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Transnational Health Insurance Schemes: A New Avenue for Congolese Immigrants in Belgium to Care for Their Relatives' Health from Abroad?

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Transnational Health Insurance Schemes: A New Avenue for Congolese Immigrants in Belgium to Care for Their Relatives' Health from Abroad?¹

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What can immigrants do for non-migrant relatives in their home country who need healthcare they cannot afford? To answer this question, we first examine four existing methods that can be found in the existing literature: mobility, remittances, workers' health insurance and diasporic health insurance. In the second part of the paper, we discuss an innovative strategy called "transnational health insurance" (THI). These insurance schemes are set up by immigrants in cooperation with a multitude of actors including health insurance companies in destination countries and healthcare providers in countries origin. THIs offer health coverage to non-migrant relatives in the home country based on a premium paid directly by immigrants to the insurance company in their country of residence. Analyzing the creation and implementation of Belgian-Congolese THIs, we discuss the strengths and weaknesses of these schemes in responding to the needs of both immigrants and their non-migrant relatives. The article concludes with a discussion on the specificities of THIs as hybrid forms of remittances.

INTRODUCTION

Several decades of research on migration have shown that a central element in the decision to migrate is the improvement of the living conditions of both those who leave and those who stay behind. Among the many drivers of migration (e.g. economic well-being, access to education, or personal safety), access to healthcare for migrants and those who depend on them in both the home and destination country is a frequently observed motivation. A very basic, but crucial, question confronting most immigrants when they leave parents, relatives and loved ones

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behind is therefore the following: What can immigrants do for non-migrant relatives in their home country who need healthcare they cannot afford?

To answer this question, we first reviewed the relevant research literature to identify existing methods in which immigrants provide healthcare for non-migrant relatives. This exercise primarily consisted in connecting different bodies of literature that have tended to be treated separately. This allowed us to identify four strategies that are commonly used by immigrants: mobility, remittances, workers' health insurance and diasporic health insurance.

In the second part of the paper, we examine in detail an innovative strategy that we call *transnational health insurance* (THI). These insurance schemes are set up by immigrant organizations in cooperation —among other actors— with insurance companies in destination countries and community-based health insurances (CBHI) in countries origin. THIs aim to offer health coverage to non-migrant relatives in the home country based on a premium paid directly by immigrants to the insurance company in their country of residence. In the course of this study we examined two schemes in particular, both set up by Congolese immigrants in Belgium to improve access to healthcare of their relatives residing in Kinshasa. Based on extensive fieldwork with migrants, non-migrant relatives and insurance administrators in Belgium and the Democratic Republic of Congo (hereafter DR Congo), we here discuss the strengths and weaknesses of these schemes in responding to the needs of both immigrants and their non-migrant relatives.

In the third and conclusive of the paper, we use our analysis of transnational insurance schemes to explore their specificities as hybrid forms of remittances that 1) combine social and economic flows, 2) generate gains for both senders and receivers, 3) blur the line between private, public and civil social society transnational cooperation efforts, and 4) reflect the specific historical and ideological contexts that link the home and host societies.

HOW IMMIGRANTS HELP NON-MIGRANT RELATIVES' ACCESS TO HEALTHCARE

1.1 The migration-health research nexus

Immigration and health as a research topic can be approached from many different angles and disciplines: public health, social policy, psychology, law, migration studies...From this diversity of approaches, several main topics of research have emerged over the years. First, scholars have been concerned with the many factors that positively and negatively affect both immigrants' health and that of their dependents through studying the quality of care received or the impact of living and working conditions on health (Lindert *et al.*, 2008, Bollini and Siem, 1995) etc. This research has revealed that, quite independently of an individual's motivation to move, migration does indeed have consequences on the health of immigrants and their dependents.

Other scholars have also highlighted the unfavorable position of many immigrants when it comes to access to welfare including (though not exclusive to) healthcare.

Two sets of issues in particular have received significant attention and led to many policy recommendations. First, the issues of working conditions and access to healthcare of both documented and (particularly) undocumented workers have gained increasing international exposure leading to a range of initiatives by international organizations to set international standards (Avato *et al.*, 2010, IOM, 2009, Portes *et al.*, 2012). Second, a body of research and associated recommendations has focused on the difficulties faced by return migrants in continuing to enjoy health coverage or disability benefits gained in the adopted country after leaving the territory of that state. This difficulty is often accompanied by additional constraints to accessing (affordable) healthcare in the home country where returning migrants have limited work history (Holzmann *et al.*, 2005, Sabates-Wheeler, 2010).

For Migration scholars, health has traditionally been considered to be a driver of migration decisions (Johnson and Whitelaw, 1974, Stark and Bloom, 1985). Existing research highlights that some immigrants move in order to obtain healthcare that is unavailable in their home country or, on the contrary, in response to labor shortages in the healthcare sector of the destination countries (Massey *et al.*, 1993, Tjadens, 2013). With the recent transnational turn in migration studies, the connections between healthcare needs in the societies where immigrants are moving to and the societies they are proceeding from have been investigated in more depth. Scholars focusing on the concepts of transnational care and care chains have been at the forefront of this effort, showing how the mobility of migrants driven by labor shortages in the care sectors of industrialized countries itself triggers new needs for care in the societies of origin (Parreñas, 2001, Yeates, 2009). In this context, the concept of transnational social welfare (Yeates, 2008) arose to identify how remittances and other channels of risk protection are enabled by migration. These works have also significantly expanded the meaning of care to embrace various forms of cross-border material and moral support governed by family and kinship ties (Kilkey and Merla, 2014).

In this article, we focus on the narrower concept of “providing access to healthcare from abroad”, which consists of the strategies developed from abroad by immigrants to allow relatives residing in their home country to access medical treatment by qualified health professionals. As we shall see, however, even within this narrower definition substantial variations can still be observed according to the status of immigrants (e.g. documented or undocumented) and the nature of ties with relatives (nuclear family, extended family, or kin).

Alongside the work on transnational families and care, migration and development scholars have also studied the transnational dimension of health. Following the growing interest of international organizations such as the World Bank in this area, the impact of remittances on health, education and investments in the country of origin have become a major research topic (Faist, 2006). Similarly, works on social remittances have invited us to look beyond the mere flow of money and instead consider that migrants also remit ideas, practices and behaviors that can affect perceptions and practices on healthcare in their home societies.

1.2 Immigrants' strategies to provide healthcare to non-migrant relatives

Identifying the whole range of strategies migrants use to provide healthcare from abroad is challenging. This work consists in connecting the transnational migration literature directly tackling the issue with other bodies of literature that have only tangentially addressed it, but have nonetheless identified practices and policies otherwise neglected by migration scholars. Our objective was thus to identify those strategies and examine — within the limits of existing literature — how accessible and desirable each of these strategies is for immigrants and their non-migrant relatives.

