1. Introduction

Globalisation has become mundane, a cliché grown ever more banal through meaningless repetition. It is everything and nothing, somehow pervasive in everyday life: a marker for our times. Largely associated with the relatively recent spread of capitalism – commercialism, consumption, global corporations, industrialisation and trade, each with seemingly Western characteristics – abetted by political, technological and cultural shifts, it has produced, and is part of, great transnational flows and circulations of people, goods, services, information and capital, creating new global divisions of labour and ever-expanding deterritorialised communities – bound together by social ties and economic transactions across ever more complex networks. The contemporary world is a site of multiple interdependencies, whether of transnational corporations, international production chains, global financial markets or real and potential pandemics. Globalisation also involves growing and evolving patterns of international migration of skilled health workers with complex consequences for service provision, at home and abroad. This book seeks to draw together much still-emerging work on the international migration of health workers – just one part of a wider flow of skilled and unskilled (or low-skilled) migrants. In practice, although the book attempts to consider a range of skilled health workers (simply defined as those with more than a year’s health training), it largely focuses on nurses and doctors, although in some contexts the migration of small numbers of specialised workers, including managers, is of particular importance. Which people move, what happens to them and the effects of their mobility are at the core of the book.

The international migration of skilled health workers (SHWs), the first significant ‘brain drain’, parallels a seemingly similar migration of other professions, notably IT workers (Xiang 2007; Millar and Salt 2007) but also financiers (Beaverstock and Smith 1996), teachers (Voigt-Graf 2003), sportsmen (Lanfranchi and Taylor 2001), engineers, geologists and various others. This steady growth in skilled migration reflects the expansion, internationalisation and accelerated globalisation of the service sector in the last two decades (e.g. Iredale 2001; Findlay and Stewart 2002), rising demand for skilled workers in developed countries (where sophisticated training is increasingly costly) and their supply in countries where once they were absent. New flows exist: small and distant
island states such as Fiji provide military and security personnel for Iraq and Kuwait, while Thai restaurateurs open restaurants in Nigeria. Such professional services as health care are part of the new internationalisation of labour, and have increasingly been demand driven (or at the very least facilitated), resulting in the growing global integration of health care markets. Demographic, economic, political, social and, of course, health transformations have had significant impacts on global, regional and local migration flows. Migration has consumption and investment benefits, affecting population size, composition and health status, and the ability of countries, through their populations, to engage in global economy and society. Health workers directly improve the quality of life for others, who can then contribute more to wider society. Ultimately health workers are different from other skilled workers: they literally keep people alive and ensure the well-being of communities and nations.

A SHORT HISTORY?

From early colonial times health workers have migrated, often in support of colonial administrations, and long before most other groups of skilled workers. Half a century ago, in the 1960s, when the international migration of SHWs first became important, doctors – mostly men – were the main migrant group, but nurses – mostly women – have gradually become more numerous, and migration has taken on a gendered structure unlike other components of skilled migration. There are both new pressures and new opportunities for women to work, that challenge simplistic representations of migrant women as passive and unskilled (Kofman and Raghuram 2006). Nurses form the majority of all SHWs: they have become the quintessential skilled migrants, transforming domestic, emotional labour in the West, while sometimes producing a vacuum in sending countries (Brush and Vasupuram 2006). Health workers share important elements of this emotional labour.

Relative declines in public sector funding have enhanced the perception that working in that sector is less desirable. A greater range of jobs for women now exists, outside a sector that is seen by some as dirty and dangerous (and unrewarding), sometimes difficult and demanding, and even perhaps degrading, especially where HIV/AIDS has become significant. In many developed countries, as the children of the ‘baby boom’ generation have grown up, fewer national workers now enter the workforce. Partly in consequence, demand for nurses far exceeds that for doctors and other health workers, so that in some countries male doctors have retrained as nurses to secure migration opportunities.
Restructuring, usually externally imposed, has affected health systems of developing countries, notably in some sub-Saharan and small island states, contributing to static or declining budgetary support for health (see Chapter 2). Declining funding has inevitably raised concerns over wages, working conditions, training and other issues, all of which have stimulated migration, enhanced by more active recruitment. Accelerated demand and recruitment by developed countries, where populations are ageing, expectations of health care increasing, recruitment of health workers (especially nurses) is not easy and attrition considerable, has increased the volume of migration and the number of countries that are involved, raising complex ethical, financial and health questions. Technology cannot easily replace workers, while the rise of HIV/AIDS and more chronic diseases has put new demands on workforces.

