Dominican Republic, Dominican law and the Constitution of the Republic guarantee universal access to health care to anyone, no matter their descent, race, nationality or immigration status. For instance, Dominican public hospitals cannot deny medical services based on nationality or legal status. In Côte d'Ivoire, access to health is a service offered equally to all members of society, immigrant or not, with formal documents or not. These policy trends are covered by the countries' national development strategies (Box 7.1).

Lack of access to such services can push individuals to leave the country or send remittances to help meet shortcomings. It may also affect return migration. Emigrants may choose not to return to their home country if they risk losing access to their pension plan accrued in the host country. Moreover, access to such services is a fundamental building block of social cohesion and by extension, part of how immigrants can be integrated. In short, the potential links between social protection and health policies and migration are complicated.

The IPPMD research attempted to tease out some patterns through empirical analysis. The findings are presented below.

In order to measure the links between health and social protection policies and migration outcomes, the IPPMD project asked households and community leaders a series of questions on their access to services and coverage of social protection (Box 7.2).

Box 7.2. Social protection policies in the IPPMD survey

The IPPMD project collected data on general access to health services, as well as policies related to social protection, particularly those covered by labour contracts. While these interventions are not always driven by the government, the government does have a role to play in ensuring all resident individuals have access to health and protection from situations that adversely affect people's well-being. The IPPMD household questionnaire includes a number of questions on policies related to health services and labour contracts (Figure 7.11). While the chapter's lens is seen through the UNRISD definition described earlier, the working definition of the sectors in this chapter is much more narrow, and focuses primarily on formal labour contracts and conditions and *de facto* access to health care.

Policies related to health services include questions on the access to health facilities, both physical access and the right to access such services, the distance to the nearest facility and medical insurance coverage of the household. The questionnaire also asked whether workers had formal labour contracts, whether they were open-ended, and whether they included benefits such as health insurance and paid holidays. The community questionnaire also included questions about policies and programmes related to social protection services available in the communities being surveyed, such as the number of health centres and the quality of the water used for drinking in the community.

Figure 7.11. Social protection and health-related policies explored in the IPPMD surveys

Policies related to health or other social protection	Policies related to labour contracts	Programmes included in the community survey
<ul style="list-style-type: none"> • Access to health services • Distance to nearest health facility • Medical insurance coverage • Access to a pension plan 	<ul style="list-style-type: none"> • Existence of a formal labour contract • Health benefits • Other subsidies and benefits • Paid holidays • Access to a labour union 	<ul style="list-style-type: none"> • Number of health centres • Water quality

Use of health facilities, which forms the basis of the analysis on access, varied from country to country, from 37% in Armenia to 65% in Costa Rica (Table 7.6).¹⁸ The number of health centres in the communities where data was collected varied greatly from country to country. In Côte d'Ivoire and Georgia, 40% and 41% of communities do not have a health centre respectively, whereas all other countries have at least one in all communities surveyed. In Armenia, 50% of communities had only one, whereas in Costa Rica and the Dominican Republic, 86% and 76% have at least one health centre per community surveyed.¹⁹

In terms of social protection coverage, nearly all individuals claimed to have access to either labour unions, work benefits or pensions. In Georgia, for example, this is because pensions are universal and everyone has access to a pension scheme, both legally and in practice. This was not necessarily the case in other countries, where individual social protection coverage varied from type to type, but coverage was nearly universal when all types were taken together.

Table 7.7. Access to some form of social protection is nearly universal

Number (and percentage) of individuals surveyed aged 16-64

Country	Use of health facilities	Has some form of social protection coverage
Armenia	2 368 (37%)	972 (98%)
Costa Rica	3 920 (65%)	1 597 (98%)
Côte d'Ivoire	3 816 (46%)	405 (68%)
Dominican Republic	3 120 (58%)	731 (99%)
Georgia	2 603 (41%)	368 (100%)
Morocco	2 545 (34%)	725 (100%)
Unweighted average	47%	94%

Source: Authors' own work based on IPPMD data.