Mobility

A primary strategy available to immigrants who wish to respond to relatives' healthcare needs in their home country is to engage in practices of mobility. Mobility can enable access to healthcare in at least two ways. First, immigrants may try to make relatives travel to their new country of residence. The healthcare costs of relatives coming to the country of residence can even be covered if the immigrants have a health insurance policy that allows this. The mobility of sick relatives can also be facilitated through medical visas and family reunification. However, as most industrialized nations are very concerned about protecting access to their territory and their welfare system, these procedures are often time-consuming and their eventual success is very uncertain. For this reason, they represent an unsatisfactory response to situations when urgent care is needed.

Second, immigrants can themselves return temporarily or permanently to their home country to respond to the healthcare needs of relatives. Even though returnees can provide relatives with indispensable assistance in case of illness, unless they are themselves health professionals they are not able to perform medical acts in response to the situation. As an exception, organizations of health professionals whose members are of immigrant origin may conduct short-term missions in the home country to carry out medical treatments that are normally unavailable in certain areas, or are simply financially inaccessible to local populations. Such organizations often rely on the immigrants' personal connections with the home country to determine the areas where the missions will be conducted (Devkota *et al.*, 2013). Other organizations, such as the association of Cameroonian Doctors in Belgium (MEDCAMBEL) may explicitly seek to work with both immigrants in destination countries and local populations in the home country. In Belgium, these doctors conduct information campaigns on health-related issues which they believe are of particular concern for Sub-Saharan immigrants. In Cameroon, they conduct short-term medical missions offering treatment and conducting information missions with local populations.

For local populations, immigrant-led medical missions have the advantage of not discriminating between households who can count on the financial support of relatives abroad and those who cannot. However, for immigrants who want to respond to the precise healthcare needs of relatives in their home country the limited duration and area of intervention of such missions is unlikely to offer a sustainable solution.

Individual and collective remittances

The most common strategy with which immigrants respond to healthcare needs in their home country is to send money to relatives for the purchase of medical treatment directly from providers (out-of-pocket payment) or the purchase of health insurance in the home country. Following the growing interest of international organizations such as the OECD and the World Bank in the impact of remittances on development, research on the role of individual remittances in access to healthcare has boomed in recent years (OECD, 2005, Fajnzylber and Humberto Lopez, 2008). While there are variations in the exact share that health expenditures represent in the total amount of remittances received by households (Frank *et al.*, 2009), there is now a strong body of evidence suggesting that remittances improve access to formal healthcare for relatives and facilitate the purchase of medicines and treatments (Lindstrom and Muñoz-Franco, 2006, Chauvet *et al.*, 2009, Drabo and Ebeke, 2010, López-Cevallos and Chi, 2012). Additionally, because health is strongly affected by social determinants (WHO, 2008), remittances that are not used directly to purchase healthcare but rather contribute to the costs of housing or education can also positively affect health.

Scholars have, however, avoided presenting remittances as the only option for immigrants' relatives to access healthcare, instead examining the interaction of remittances with the various public, private, or community-based health insurance schemes available in the home country. Unsurprisingly, they found that households receiving remittances while also holding some form of health coverage tend to spend less of remittance income on health (Amuedo-Dorantes and Pozo, 2009, Smith, 2007).

Nonetheless, research conducted in countries that have little tradition of public, community-based or private health insurance also showed that immigrants' relatives often prefer out-of-pocket payments over medical insurance policies (Kabki, 2007). Even though this approach is dependent on the willingness of immigrants to respond to kinship obligations, relatives see two advantages. First, unlike formal insurance policies that must be paid independently of the occurrence of disease, out-of-pocket payments are perceived to offer greater flexibility in the management of remittances. Second, unlike many insurance schemes, out-of-pocket payments do not restrict patients' liberty to see the practitioner of their choice. Such a decision is, however, costlier both for the relatives and the immigrants who financially support them. Indeed, out-of-pocket purchase of medical services usually results in delaying purchase of medical treatment and paying higher costs for treatment, which ultimately result in further impoverishment of households (McIntyre *et al.*, 2006). For immigrants, this also entails greater uncertainty in the management of remittances and, ultimately, greater costs. Yet, as demonstrated by Mazzucato (2009), family remittances can represent only one element in larger schemes of informal insurance between migrants and kin groups in the home country. In such systems of reciprocal obligations, relatives are also expected to send "reverse remittances" (mainly in the form of services) to help migrants in situations of need. Financing relatives' out-of-pocket purchase of medical services can thus also be a form of investment for migrants.

This non-material system of transnational exchanges belongs to what Levitt called social remittances (1998): the ideas, norms and behaviors that circulate between sending and receiving societies through migration. Such remittances do not *per se* finance access to healthcare and therefore technically fall outside the scope of this paper. Nonetheless, social remittances do trigger changes in the behaviors of immigrants' relatives that can indirectly prevent the need for healthcare or limit its cost. It should be noted, however, that social remittances do not *de facto* positively impact relatives' health as harmful behaviors (e.g. poor eating habits or drug use) can also be triggered by migration.

Alongside the research on individual remittances, we have identified a second form of remittances that can improve relatives' access to healthcare in the home country: collective remittances. The literature on immigrant transnationalism and development has given numerous examples of this practice which comprises formal or informal immigrant groups pulling resources together in order to respond to individual or collective needs in the home country (Goldring, 2004, Orozco and Lapointe, 2004, Lacroix, 2005, Portes *et al.*, 2007). Ethnic-based forms of solidarity utilized to face unexpected expenditures in the home or host society are not new. Many Sub-Saharan African immigrants, for instance, have been practicing the microloan system called "tontine" for decades (Boulanger, 2014). Such system makes large sums of money available to immigrants who do not have the necessary capital to help relatives and/or are excluded from the banking system because of their legal status.

Scholars have also taken interest in hometown associations (HTA) as agents of development in the home country. Such associations are known to collect money among immigrants to finance infrastructures in their locality of origin (Lacroix, 2003, Smith, 2006, Alarcón, 2002, Mazzucato and Kabki, 2009). Among the projects supported by immigrants, the building of hospitals and water supply facilities as well as the purchase of medical equipment are quite common. Such activities have triggered the interest of public authorities in the immigrants' origin and destination countries. Mexico, for instance, is eager to maximize the local impact of collective remittances by creating schemes match-funding every dollar invested by hometown associations in local infrastructures (Moctezuma Longoria, 2003). In countries of residence, authorities have also been eager to set up co-development policies, cooperating with migrant associations to maximize their impact in sending communities (Østergaard-Nielsen, 2009). The obvious appeal of HTA's investments is that the public health impact of these investments is more durable. Most importantly, they are also equally distributed in the home country communities between households who have relatives living abroad and those who don't. Nonetheless, these investments do not entirely respond to the need of immigrants' and their relatives. Unless immigrants also subsidize drugs and the wages of health professionals, relatives continue to depend on remittances to purchase medical treatment in case of disease.