Public health provision emerged historically as a key policy of most nation states, a crucial element of state responsibility for the welfare of its citizens and typified in variants of the post-war British welfare state. The role of the state in health care has significantly altered with the rise of migration. To a greater extent than for the international migration of other skilled workers, the state plays a crucial role in its organisation and regulation: through defining standards, the domestic production of skills, the formulation of migration criteria (skills and points), structured bilateral labour movements and, less directly, by the establishment of skill mixes, wage levels and working conditions. States bond scholarship holders and seek to direct SHWs to particular regions and specialities. Recruitment agencies, licensed by the states and partially regulated by national and international codes, play an increasing role in stimulating and directing migration flows. The economic logic of market forces is both blunted and restructured by the institutional barriers and channeling mechanisms of state policies, within which context individuals and their families make critical choices over occupations and destinations. Significantly, the health sector is also somewhat different from most other skilled sectors since the bulk of employment usually remains in the public sector, with the singular prominent exception of the USA, but where conditions have tended to worsen (relatively and sometimes absolutely) with restructuring and inadequate funding. Virtually ubiquitously there has been movement of workers and patients from the public to the private sector.

The first significant wave of international migration of SHWs in the 1960s was of doctors, from large Asian states like the Philippines and India, and also Iran, mainly to the USA. With training oriented to overseas needs, the Philippines had already contributed the largest number of overseas doctors in the USA. Doctors and nurses from the Philippines
and South Asia had started to go to the Gulf and the UK (Mejia et al. 1979). Over time, what were then relatively simple migration flows, usually reflecting linguistic, colonial and post-colonial ties, became steadily more complex, more obviously perverse (being away from areas of greatest need, nationally and internationally), and stimulated by active recruitment. As health care has become more commercialised, so too has migration. Migration routes came to encompass most countries, some as both sources and destinations, with few parts of the world unaffected. China and East European countries have recently become important sources and Japan a destination. The countries most affected by emigration are mainly anglophone states in sub-Saharan Africa alongside some small island states in the Caribbean, Atlantic and Pacific (although numbers have been greatest from such Asian countries as India and the Philippines). In many source countries national economies are often performing poorly, and populations still growing steadily, thus putting increased pressures on health systems. The major recipient countries are the developed nations, including the USA, Canada, the UK, Australia and New Zealand, but also several in the Gulf, notably Saudi Arabia, Kuwait and the United Arab Emirates.

Increasingly, global migration is linked to skill status. Skilled professionals constitute a growing proportion of all migrants, as new technologies enable and promote a global labour market, and production of skilled workers is inadequate in most developed countries, which therefore seek to hire, regulate and recruit skilled migrants. Many of the relatively affluent Organization for Economic Co-operation and Development (OECD) countries have eased legislation on the entry of highly skilled workers (OECD 2005). Countries like Canada, Australia, New Zealand, and more recently the UK, have developed and expanded migration points systems that favour skills to regulate and facilitate entry, and the EU has moved towards a ‘blue card’, to expedite the movement of skilled workers. The migration of health workers is a key element of these global changes, as health skills are in international demand, linking countries through waves of increasingly diverse migration in a now global and hierarchical health care chain.

A WIDENING CONTEXT

Health workers may be skilled but their migration is not necessarily distinct from that of others. In south India, the Philippines and many small island states, migration of SHWs has occurred over more than one generation, and is embedded in a context where it has become pervasive, based
on established historical precedent and widely accepted as an appropriate means of achieving economic and social well-being. It is thus nurtured and enhanced by the presence of overseas or otherwise distant kin, and the incomes and prestige attached to migration, to the extent that it has become normal and expected. In such circumstances a ‘culture of migration’ exists (Connell 2008b), which extends equally to skilled and unskilled workers. Policies that discourage migration may be scarcely feasible.

Migration of SHWs usually occurs in a wider cultural and mobility context, even involving the creation of extended household ‘transnational corporations of kin’ (Marcus 1981), with great significance for the creation of human capital and the flow of remittances to home countries and households. Migration is a response to rising expectations over what constitutes a satisfactory standard of living, a desirable occupation, a suitable mix of accessible services and amenities for workers and their children, and, perhaps, even a chance to live in a pleasant place. Since health workers do not necessarily make individual decisions to migrate, but are part of extended households, influences on migration coming from within the health sector may sometimes be trivial. While ‘push’ and ‘pull’ factors usefully explain particular migration decisions, such choices are better seen as part of a fluctuating household dynamics, where migration diversifies livelihoods within an evolving transnational network. Cultural and political complexities permeate what might otherwise be merely a ‘new economics’ of migration.

Health workers move primarily for economic reasons, in much the same way as many other migrants, and increasingly choose health careers because they offer migration prospects, and social and economic mobility. Because of relatively high incomes in the health sector, international salary differences are greater than for unskilled workers, hence the likelihood of becoming an ‘economic migrant’ may also be greater. Tertiary health training can provide a passport to distant prosperity. A substantial element of the migration of SHWs represents a strategic investment in education as part of a broader investment in migration within a globalising world. Otherwise health workers, in most respects, are little different from many other migrants – they take account of extended-family locations and aspirations in choosing destinations and migration strategies, and play a key role in sending remittances.