Better access to social protection can reduce the rate at which individuals migrate

The project investigated whether access to social protection programmes affects native-born individuals' plan to emigrate, immigrants' plan to return and return migrants' plan to migrate away again. The results were verified by regression analysis.

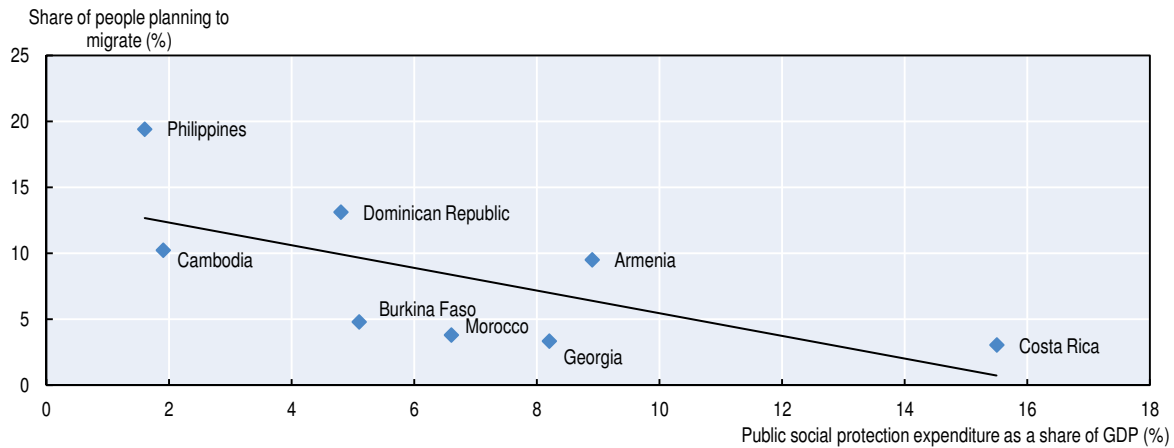
Emigration is often a response to shocks, uncertainty and vulnerability in the home country (Hagen-Zanker and Himmelstine, 2013; Sabates-Wheeler and Waite, 2003). By reducing vulnerability, social protection programmes can prevent individuals from being forced to emigrate, rather than freely choosing to do so. In fact, within the group of eight IPPMD countries where data is available, public social expenditure (as a share of GDP) is negatively correlated to the share of people planning to migrate from that country, suggesting that such expenditures have the ability to reduce emigration (Figure 7.12).

More specifically, the lack of a formal labour contract is positively correlated with the share of those planning to migrate in each country (Figure 7.13). In fact, according to regression analysis, having a formal contract in Morocco is correlated with not having plans to emigrate (Table 7.9), as is having an open-ended contract in Georgia (not shown).

However, there are many cases where plans to emigrate among native-born individuals increase with social protection coverage. The scenario seems to be one of individuals having access to outside options, through aptitude and social standing. For instance, having access to a labour union in Armenia, or being a member of one in Costa Rica, increases the probability of planning to emigrate, as does having health benefits through one's employment contract in Costa Rica. These are likely related to individuals having decent jobs in their home country and good job prospects abroad. Marginalised groups, such as those denied health care during their last visit to a health facility, are less likely to plan to emigrate in Armenia, Costa Rica, the Dominican Republic and Morocco (Table 7.8).

Figure 7.12. Public social expenditures reduce the rate of migration

Share of people planning to emigrate and public social expenditures as a share of GDP (%)