Workers' health insurance covering dependents abroad

The third strategy available to some immigrants in responding to healthcare needs abroad is to extend the coverage of their own public or private health insurance purchased in the country of residence to relatives living in the country of origin. In

other words, medical expenditures incurred abroad by immigrants' relatives are only reimbursed because the immigrants' own health insurance includes specific provisions for relatives abroad.

On the private market, numerous health insurance companies offer plans that cover citizens residing abroad and their family (whether those dependents move or stay behind). Because of their cost, these options are only available to a minority of highly-skilled immigrants. The fact that these plans are explicitly defined as "expatriate insurance" and not "migrant insurance" is a further sign that they are targeted towards the socio-economic elite among mobile citizens.

Public health insurance, on the contrary, offers greater opportunities to immigrants to care for relatives from abroad. Immigrants' ability to export social security coverage to relatives residing abroad is, however, dependent on both their legal status in their destination country and on the legal and bureaucratic barriers that enable or deny the coverage of health expenditures incurred abroad (Holzmann *et al.*, 2005). Such hurdles can be specifically addressed in bilateral and multilateral social security agreements. These agreements between social security institutions of different countries mainly address social security issues faced by immigrants themselves while residing abroad or upon return: equality of treatment, exportability of benefits, double taxation, "totalization" of period of contribution to social security in different countries and administrative assistance in claiming benefits (Sabates-Wheeler, 2010: 125, Pasadilla, 2011: 11). The coverage of non-migrant relatives is thus often not a priority.

This notwithstanding, several bilateral agreements explicitly allow provision for coverage of non-migrant relatives. The 1979 Social Security Convention between France and Mali, for instance, contains specific provisions for family members — understood as children, spouse or parents — of Malian workers residing in France. In this case, the social security contributions made by immigrants in France automatically entitle their dependents in Mali to access social security coverage there. However, bureaucratic hurdles and the limited number of clinics run by the Malian social security prevent many immigrants' relatives from accessing healthcare through this scheme (Boulanger, 2014).

At the multilateral level, the European Union is a supranational body that has gone further in limiting the effects of mobility on social security entitlements of EU migrants and their dependents with Regulations 883/2004 and 987/2009. The effects of these pieces of legislation are, however, limited to immigrants and their relatives who remain within the borders of the EU. These regulations guarantee EU workers that their spouse and children who stay in the home country are entitled to health coverage there. Under this system, the State where the immigrant is employed reimburses the State where the family is residing for any costs incurred. Such agreement requires both trust and coordination between social security institutions. As noted by Holzmann (2005), the European model thus remains an exception as only a minority of migrants and their dependents worldwide have access to such favorable status.

Alongside social security agreements and expatriate insurances, the binational health insurance system between Mexico and the State of California represents a

third form of extension of immigrants' health coverage to dependents residing abroad. The Knox-Keene Act of 1998 aimed to increase health coverage among documented Mexicans working in the US. It allows US employers to subscribe cheaper private insurance plans for employees willing to receive healthcare in pre-approved health centers located in Mexican border cities. Under these plans, dependents residing in Mexico are also eligible for coverage. However, only a minority of eligible immigrants participate in those schemes. Scholars identified different reasons such as the exclusion of undocumented workers, the limited number of Mexican border cities where health centers are located, the difficulty in crossing the border, and the potential competition with Mexican public insurance schemes (see below) as possible explanations (Fulton *et al.*, 2013, Vargas Bustamante *et al.*, 2012).

Overall, and with the exception of expatriate insurance schemes, these different ways of extending coverage to relatives abroad represent cheaper options for immigrants to respond to healthcare needs in their home country. They are, however, limited to documented migrants whose States of residence and origin have agreed to cooperate. They also require immigrants to be informed about their rights and to be able to overcome bureaucratic barriers that may hamper the extension of coverage to relatives abroad. In addition, these provisions rely on western-based conceptions of the family and are therefore often limited to spouse, children and parents.

Diasporic health policies

In the more recent literature on diaspora and transnationalism, scholars have noted that immigrants' countries of origin are increasingly willing to engage with citizens abroad and address some of their needs (Gamlen, 2006, Brand, 2006, Delano, 2011, Lafleur, 2013, Ragazzi, 2014). Among the variety of policies that Smith (2003) defines as "diasporic policies", there exist a series of health-related initiatives. Many governments are indeed concerned that their citizens abroad do not have appropriate access to healthcare and take measures to inform citizens abroad about health options in their country of residence (Délano, 2014). Diasporic health policies can even go as far as offering public health insurance to both citizens abroad and family members residing in the home country. Such insurance can take two forms, outlined below.

First, home states set up welfare funds that cover — among other services — disabilities and diseases incurred by immigrants while working abroad. Some of these funds, such as the Philippine Overseas Workers Welfare Fund, also offer medical coverage to family members of immigrants who stay in the home country. By paying a small premium of about \$16 to the Fund, immigrants can therefore receive basic health coverage for themselves and their dependents in the home country. However, scholars have noted that such *ad hoc* funds that promise a wide-array of services in exchange for small premiums often fail to deliver the promised services. In addition, the risk of mismanagement of those funds is great in states where institutions are weaker (Mackenzie, 2005).

Second, home states can take specific provisions to include immigrants and non-migrant family members in existing social security schemes. In 2005, Mexico

introduced universal health coverage through a prepaid and subsidized plan called *Seguro Popular*. This plan — designed to limit out-of-pocket payments — guarantees basic healthcare (medical, surgical, pharmaceutical and hospital services) to millions of Mexicans who do not have access to health insurance through work. The poorest Mexicans get free access to the plan whereas other beneficiaries are expected to contribute through pre-payments that do not exceed 5% of disposable income. Immigrants can also register for this plan in Mexican consulates and get access to care when they visit or return to Mexico. Most interestingly however, *Seguro Popular* was also designed to respond to immigrants' concerns about the health of those who stay behind (Vargas Bustamante A. *et al.*, 2008). Immigrants can indeed initiate the registration process of relatives from abroad, at no cost. Relatives then only need to finalize the registration process in person in Mexico. As shown by Frank and colleagues (2009), access of immigrant relatives to *Seguro Popular* does not necessarily mean that remittances are no longer used for health purposes in Mexico. Instead, remittances may be used to pay for enrolment fees and to access medical treatment that is not included in the universal health coverage. Overall, this system guarantees immigrants more certainty with regards to the health expenditures of relatives who, in turn, benefit from better access to healthcare. Furthermore, contrarily to social security coverage provided by the country of residence, such a system does not exclude undocumented immigrants.