The globalisation of migration is simply a new form of what has long been referred to as step migration, often via intermediate ‘transit stations’ and ‘stepping stones’, as health workers engage in ‘cascade migration’, often culminating in the USA, or more dramatically along a ‘global conveyor belt’ or ‘medical carousel’, that transfers professionals from poorer to richer countries, and ‘from the bottom to the top’ (Schrecker
and Labonté 2004; Kingma 2006). Seemingly inexorable, the ever-shifting carousel, that a century ago took missionaries to developing countries, now draws health workers from just those countries to richer countries. In recent years it has even begun to take health workers from the richest countries, such as France and Germany, to the UK and elsewhere, alongside commuter migration (see Epigraphs). The more ethical migration of the missionary era has evolved into a more materialistic contemporary migration.

**POLICY AND PRACTICE**

Health care ministries and national and regional governments throughout the world have had to respond to new migration flows, even where they instigated them, through policies that seek to train and retain skilled staff, or encourage them into new places or positions, while ensuring the effective delivery of care. The particular significance of health care has posed ethical issues and led to pressure for international codes of practice for recruitment. Globalisation (and also urbanisation, with half the world’s population now being urban) has increased migration flows, of people (whether as refugees, migrant health workers or medical tourists) and diseases (notably HIV/AIDS, but also SARS, swine flu and avian flu), emphasised new forms of inequality and provided (and demanded) opportunities for a global commitment to improved health, evident in the Global Fund, PEPFAR, the Global Health Programme of the Bill and Melinda Gates Foundation and other similar initiatives. A greater concern for social justice and equity, evident in the Alma Ata declaration of 1978 and the initial WHO Health for All slogan and strategy, has entered most debates on globalisation and health, and been enshrined in the United Nations Millennium Development Goals (MDGs), where health issues have some prominence, and a renewed focus on primary health care.

Despite the growth and significance of migration, in numbers, impacts (medical, economic, social and political), few books examine the overall situation in any detail, despite past studies (Gish 1971; Mejia et al. 1979) and recent work on the migration of nurses (Kingma 2006). Similarly, most of the literature on health-worker migration from particular regions, such as SSA, has tended to focus on migration towards the USA, the UK and Canada (Hagopian et al. 2005; Mullan 2005; Ross et al. 2005). Little has been documented on the extent of migration to the Gulf, Australia or New Zealand, although the last has one of the highest proportions of overseas trained health workers in the world (Zurn and Dumont 2008). Good data on migration flows are largely absent, even for most countries
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where migration is significant. Despite the impact of health worker migration on the functioning of health systems, there is a remarkable paucity and incompleteness of data, much of which is collected in quite different ways in sources and destinations. It is therefore difficult to determine the real extent of migration from, and within, most source countries, and thus develop effective forecasting or remedial policies (Stilwell et al. 2003). For a decade the ‘fact’ that there are more Malawian doctors in Manchester than in the whole of Malawi has been widely circulated but without supporting data. Less visible health workers, such as pharmacists and radiologists, whose migration may be as critical as that of better-documented nurses and doctors, have largely been ignored. Without better data, reaching definitive conclusions on the structure and impact of migration is challenging, and evidence-based policy formation problematic.

A growing number of studies have examined the migration of skilled workers from the perspective of human resources but relatively few have examined migration from the migrants’ perspectives. While the human resource context is central to migration (and its outcomes), rather more attention is given here to the migrants themselves and their aspirations. A distinctive feature of the migration of mainly women health workers is that high earnings, comfortable status and accelerated professional status, the outcomes for many skilled migrants (Favell et al. 2006: 18), are less frequent for skilled nurses. Moreover, social costs have followed, especially as women workers are separated from families. Yet migration meets individual, household and, increasingly, even national aspirations. New skills and experience are acquired and remittances support extended families at home. This book seeks therefore to provide new, interdisciplinary reflections on such core issues as the brain drain, gender roles, remittances and sustainable development at a time when there has never been greater public and political interest in the migration of health workers.

Migration has been at some economic cost, has left gaps and depleted workforces, diminished the effectiveness of health care delivery and reduced the morale of the remaining workforce. In many source countries, but in SSA especially, failure to invest adequately in health systems and professional health education, the rising death toll from AIDS, and consequent migration of SHWs, are all major factors contributing to the ongoing health workforce crisis, and explain contemporary emphasis on ‘scaling up’: the substantial global expansion of education and training (Global Health Workforce Alliance 2008). Overall shortages tend to be aggravated by uneven distribution within countries, the movement of health workers from rural to urban areas, and from the public to the private sector, alongside attrition and retirement. As demand in rich countries increases, such shortages are likely to persist, and unless there is
greater recruitment into the health workforce, less attrition, or significant policy changes, migration too is likely to continue. Changing expectations will place further demands on health systems.