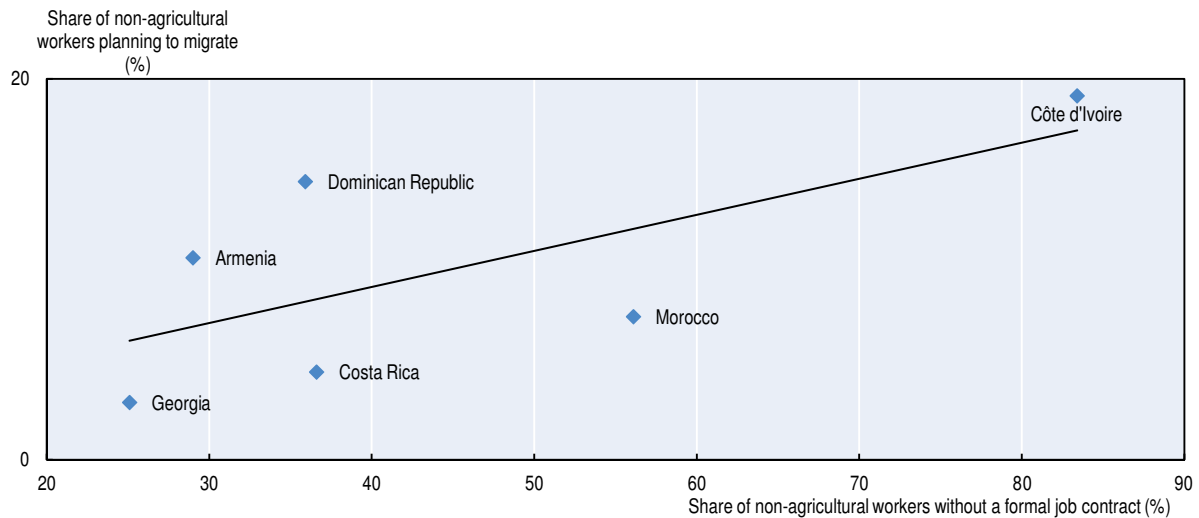
Note: Data on public social expenditures taken from last year available, ranging from 2010 to 2012. Côte d'Ivoire and Haiti are not included due to data limitations.

Source: Public social protection expenditures are from ILO, ILOSTAT Database <http://www.ilo.org/ilostat/>. Share of people planning to emigrate is authors' own work based on IPPMD data.

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Figure 7.13. Lack of formal labour contracts increases the rate of emigration

Share of people planning to emigrate (%) and the share of workers without a formal job contract (%)



Source: Authors' own work based on IPPMD data.

StatLink  <http://dx.doi.org/10.1787/888933418230>

Social protection also affects the likelihood of immigrants planning to return. For instance, the time it takes for a worker to get to the nearest health facility in Costa Rica is correlated with immigrants planning to go back to their home country. In the Dominican Republic, access to employment benefits – such as medical insurance, a pension, membership of a labour union and other benefits such as for transport and electricity – are correlated with immigrants having a lower likelihood of returning to their home country. In Costa Rica, immigrant workers without a formal labour contract are also more likely to return (Table 7.9). However, in some cases, social protections have an unexpected effect. In Costa

Rica, for instance, access to benefits other than medical insurance is correlated with an increase in immigrants planning to return. This is possibly because immigrants may have access to such benefits through seasonal migration contracts.

Table 7.8. **The links between lack of access to health services and migration**

Dependent variable (sample):	Plans to emigrate (non-migrants)	Plans to return (immigrants)	Plans to emigrate again (return migrants)
Armenia	↓	n/a	n/a
Costa Rica	↓		n/a
Côte d'Ivoire			↓
Dominican Republic	↓		n/a
Georgia		n/a	
Morocco	↓	n/a	↓

Note: The arrows indicate a statistically significant positive or negative relation between the dependent variable and main independent variable of interest. The group of individuals analysed according to whether they plan to emigrate or not does not include return migrants and immigrants. Results denoted n/a indicate that data was not collected for the country in question.²⁰

Table 7.9. **The links between labour contracts and migration**

Dependent variable (sample):	Plans to emigrate (non-migrants)	Plans to return (immigrants)	Plans to emigrate again (return migrants)
Armenia		n/a	↑
Costa Rica		↑	↓
Côte d'Ivoire			
Dominican Republic			
Georgia		n/a	
Morocco	↑	n/a	

Note: The arrows indicate a statistically significant positive or negative relation between the dependent variable and main independent variable of interest. The group of individuals analysed according to whether they plan to emigrate or not does not include return migrants and immigrants. Results denoted n/a indicate that data was not collected for the country in question.²¹

Similar results are found when asking return migrants about their plans to emigrate abroad again. Being a member of a labour union in Costa Rica, having a formal labour contract in Armenia or having an open-ended contract in Morocco reduces the probability of return migrants planning to emigrate again, as does having a pension plan in Armenia – perhaps because they may risk losing the right to claim it when they retire. This is consistent with stakeholder interviews providing a positive picture of the reintegration services available to return migrants in Armenia.