Transnational health insurances

Unlike Mexico, many low-income countries do not offer universal healthcare coverage to citizens. In these cases, immigrants' relatives are unable to use remittances to access public health coverage. In many such countries community-based health insurance schemes (CBHI) have been increasingly implemented to palliate the weakness of state provision. CBHI are voluntary risk-pooling schemes run by not-for-profit organizations; they collect fees among users at the local level and organize access to care with providers (Criel and Dormael, 1999). Scholars have noted a series of difficulties with CBHI, such as the affordability of premiums, trust in the integrity and competence of the managers, the attractiveness of the benefits proposed, and the quality of care (Carrin *et al.*, 2005). In spite of these weaknesses, CBHI constitute an interesting alternative to out-of-pocket payments that potentially limits immigrants' spending on relatives' health and increases access to healthcare in the home country.

Some immigrants have gone further than just encouraging relatives to purchase CBHI with remittances. As the next section of the article examines in detail, Congolese immigrant organizations have joined forces with mutual health insurance companies in Belgium and healthcare providers in DR Congo to set up transnational health insurances (THI). These schemes work similarly to CBHI, with the primary difference that premiums are paid directly from abroad by immigrants who do not receive coverage for themselves but decide who they want to offer health coverage to in the home country. As no existing literature has previously studied the implementation of such schemes, we have sought to examine how significant a response THI represent in meeting the needs of immigrants and their relatives.

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TABLE 1. IMMIGRANT STRATEGIES IN RESPONDING TO HEALTHCARE NEEDS IN THE HOME COUNTRY

Strategy	Sub-categories	Examples	Potential benefits	Potential challenges
Mobility	Mobility of relatives to reunite with immigrant in destination country	-Family reunification -Medical visa	-Covered by migrants' health insurance -Access to healthcare providers of destination country	-Strict migration laws
	Medical mission of qualified immigrants to home country	-Medcambel	-Access to treatment normally not available -Households who do not have relatives abroad also benefit	-Limited in time -Limited in geographic coverage -No response to specific needs of immigrant relatives
Remittances	Individual remittances for out-of-pocket purchase of medical treatment	- Purchase of medical treatment in private health centers by immigrants' relatives in DR Congo	-Access to care on demand -Immigrants are not committed to fixed healthcare costs -Flexibility in choice of provider for relatives -Strategy available to undocumented migrants	-Requires trust between immigrants and relatives -Unpredictability of expenditures for migrants -Most costly form of accessing care

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	private or community based health insurance	immigrants' relatives in DR Congo	<ul style="list-style-type: none"> - Reinforces local insurance schemes (risk pooling) -Strategy available to undocumented migrants 	<ul style="list-style-type: none"> relatives -Some treatments may be excluded -Choice of provider may be limited
	Collective remittances	<ul style="list-style-type: none"> -Financing of hospital in home community -Purchase of medical equipment 	<ul style="list-style-type: none"> -Households who do not have relatives abroad also benefit -Co-financing available from host and home country governments 	<ul style="list-style-type: none"> -Relatives still need money or insurance to access to health infrastructures
Workers' health insurance covering dependents abroad	Expatriate insurance	-Private insurance purchased by employers for highly-skilled mobile workers	-Extensive coverage	-High cost
	Bilateral/multilateral social security agreement	<ul style="list-style-type: none"> -Social Security Convention between France and Mali -EU Regulation 883/2004 	-Coverage through public insurance for relatives according to the terms of the agreement	<ul style="list-style-type: none"> -Complex legal structure -Coordination and trust between home and host country social security needed -Not available to undocumented immigrants
	Binational health insurance	-California's Knox-Keene Act of 1998	<ul style="list-style-type: none"> -Coverage through insurance -Access to high quality health 	<ul style="list-style-type: none"> -Limited in geographical scope - Not available to

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			centers	undocumented immigrants
Diasporic health policy	Welfare fund	-Philippine Overseas Workers Welfare Fund	-Coverage through insurance	-Weak funding -Risk of mismanagement
	Universal health coverage of the home country	Mexico's Seguro Popular	-Basic health coverage -Premium based on income level -Inclusion of immigrants reinforces social security (risk pooling) -Strategy available to undocumented migrants	-Remittances still necessary to pay premium -Treatments excluded from basic coverage not available
Transnational Health Insurance		MNK Solidarco	-Health coverage -Inclusion of immigrants can reinforce local CBHI -Predictability of health expenditures for immigrants	-Limited number of relatives covered -Requires trust within families and towards institutions -No flexibility in management of health expenditure (fixed monthly premiums) -Limits in choice of healthcare provider

2. TRANSNATIONAL HEALTH INSURANCE SCHEMES: A NEW STRATEGY FOR CONGOLESE IMMIGRANTS RESPONDING TO THE HEALTHCARE NEEDS OF RELATIVES IN THEIR HOME COUNTRY

2.1 The Belgium-DR Congo health context

Few countries have such stark similarities and differences than Belgium and the DR Congo when it comes to their healthcare systems. The organization of healthcare in the DR Congo today is still heavily influenced by the system put in place by the Belgian colonial authority before Independence in 1960: networks of 10 to 15 health centers form a network around one major hospital. Each health center can offer basic healthcare but sends patients with more serious conditions to the parent hospital. However, access to care remains a major issue in the DR Congo five decades after the independence. No universal health coverage has yet been achieved and the overall health performance of its healthcare system is still among the lowest in the world (WHO, 2014). It is thus unsurprising that access to healthcare remains one of the major motives in sending remittances for the 45,000 Congolese citizens residing in Belgium and the (much larger though not statistically measurable) Belgian population of Congolese origin (Schoonvaere, 2010). Their response to the healthcare needs of relatives in the DR Congo is also influenced by their own access to healthcare in Belgium. The Belgian system offers universal health coverage through not-for-profit mutual funds that reimburse health expenditures of their members through a system of co-payment. As membership in one of these mutual funds is mandatory to obtain health coverage in Belgium, some of these funds count millions of members, giving them significant financial and political leverage in Belgium.

The following subsections demonstrate how these different actors (immigrants, Belgian Mutual Funds, and Congolese CBHI) cooperate to provide an innovative form of health coverage to immigrants' relatives in the DR Congo. The data used was collected during multi-sited fieldwork in Belgium and the DR Congo between January 2012 and August 2013. Fieldwork included long-term participant observation in one THI in Brussels and Kinshasa as well as 80 semi-structured interviews. Interviewees belonged to the following categories: Congolese immigrants in Belgium; insurance fund managers in Belgium; THI managers in DR Congo; beneficiaries in DR Congo; and development aid workers (Lizin, 2013).

2.2 Origins of Belgian-Congolese THIs

Two competing THI supported by two large Belgian mutual funds have been created exclusively for Congolese immigrants. The conditions of their creation, however, vary greatly. *MNK Oeuvre de Santé* (hereafter referred to as MNK) is a top-down initiative that started within the Belgian mutual fund Symbio. This mutual fund has supported the expansion of Congolese CBHI for many years as part of its philanthropic policy. Thanks to this experience, experts within Symbio realized that remittances were used to access healthcare in the DR Congo but were mostly used for costly out-of-pocket purchases of medical treatment. In 2009, they thus created a task force within the mutual fund and invited prominent members of the

Congolese community in Belgium to join them in setting up a THI that would divert part of the diaspora's remittances to an actual health insurance scheme for their relatives. MNK can accordingly be considered as a spin-off of a Belgian mutual fund with limited immigrant involvement.