Countries have sought to implement national policies on wage rates, incentives and working conditions to gain and retain workers, sometimes with desperate strategies (see Epigraphs), but most recipient countries have been reluctant to establish effective ethical codes of recruitment (itself made easier by instantaneous access to websites through the Internet), or modes of compensation. In a context of existing shortages, migration has further weakened fragile health systems, and been perceived as a financial subsidy from the poor to the rich. Yet migration may increase further, diminishing the possibility of achieving the MDGs, challenging workforces to manage HIV/AIDS and exacerbating existing inequalities in access to adequate health care.

Where needs are greatest, and where recruitment has been significant throughout this century (Connell and Stilwell 2006; Rogerson and Crush 2008), words such as ‘poaching’, ‘looting’, ‘stealing’, and even the ‘new slave trade’, a ‘tug of war’ (Hamilton and Yau 2004) and the ‘great brain robbery’ (Patel 2003) have entered the literature. Richards has argued that migration is not so much a drain but ‘a positive suction on the part of many developed countries’ (2002: 112). No less than Nelson Mandela spoke out in 1997 about Britain’s poaching of nurses from South Africa, while also accusing the migrant health workers of being ‘cowardly and unpatriotic citizens’, perpetuating a ‘fundamental betrayal of the nation’. More sober concepts of brain and skill drain have become common alongside more polemical newspaper articles. In May 2005 the English newspaper *The Independent* splashed across its front page, above the photo of an obviously sick child, the banner headline ‘An African Child Four Weeks Old Disabled by Britain’ which was attributed to Britain’s ‘voracious demand for Third World doctors nurses and midwives’ so that too few remained in Ghana (27 May 2005). Three months earlier *The Times* had a headline ‘NHS Strips Africa of its Doctors’ (22 February 2005). More sober academic accounts have referred to ‘fatal flows’ (Chen and Boufford 2005) and ‘care drains’ (Kittay et al. 2005); Kingma (2006) has queried whether a ‘global treasure hunt’ will be a ‘disaster in the making’ and Mullan et al. have argued that the approximately 5000 international medical graduates (IMGs) who join the permanent physician workforce in the USA alone each year ‘represent the equivalent of the entire graduating classes of some 50 medical schools around the world’ (1995: 1521). A group of academics later asked ‘Should active recruitment of health workers from sub-Saharan Africa be viewed as a crime?’ and argued that it should (Mills et al. 2008). In the same year the Ugandan Minister of Health argued that
'Rich nations are snatching our doctors' (quoted in Wasswa 2008: 579). Such phrases and negative perspectives can be repeated seemingly indefinitely. It is widely argued that the excessive migration of health workers is unethical and challenges goals of redistributive justice and universal access to adequate health care, since the erosion of human capital that migration usually entails has a direct impact on the provision of welfare, measured through static or falling health indicators in primarily source countries. Yet amidst all such emotion and argumentation migrant health workers are themselves choosing to move, even if from challenging socioeconomic contexts in circumstances only partly of their own choosing. This book makes some effort to examine these assertions, rectify past omissions, distinguish anecdote from data, balance polemic with argument and provide a more comprehensive perspective.

Chapter 2 examines the need for health workers and the broad relationship between disease burdens and the actual distribution of health workers, with SSA emerging as a region of unresolved need, where migration is none the less significant. Chapter 3 discusses the lengthy history of migration and the transition from a more evidently colonial migration towards needy places, to a more perverse, complex and global migration away from them. Chapter 4 assesses the extent to which developed countries have stimulated demand for SHWs, as demographic shift produces ageing societies and ageing health workers, and attrition takes its toll on the workforce. The following three chapters shift attention to developing countries, initially examining why people become health workers, and what role opportunities for migration play in this (Chapter 5), the broad rationale for migration, from discontent with salaries and working conditions to the blandishments of recruitment agencies (Chapter 6), and the effect that migration has on health care provision and on health workers in sending societies (Chapter 7). These impacts lead into an assessment of the brain drain, which seeks to balance the economic costs of migration, largely from training, with the rewards from remittances and return migration (Chapter 8). Since many, but not all, countries recognise costs to migration, a range of policies has been developed to discourage migration, increase the gains from migration, regulate it more effectively or even stimulate it, although few policies have had enormous success (Chapter 9). Finally the Conclusion points to the distinctiveness of the skilled migration of health workers and reflects on the remarkable and recent globalisation of health care that has produced new forms of uneven development.