However, the results are not all as expected. Having access to a labour union in the Dominican Republic and having medical insurance in Costa Rica are both indicative of plans to emigrate again for return migrants, even though one would expect such services to keep people from needing to do so. This might suggest that returned individuals with access to

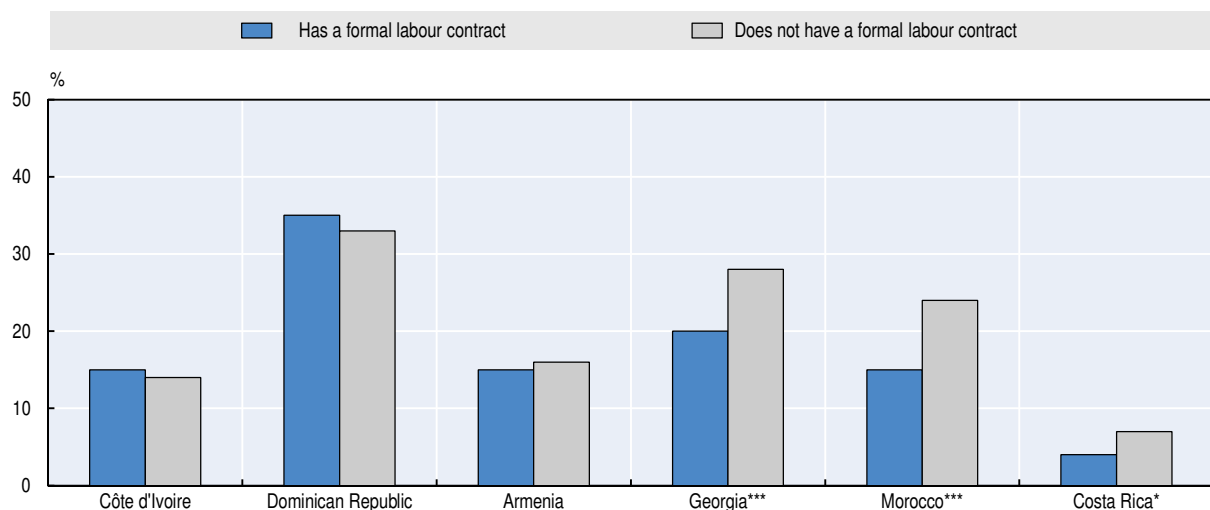
these services have good jobs, which provide them with an advantage when considering whether to emigrate again or not.

Being covered by social protection reduces remittance flows

Social protection coverage may also affect remittances. Remittances may substitute for a lack in coverage, and there is ample evidence that remittances act as a sort of insurance mechanism. Essentially, the literature finds that remittances can act as a sort of private social protection strategy, providing income transfers to disadvantaged households. It suggests two main reasons or strategies for such transfers. The first is a coping strategy, in which households use remittances for insurance and risk diversification. The second, more focused on the migrants themselves, is one of investment and inheritance – where migrants invest in the family in hopes of an inheritance (see Sabates-Wheeler and Waite, 2003 for a review). Empirically, remittances have been found to increase in the absence of social protection systems or programmes (Valero-Gil, 2008; Amuedo-Dorantes and Pozo, 2009; Bebczuk and Battistón, 2010; Brown et al., 2013). The analysis here focuses on the first hypothesis.