The second initiative, Solidarco, is a genuine bottom-up initiative started by a core group of Congolese immigrants who wanted to address two difficulties encountered in sending money for out-of-pocket purchases of medical treatment. First, recurring demands for money represented a heavy burden on their own budgets and rendered any kind of financial planning difficult within immigrant households. Second, due to the distance separating immigrants from relatives, trust issues frequently arose between immigrants and relatives over the legitimacy of the latter's requests for financial support. In this context, Congolese migrant leaders asked one of Belgium's largest Mutual Fund (*Solidaris*) to jointly set up a foundation that would work towards the creation of a THI in 2010. The mutual fund agreed to offer office space and technical support to the foundation but left the responsibility of promoting the THI and recruiting subscribers to the immigrants themselves. In addition, the foundation received 62.140 EUR in financial support from the Development Ministry of the French-speaking regional government of Belgium to launch and monitor the initiative. For this reason, Solidarco can be considered as a form of co-development policy as it is an immigrant-lead grassroots initiative that depends on the technical and financial support of both the Mutual Fund and Public Authorities in the host country.

2.3 How THIs work

In spite of variations in their exact legal status, Solidarco and MNK work in a similar fashion. In Belgium, a not-for-profit organization is charge of recruiting donors and manages the financial aspects of the scheme. With Solidarco, immigrants pay premiums of 30 EUR per month to cover for up to 7 persons of their choice. With MNK, immigrants pay premiums of 18 EUR per month to cover one person of their choice. Both THIs are only available to immigrants' relatives who live in Kinshasa. Also, to prevent the possible exclusion of undocumented migrants who do not have a bank account, MNK signed a partnership with a large remittance-sending company.

In the DR Congo, local representatives of the THI negotiate partnerships with healthcare providers and give administrative assistance to immigrants' relatives who wish to access healthcare. Solidarco works primarily with local health centers, providing basic health coverage and referring patients to hospitals when needed. MNK, instead works exclusively with local hospitals which offer direct and comprehensive treatment to their patients.

As illustrated in Figure 2, the variety of parties involved and the transnational coordination efforts required for THIs to operate make the whole system much more complex than a normal CBHI. Belgian and Congolese administrators run the scheme jointly, but financial matters are handled in Belgium only. Miscommunications and tensions therefore occur on a regular basis. In addition, misunderstandings have progressively developed between immigrants and Belgian

mutual funds with regards to the commitment of the latter to THIs. On the one hand, immigrants originally expected that mutual funds could financially and logistically support THIs in the long term as part of their philanthropic missions. On the other hand, mutual funds — despite being non-profit organizations — are private institutions committed to financial objectives which push them to abandon initiatives that are not self-supportive.

To make THIs sustainable, mutual funds have convinced immigrants to expand the scope of potential donors to the schemes. MNK decided to allow Kinshasa residents to register with them directly. They also allowed Congolese companies and associations to buy coverage for their workers. Their strategy was therefore to transform a scheme that was initially reserved to immigrants into a CBHI that primarily serves the local population but remains accessible to immigrants who want to register family members. Solidarco expanded its membership by allowing Congolese immigrants residing in countries other than Belgium to join the scheme. This THI now counts donors from different parts of Europe and North America. Solidarco thus continues to primarily serve immigrants but has become a truly transnational scheme that allows Congolese immigrants residing anywhere in the world to respond to healthcare needs of non-migrant relatives through a Belgian initiative.

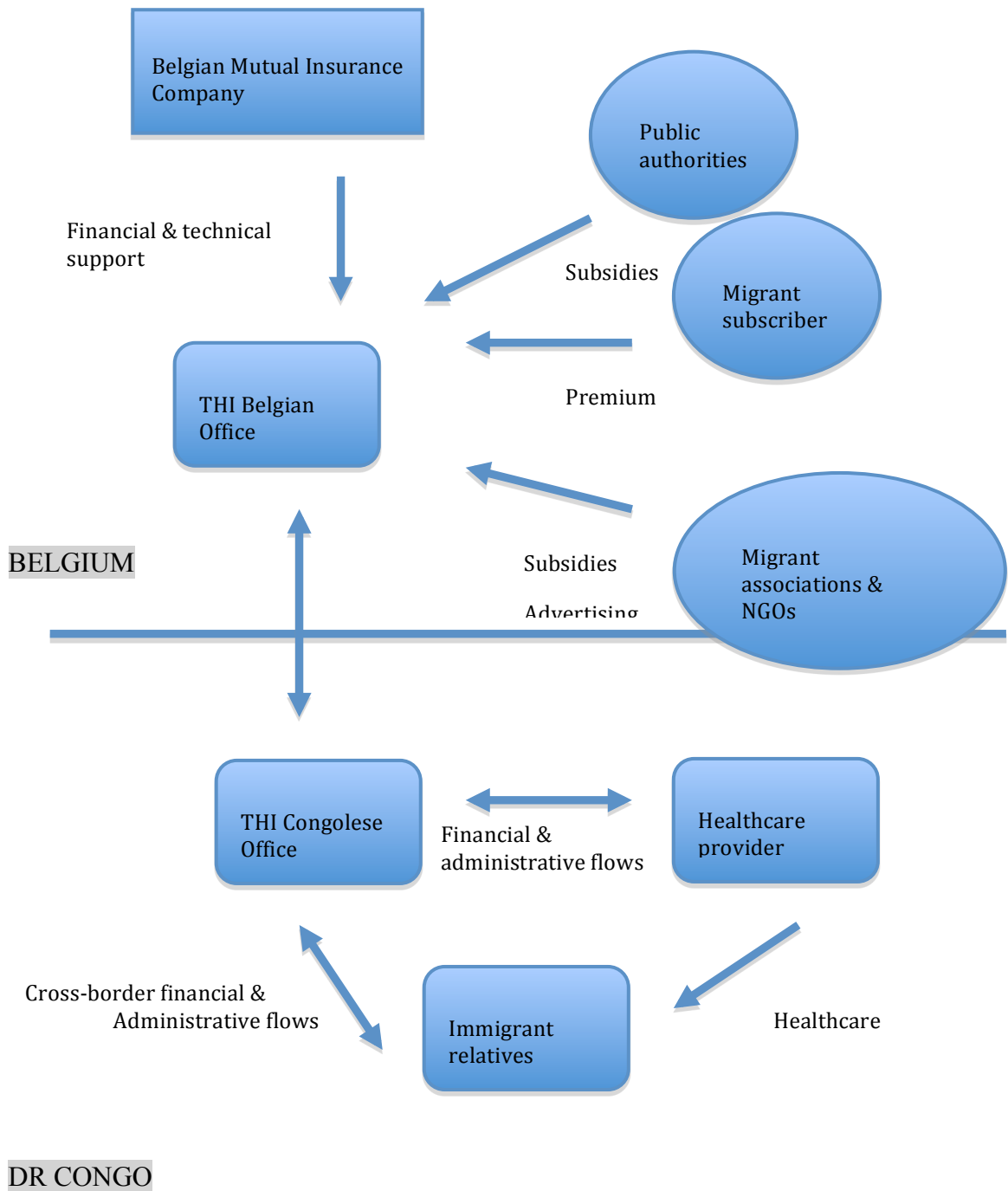
2.4 How THIs perform as a strategy for immigrants and relatives

Immigrant elite groups involved in the creation of these two THIs had high expectations for those schemes. They were convinced that there was a need for health coverage among the local population in the DR Congo and they knew that immigrants wanted to rationalize and control the healthcare expenditures of relatives. For these reasons, they envisaged that, soon after the first immigrants registered and their relatives started to receive care, word-to-mouth in Belgium and Kinshasa would ensure the success of the THIs. In practice, these initiatives met limited initial success. In addition, one of the THIs (MNK) eventually shut down in 2014⁴. During fieldwork in Brussels and Kinshasa, we could identify several reasons for the difficulties in implementing THIs, but we were also able confirm that THIs have some potentialities to improve large-scale access to healthcare in DR Congo.

These potentialities are most evidently illustrated by the participation in Solidarco of 172 Congolese migrants residing primarily in Belgium but also in France, Germany and Canada (as of September 2014). By virtue of the THI, these migrants offer health coverage to 1,204 beneficiaries in Kinshasa. In terms of access to care in the DR Congo, the latest available data from May 2014 show that the insurance scheme intervened in 236 instances in one month for a total cost of 2,343 EUR (excluding administrative fees). This basic data easily demonstrates the advantage of THIs. From a purely financial viewpoint, all these interventions represent savings for immigrants. These are costly out-of-pocket interventions and remittances transaction fees they did not have to pay for. For relatives, these represent

⁴ Because of legal issues related to the closure of MNK, we are unable to present specific financial and membership data on this scheme.

FIGURE 2. INTERESTED PARTIES' INTERACTIONS WITHIN TRANSNATIONAL INSURANCE SCHEMES



treatments they did not have to pay for (or had to ask financial transfers for). A closer look at THIs however also point out to some difficulties of implementation.

One primary difficulty we identified was a misperception about the potential financial gains of THIs. Immigrants seemed reluctant to commit spending 18 to 30 EUR a month for health coverage when the need for healthcare in the family does not necessarily occur every month. This proves particularly true bearing in mind that the Congolese-origin population in Belgium is particularly at risk when it comes to social exclusion (SPF Emploi & CECLR, 2013). Several interviewees therefore preferred to send remittances only when requested through agencies such as Western Union. For low-income immigrants, the predictability offered by THIs does not compensate for the greater flexibility in payments offered by individual remittances, even though they are aware that this strategy often entails bigger transaction fees and costlier out-of-pockets purchases of medical treatment.

The second difficulty encountered was the pressure exerted by relatives on migrants not to join THIs. Two reasons in particular may explain this pressure. Firstly, the limits set by both THIs to the number of relatives that can be covered in Kinshasa seems to run counter to the logic of transnational solidarity among Congolese families. For relatives, THIs thus seem to unfairly relieve immigrants of the responsibility to respond to kinship obligations. Secondly, THIs entail a loss of control over remittances that were formerly sent for health purposes. With THIs, relatives can no longer use left-over remittances for other purchases of their choice after their medical treatment has been paid for.

In addition, THIs face the difficulty that residents in DR Congo are unfamiliar with the concept of risk-pooling and distrustful of insurance schemes. Several interviewees found it abnormal that immigrants or relatives were not entitled to a reimbursement of the premium when no one needs to receive care. Also, as observed in previous studies about CBHI (BIT-STEP, 2002), trust in institutions is central to the success of such initiatives. In the DR Congo trust is affected by the authorities' inability to respond to the basic needs of the population over the past decades. Not-for-profit organizations that involve the diaspora such as THIs could however be less affected by this stigma; however the fact that these initiatives are promoted by Belgian institutions made several interviewees wonder whether THIs were not a new form of paternalism coming from Brussels.

Another major challenge for THIs is a bureaucratic one. These schemes involve significant coordination efforts between a large number of parties that are geographically distant and have different expectations towards THIs. The decision of the Belgian mutual insurance Symbio to shut down its THI in July 2014 is particularly illustrative of these difficulties. Over the years, MNK became increasingly affected by adverse selection (i.e. the over-representation of

immigrant relatives in poor health among the people covered by the THI). To solve this problem, MNK unsuccessfully tried to increase membership by inviting Congolese private companies to join the scheme. Simultaneously, Belgian administrators grew increasingly wary of the request of healthcare providers in Kinshasa to increase payments for the treatment of MNK patients. These setbacks seriously affected trust between Belgian and Congolese partners of the THIs which eventually led Symbio to shut down the program.

Overall, the experience of Belgian-Congolese THIs illustrate the potentialities of such schemes in a context of limited access to healthcare for immigrant relatives and the non-migrant population in home countries. At first sight, THIs offer two obvious means of adding value: they offer insurance to formerly unprotected populations; and they relieve immigrants from family members' requests for healthcare remittances. The biggest potentiality of these schemes however lies in their ability to connect with local CBHI in destination countries. Increasing risk pooling by including immigrant-sponsored local customers can indeed benefit citizens in home countries whether they have relatives abroad or not. In this sense, THIs could be instrumental in supporting the implementation of affordable health insurances in home societies. To achieve this goal, however, THIs require significant investment in terms of both time and resources in order to build trust across borders between players guided by philanthropic objectives on the one hand, and players guided by financial gains on the other.

CONCLUSION: TRANSNATIONAL HEALTH INSURANCES AS SOCIAL REMITTANCES

In the course of this article, we have identified a series of strategies that are available to immigrants who want to respond to healthcare needs of relatives in the home country. As summarized in Table 1, each of these strategies perform differently depending on whether we focus on their accessibility for immigrants, their ability to address relatives' needs, or their external effects on the availability of healthcare for all in the home society. We focused in particular on THIs as an innovative healthcare strategy for immigrants wishing to help relatives and argued that these schemes' greatest potential lie in their ability to promote the acceptance of (public or community-based) health insurance as a more efficient strategy than out-of-pocket payment. As such, THIs can trigger better access to healthcare for all citizens in the home country, whether they have relatives abroad or not.