A main finding has to do with formal labour contracts, which often come with a minimum social protection assured by the state. As seen earlier, the rate of workers with a formal labour contract varies widely across countries. In Costa Rica, Georgia and Morocco, non-agricultural workers without a formal labour contract are more likely to live in households receiving remittances (Figure 7.14). This is in line with the idea that remittances compensate for the lack of social coverage in the household. In Georgia and Morocco the findings are also robust to a probit model, accounting for age, education level and gender, as well as the household's size, wealth, whether it lies in a rural or urban area and its geographic region. In addition, a separate OLS regression shows that individuals without formal labour contracts in Côte d'Ivoire and Georgia are in households that receive smaller amounts of remittances.²²

Figure 7.14. **Individuals without formal contracts are more likely to be in receipt of remittances**
Share of non-agricultural workers living in households receiving remittances (%), by type of contract



Note: Statistical significance calculated using a chi-squared test is indicated as follows: ^{***}: 99%, ^{**}: 95%, ^{*}: 90%. Countries are ordered by the ratio of individuals with formal labour contracts over those without a formal labour contract. Immigrants and return migrants are not included in the figures. Burkina Faso, Cambodia, Haiti and the Philippines are not included due to data limitations.

Source: Authors' own work based on IPPMD data.

StatLink  <http://dx.doi.org/10.1787/888933418247>

In addition, having access to a labour union provides the opportunity for workers to negotiate better working conditions and other work-related benefits. Remittances may fill the void in cases where workers do not have such access. In fact, individuals with access to a labour union in Costa Rica and Morocco, live in households that are less likely to receive remittances. Table 7.10 summarises the findings for labour contracts and access to a labour union (other results not shown).

Table 7.10. **The links between social protection and remittances**

Dependent variables: Household receives remittances and amount of remittances received				
Main variables of interest: Individual lacks a formal labour contract and individual has access to a labour union				
Type of model: Probit and OLS				
Sample: Employed individuals 15+				
Dependent variable:	Household receives remittances		Amount of remittances received	
Variable of interest:	Individual lacks a formal labour contract	Individual has access to a labour union	Individual lacks a formal labour contract	Individual has access to a labour union
Armenia				
Costa Rica		↓		
Côte d'Ivoire			↓	↑
Dominican Republic				
Georgia	↑		↓	
Morocco	↑	↓		

Note: The arrows indicate a statistically significant positive or negative relation between the dependent variable and main independent variable of interest. The group of individuals analysed according to whether they plan to emigrate or not does not include return migrants and immigrants. Results denoted n/a indicate that data was not collected for the country in question.²³

The fact that households covered by social protection mechanisms tend to receive fewer remittances suggests that remittances serve as a social safety net in countries where the welfare state is weak. It could also imply that those who receive remittances could use them in a more productive way when they already benefit from social protection. Yet, the IPPMD data do not show any evidence that being the owner of a business is directly linked to social protection coverage. This may be related to the fact that although individuals not covered by social protection are in households receiving remittances, in some cases, those households also receive smaller amounts of remittances (Table 7.10). These households are likely at the margin between receiving remittances and not, and therefore at the lower end of the scale in terms of remittance amounts.

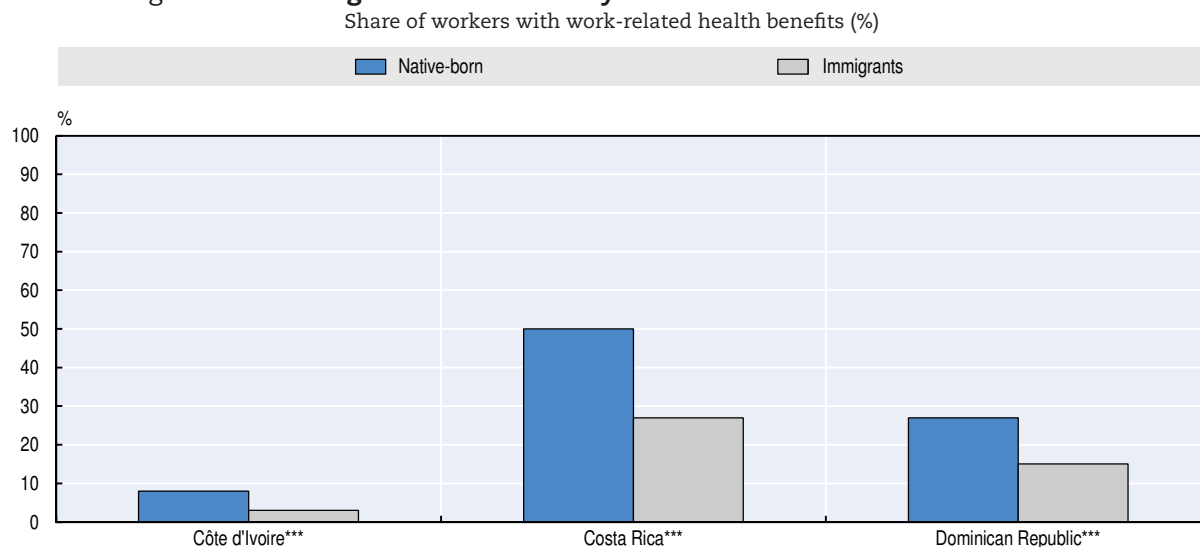
Immigrants benefit less from social protection, possibly hampering integration

A final aspect of how social protection policies affect the migration process is immigrants' integration experience. It is difficult to measure integration in a single variable. Chapter 3 considered inclusion in the labour market and Chapter 5 educational inclusion. This chapter considers whether social protection coverage leads to a sense of inclusion in society.

The picture is rather grim for immigrants, as they are often further away from the nearest health clinic and less likely to be covered by medical insurance through their employment (Figure 7.15), to have a pension plan and access to a labour union. This is likely due to the fact that they are also less likely to have a non-agricultural formal labour contract, or an open-ended contract. Figure 7.9 and Table 7.4 have already pointed to the fact that immigrants more often lack a formal labour contract compared to native-born individuals. Table 7.11 plots regression results in which a probit model²⁴ compares immigrants with native-born individuals in their access to a number of social protection outcomes, controlling for the

individual's age, education level, gender, household size and wealth, as well as its rural or urban setting and geographic region. In addition to a formal labour contract, they are also less likely to have an open-ended contract than native-born individuals.

Figure 7.15. **Immigrants are less likely to have work-related health benefits**



Note: Statistical significance calculated using a chi-squared test is indicated as follows: ***: 99%, **: 95%, *: 90%. Countries are ordered by the ratio of native-born individuals over immigrants.

Source: Authors' own work based on IPPMD data.

StatLink <http://dx.doi.org/10.1787/888933418255>

According to the stakeholder interviews, part of the issue in Costa Rica is the difficulty of obtaining official documents, such as a residency permit. Although these are not always necessary for access in law, they do make access easier in practice. According to the interviews, official documents can be difficult to obtain and require funds and some minimum literacy skills.

Table 7.11. **The links between immigrant status and social protection coverage**

Dependent variable: Individual is an immigrant
Main variable of interest: Access to social protection
Type of model: Probit and OLS
Sample: Employed individuals 15+) and all individuals 15+

Variable of interest:	Has access to a labour union	Has a pension plan	Has medical benefits through employment	Time to nearest medical clinic
Sample:	Employed individuals 15+			All individuals 15+
Costa Rica	↓	↓	↓	↑
Côte d'Ivoire	↓	↓	↓	↑
Dominican Republic		↓	↓	

Note: The arrows indicate a statistically positive or negative relation between the dependent and main independent variable of interest.²⁵

Table 7.11 already points to poor integration of immigrants, but discrimination and home ownership further clarify the picture. Data was collected that could be used as a proxy, albeit imperfect, for whether an immigrant has integrated. The first is whether an immigrant feels discriminated against or not in the host country. This chapter does not

delve into why individuals feel discriminated against, but only whether or not they do. The second is whether the household has purchased a house. Purchasing a house is typically a good indicator that an individual intends to stay and is content in the host country (OECD and EU, 2015). Due to the small sample of working immigrants, the data is insufficient for regression analysis. They do suggest in general, however, that whether or not an immigrant has coverage does not seem to have much of an impact on the incidence of discrimination nor on the ownership of a house in the host country. In Costa Rica (36% vs. 44%) and the Dominican Republic (13% vs. 23%), immigrants who lack a formal labour contract are less likely to own a house, while they are more likely in Cote d'Ivoire (57% vs. 43%). However, lacking a formal employment contract has little incidence on claims of feeling discriminated in all three countries.