At a theoretical level, the analysis of THIs contributes to our collective understanding of social remittances as processes of hybridization at four different levels. First, THIs further blur the limits between material and

immaterial remittances. Material elements are central to THIs: immigrants spend money to pay for premiums and relatives in the Congo receive medical care and drugs. However, when immigrants purchase coverage and relatives accept access to healthcare through THIs, more than simply material benefits are exchanged. Indeed, THIs are reflective of transnational families' acceptance of the idea that the financial management of health can be mediated by institutions, even in a context of long-lasting distrust between citizens and authorities. Therefore the political implications of THIs should not be underestimated.

Second, even though the concept of social remittances insists on the circulation of norms, ideas and behaviors between sending and receiving spaces, most research considers remittances as practices that primarily provide material benefits to home communities or triggers social transformations there. With THIs, many relatives in the home country perceive that immigrants, rather than relatives themselves, benefit the most from these schemes. Indeed, while they enjoy coverage, relatives often believe that THIs are primarily devices that help immigrants rationalize transnational solidarity and escape their kinship obligations. Conceptually speaking, and in line with Mazzucatto (2009), we contend that some forms of remittances may thus be equally beneficial for the sender and the receiver or can even benefit the sender more than the receiver.

Third, because of the multitude of players involved and the complex administrative process required to set up THIs, these schemes blur the distinction between state-led, business-led and civic-society-led channels of transnational relations. As we demonstrated, THIs are simultaneously: 1) individual remittances sent by migrants; 2) co-development policies sponsored by public authorities; 3) philanthropic projects sponsored by non-profit organizations; and 4) transnational businesses run by private parties with primarily financial objectives. As such, THIs are reflective of the turn taken by modern welfare states in Europe where social and market imperatives are increasingly intertwined in the provision of welfare.

This relates to our fourth conclusion which is that social remittances are not sent in ideologically neutral historical contexts. A full understanding of circulation of both financial and social remittances needs to take into consideration the relations between sending and receiving states. The creation and implementation of Belgian-Congolese THIs are not only the result of migrants' exposure to universal healthcare in Belgium. They are also determined by the expertise gained by Belgian authorities and civil society actors in the Congo as a result of colonization, and conversely, by the distrust that the colonial presence has generated in the sending society. Social remittances are thus also a mirror of the particular historical context in which they are generated.

Overall, this article on immigrants' strategies in the provision of healthcare to relatives in their home country has demonstrated that a multitude of disciplines including Social Policy, Public Health, and Migration and Diaspora Studies have a stake in this issue. While they do not necessarily acknowledge each other's existence, these different research fields all have conceptual and methodological tools that contribute to the understanding of this multi-faceted research object. As the academic and political interest in welfare and migration is growing throughout different parts of the world, more systematic dialogue appears necessary to make further progress in this area.

REFERENCES

- Alarcón, R. (2002) 'The Development of Home Town Associations in the United States and the Use of Social Remittances in Mexico', In De La Garza, R. O. & Lowell, B. L. (eds) *Sending Money Home: Hispanic Remittances and Community Development*. Lanham, Rowman & Littlefield Publishers.
- Amuedo-Dorantes, C. & Pozo, S. (2009) 'New evidence on the role of remittances on health care expenditures by Mexican households', Bonn, Germany, Forschungsinstitut zur Zukunft der Arbeit.
- Avato, J., Koettl, J. & Sabates-Wheeler, R. (2010) 'Social Security Regimes, Global Estimates, and Good Practices: The Status of Social Protection for International Migrants', *World Development*, 38, 455-66.
- Bit-Step (2002) 'Micro-assurance santé. Guide d'introduction aux mutuelles de santé en Afrique', BIT-STEP.
- Bollini, P. & Siem, H. (1995) 'No real progress towards equity: Health of migrants and ethnic minorities on the eve of the year 2000', *Social Science & Medicine*, 41, 819-28.
- Boulanger, C. (2014) 'Comment agir sur la couverture santé de ses proches restés au pays?', *Unpublished working paper*.
- Brand, L. A. (2006) *Citizens Abroad : Emigration and the State in the Middle East and North Africa*, Cambridge, Cambridge University Press.
- Carrin, G., Waelkens, M.-P. & Criel, B. (2005) 'Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems', *Tropical Medicine & International Health*, 10, 799-811.
- Chauvet, L., Mesple-Somps, S. & Gubert, F. (2009) 'Les transferts des migrants sont-ils plus efficaces que l'aide pour améliorer la santé des enfants? Une évaluation économétrique sur des données inter et intra-pays', *Revue d'Economie du Développement*, 23, 41-80.
- Criel, B. & Dormael, M. (1999) 'Editorial: Mutuelles de santé en Afrique et systèmes nationaux d'assurance-maladie obligatoire: l'histoire Européenne se répétera-t-elle?', *Tropical Medicine & International Health*, 4, 155-59.

- Delano, A. (2011) *Mexico and its diaspora in the United States : policies of emigration since 1848*, New York, Cambridge University Press.
- Délano, A. (2014) 'The diffusion of diaspora engagement policies: A Latin American agenda', *Political Geography*, 41, 90-100.
- Devkota, A., Devkota, B., Ghimire, J., Mahato, R. K., Gupta, R. P. & Hada, A. (2013) 'Involving diaspora and expatriates as human resources in the health sector in Nepal', *Journal of Nepal Health Research Council*, 11, 119-25.
- Drabo, A. & Ebeke, C. (2010) 'Remittances, Public Health Spending and Foreign Aid in the Access to Health Care Services in Developing Countries', *Etudes et Documents du CERDI*, 1-31. <http://halshs.archives-ouvertes.fr/halshs-00552996/en/>.
- Faist, T. (2006) 'The Transnational Social Spaces of Migration', *Center on Migration, Citizenship and Development's Working Papers*, 1-8.
- Fajnzylber, P. & Humberto Lopez, J. (2008) 'Remittances and development lessons from Latin America', Washington, D.C., World Bank.
- Frank, R., Palma-Coca, O., Rauda-Esquivel, J., Olaiz-Fernandez, G., Diaz-Olavarrieta, C. & Acevedo-Garcia, D. (2009) 'The Relationship Between Remittances and Health Care Provision in Mexico', *American Journal of Public Health*, 99, 1227-31.
- Fulton, B. D., Galarraga, O. & Dow, W. H. (2013) 'Informing public policy toward binational health insurance: Empirical evidence from California', *Salud Publica de Mexico*, 55, 468-76.
- Gamlen, A. (2006) 'Diaspora Engagement Policies: What Are They, and What Kinds of States Use Them?', *COMPAS Working paper*, 06, 1-31. http://www.ssrc.org/workspace/images/crm/new_publication_3/%7B0a6ab151-8050-de11-afac-001cc477ec70%7D.pdf.
- Goldring, L. (2004) 'Family and Collective Remittances to Mexico: A Multi-dimensional Typology', *Development and Change*, 35, 799-840.
- Holzmann, R., Koettl, J. & Chernetsky, T. (2005) 'Portability regimes of pension and health care benefits for international migrants an analysis of issues and good practices', *World Bank Social Protection Research Paper*. Geneva, Global Commission on International Migration.
- Iom (2009) *Migration and the right to health : a review of international law*, Geneva, International Organization for Migration.
- Johnson, G. E. & Whitelaw, W. E. (1974) 'Urban-Rural Income Transfers in Kenya: An Estimated-Remittances Function', *Economic Development and Cultural Change*, 22, 473-79.
- Kabki, M. J. E. (2007) *Transnationalism, local development and social security. The functioning of support networks in rural Ghana*, Leiden, African Studies Centre.
- Kilkey, M. & Merla, L. (2014) 'Situating transnational families' care-giving arrangements: the role of institutional contexts', *Global Networks*, 14, 210-29.

- Lacroix, T. (2003) 'Les réseaux marocains d'aide au développement', *Hommes et Migrations*, 121-28.
- Lacroix, T. (2005) *Les réseaux marocains du développement : géographie du transnational et politiques du territorial*, Paris, Les presse de Sciences po.
- Lafleur, J.-M. (2013) *Transnational Politics and the State. The External Voting Rights of Diasporas*, New York, Routledge.
- Levitt, P. (1998) 'Social remittances: migration driven local-level forms of cultural diffusion', *The International migration review*, 32, 926-48.
- Lindert, J., Schouler-Ocak, M., Heinz, A. & Priebe, S. (2008) 'Mental health, health care utilisation of migrants in Europe', *European Psychiatry*, 23, Supplement 1, 14-20.
- Lindstrom, D. P. & Muñoz-Franco, E. (2006) 'Migration and maternal health services utilization in rural Guatemala', *Social Science & Medicine Social Science & Medicine*, 63, 706-21.
- Lizin, O. (2013) 'Analyse des pratiques, représentations et interactions acteurs investis dans les projets mutualistes internationaux, De Bruxelles à Kinshasa, de Kinshasa à Bruxelles : Solidarco et MNK Œuvre de Santé (Master Thesis)', Université de Liège.
- López-Cevallos, D. F. & Chi, C. (2012) 'Migration, remittances, and health care utilization in Ecuador', *Pan American journal of public health*, 31, 9-16.
- Mackenzie, C. (2005) *Labour migration in Asia : protection of migrant workers, support services and enhancing development benefits*, Geneva, International Organization for Migration.
- Massey, D. S., Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A. & Taylor, J. E. (1993) 'Theories of International Migration: A Review and Appraisal', *Population and Development Review*, 19, 431-66.
- Mazzucato, V. (2009) 'Informal Insurance Arrangements in Ghanaian Migrants' Transnational Networks: The Role of Reverse Remittances and Geographic Proximity', *World Development*, 37, 1105-15.
- Mazzucato, V. & Kabki, M. (2009) 'Small is beautiful: the micro-politics of transnational relationships between Ghanaian hometown associations and communities back home', *Global Networks*, 9, 227-51.
- Mcintyre, D., Thiede, M., Dahlgren, G. & Whitehead, M. (2006) 'What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts?', *Social Science & Medicine*, 62, 858-65.
- Moctezuma Longoria, M. (2003) 'Inversión social y productividad de los migrantes mexicanos en los estados unidos', *Migración y Desarrollo*.
http://rimd.reduaz.mx/documentos_miembros/191715.pdf.
- Oecd (2005) *Migrations, transferts de fonds et développement*, Paris, OECD Publishing.

- Orozco, M. & Lapointe, M. (2004) 'Mexican Hometown Associations and Development Opportunities', *Journal of international affairs*, 57, 1-21.
- Østergaard-Nielsen, E. (2009) 'Mobilising the Moroccans: Policies and Perceptions of Transnational Co-Development Engagement Among Moroccan Migrants in Catalonia', *Journal of Ethnic and Migration Studies*, 35, 1623-41.
- Parreñas, R. S. (2001) *Servants of globalization : women, migration and domestic work*, Stanford, Calif., Stanford University Press.
- Pasadilla, G. O. (2011) 'Social protection for migrant workers in ASEAN', *Research policy brief of the Asian Development Bank Institute*, 1-21.
- Portes, A., Escobar, C. & Radford, A. W. (2007) 'Immigrant Transnational Organizations and Development: A Comparative Study', *International Migration Review*, 41, 242-81.
- Portes, A., Fernandez-Kelly, P. & Light, D. (2012) 'Life on the edge: immigrants confront the American health system', *Ethnic and Racial Studies*, 35, 3-22.
- Ragazzi, F. (2014) 'A comparative analysis of diaspora policies', *Political Geography*, 41, 74-89.
- Sabates-Wheeler, R. K. J. (2010) 'Social protection for migrants : the challenges of delivery in the context of changing migration flows', *International Social Security Review*, 63, 115-44.
- Schoonvaere, Q. (2010) 'Etude de la Migration Congolaise et de son Impact sur la Présence Congolaise en Belgique: Analyse des principales données démographiques', Bruxelles, Centre pour l'Egalité des Chances et la Lutte contre le Racisme.
- Smith, L. (2007) *Tied to migrants : transnational influences on the economy of Accra, Ghana*, Leiden, African Studies Centre.
- Smith, R. C. (2003) 'Diasporic Memberships in Historical Perspective: Comparative Insights from the Mexican, Italian and Polish Cases', *International Migration Review* 37, 722-57.
- Smith, R. C. (2006) 'Mexican New York transnational lives of new immigrants', Berkeley, University of California Press.
- Spf Emploi & Ceclr (2013) 'Monitoring Socio-economique', Brussels.
- Stark, O. & Bloom, D. E. (1985) 'The New Economics of Labor Migration', *The American Economic Review*, 75, 173-78.
- Tjadens, F. L. J. W. C. E. J. (2013) 'Mobility of health professionals health systems, work conditions, patterns of health workers' mobility and implications for policy makers', Berlin, Springer.
- Vargas Bustamante, A., Laugesen, M., Caban, M. & Rosenau, P. (2012) 'United States-Mexico cross-border health insurance initiatives: Salud Migrante and Medicare in Mexico', *Revista Panamericana de Salud Pública*, 31, 74-80.
- Vargas Bustamante A., Ojeda, G. & Castañeda, X. (2008) 'Willingness to pay for cross-border health insurance between the United States and Mexico', *Health affairs*, 27, 169-78.

- Who (2008) 'Closing the gap in a generation: Health equity through action on the social determinants of health. Report of the Commission on Social Determinants of Health', Geneva.
- Who (2014) *World health statistics 2014*, Geneva, World Health Organization.
- Yeates, N. (2008) 'Global Migration Policy', In Yeates, N. (ed) *Understanding Global Social Policy*. Bristol, Policy.
- Yeates, N. (2009) *Globalizing care economies and migrant workers : explorations in global care chains*, Houndmills, Basingstoke, Hampshire, New York, N.Y. : Palgrave Macmillan.