Policy recommendations

Social protection has garnered lots of attention recently, with many countries increasing their budgets, aiming for a greater coverage and better social cohesion. This has ultimately been reflected throughout the SDGs. This chapter has focused on the relationship between social protection and health, and migration.

It finds that immigrants, contrary to common beliefs, do not use social services more than native-born individuals, as well as return migrants compared to non-migrants. And while they are less likely to pay taxes, they are also less likely to have a formal labour contract, which limits the opportunities for the state to tax them. Remittances, in a few cases, seem to also be used for social and health expenditures.

On the other hand, social protection and health coverage can affect migration outcomes. In general, social protection tends to reduce emigration outflows, the rate at which immigrants return to their home country, but also increase the rate at which return migrants stay in their country of origin once they return. Many of the social protection mechanisms that are effective are through one's employment. Therefore, providing incentives to both employers and employees to be covered by formal labour contracts can reduce the need to migrate, as are employment benefits and protection such as access to a labour union, health benefits and pension plans. In addition, when providing new benefits to regions, such as health facilities, policy makers should ensure that adequate labour market mechanisms and infrastructure are in place so that individuals are given an opportunity to stay. Bilateral agreements on pension portability between countries of origin and destination can also be a useful way to facilitate the return of migrants (Holzmann, 2016).

Increased social protection coverage also contributes to diminishing remittance inflows. Therefore, when instituting new social protection policies, it is advisable to couple them with alternative incentives to invest and reroute remittances to other productive uses.

Immigrants are by a large margin not covered by most social protection services, compared to native-born individuals. While samples are very small and hence not representative, this lack of coverage seems to affect integration in terms of home ownership, especially in Costa Rica and the Dominican Republic.

Table 7.12. **Expanding the coverage of social protection and health services for better migration and development outcomes**

Policy recommendations	
Emigration	<ul style="list-style-type: none"> ● Strengthen compliance with labour regulations, such as requirements to provide employees with social protection benefits and to grant freedom of association, and facilitate the procedures for employers and employees to register formal labour contracts, in order to ensure decent working conditions thereby reducing the need to look for jobs elsewhere (through emigration). ● Ensure that new provisions in health facilities and social protection in marginalised or isolated regions are accompanied by adequate infrastructure and labour market mechanisms, in order to capitalise on improved human development and alleviate the pressure to emigrate.
Remittances	<ul style="list-style-type: none"> ● Develop and provide health-related services to meet demand by remittance recipients. To make them more accessible, such services could be coupled with microfinance institutions or other financial institutions.
Return migration	<ul style="list-style-type: none"> ● Ensure that return migrants find it easy to register for social protection and health facilities when they return, to reduce the need to emigrate again. ● Invest in bilateral agreements with main destination countries to ensure portability of pension funds and other social benefits.
Immigration	<ul style="list-style-type: none"> ● Increase <i>de jure</i> and <i>de facto</i> access to social protection, such as pension plans, medical benefits, access to labour unions and the provisions covered by formal labour contracts. ● Adjust investments in health facilities in neighbourhoods where there are high levels of immigration.

Notes

1. Some of the policies already covered in the previous chapters may form part of the social protection sector, but are not discussed in this chapter. The labour interventions discussed in this chapter, for instance, are those that are directly concerned with providing decent work, such as employment benefits, union access and formal labour contracts. Conditional cash transfers (CCT) linked to education, as well as all policies and programmes dealing specifically with the educational sector, were also discussed in the context of the education sector, in Chapter 5.
2. Although other chapters include Burkina Faso in the analysis on immigration, adequate data on social protection were not collected there and Burkina Faso is therefore excluded from the analysis in this chapter.
3. As per statistical convention, agricultural workers are excluded from such measures.
4. Data are not available for Georgia and Morocco.
5. Informal employment outside the informal sector is terminology used by the ILO to mean employees holding informal jobs in formal enterprises, as paid domestic workers employed by households, or as contributing family workers in formal enterprises.
6. While this chapter will not focus on this question, it is notable that Chapter 3 showed that the health sector is significantly affected by emigration in the Philippines and argued that stakeholders in Manila noted the health sector has considerable shortages, especially in rural areas.
7. Data on governmental transfers were collected at the household level and questions on the use of health facilities were asked to every working individual over the age of 15.
8. Control variables in the regressions include household size, whether it is in a rural region, an indicator for household wealth. In the regression model specific to immigrants, an additional control for whether the household has any other link with migration, besides immigration was included. Standard errors are robust to heteroskedasticity.
9. The model includes household-level control variables (size, wealth) as well as controls for rural and administrative regions. Standard errors are robust to heteroskedasticity.
10. The tax data collected for the IPPMD project did not differentiate between different types of taxes. However, as the information is derived from the expenditure module, it is reasonable to expect that they reflect income and property taxes paid by the household, and therefore direct taxes. Immigrants may, in addition, pay indirect taxes such as those applied on the sale of goods and services.
11. When comparing households based on whether they paid taxes or not, it is important to keep in mind potential self-selection in their willingness to answer the question. It is possible that wealthier or tax-evading households would be less likely to answer. The share of households responding to

- the question on taxes was very low in Georgia and the Dominican Republic, and therefore this section concentrates more on Armenia, Costa Rica, Côte d'Ivoire and Morocco, where the response rate was higher.
12. The model includes household-level control variables (size, wealth) as well as controls for rural regions and a fixed effect for geographic regions. Standard errors are robust to heteroskedasticity.
 13. The model includes individual (age, gender and education level) and household-level control variables (size, wealth) as well as for rural regions and a fixed effect for geographic regions. Standard errors are robust to heteroskedasticity.
 14. This data is derived from a list of expenditures asked to the household drawing from a specific module of the questionnaire. As such, while health expenditures are relatively more straightforward expenditures to interpret, the expenditures on pensions and insurance are relatively more difficult to do so. As such, they are interpreted as private expenditures incurred by the household for this analysis.
 15. No statistically significant link was found for the other countries.
 16. Only in urban regions.
 17. The model in column 1 includes household level control variables (size, wealth) as well as for whether the household is in a rural region and a fixed effect for geographic regions. In column 2, the model includes household-level control variables (size, wealth), whether the household is in a rural region and a fixed effect for the household's geographic location as well individual-level control variables (gender, age, education level). Standard errors are robust to heteroskedasticity.
 18. In many countries of the project, *de jure* access to health services is universal. However, *de facto* access varies and for this reason analysis focuses on this aspect.
 19. Data was not available for Morocco for this question.
 20. The model includes control variables at individual (age, gender, education level) and household levels (size, wealth) as well as for rural region. A fixed effect for geographic region was not included due to the small sample sizes. Standard errors are robust to heteroskedasticity.
 21. The model includes control variables at individual (age, gender, education level) and household levels (size, wealth) as well as for rural region. A fixed effect for geographic region was not included due to the small sample sizes. Standard errors are robust to heteroskedasticity.
 22. The amount of remittances is based on households with former members that are currently emigrated, as opposed to remittances from any source.
 23. Standard errors are robust to heteroskedasticity. The model includes control variables at individual (age, gender, education level) and household levels (size, wealth) as well as for rural regions and a fixed effect for geographic regions.
 24. For the regression measuring the distance to the nearest clinic, an OLS model was applied.
 25. The model includes control variables at individual (age, gender, education level) and household levels (size, wealth) as well as for rural regions and a fixed effect for geographic regions. Standard errors are robust to heteroskedasticity and clustered at the household level in regressions featuring policies or coverage measured at the household level.

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