MIGRATION AND SOCIAL POLICY IN INTERNATIONAL CONTEXT:
THE ANALYTICAL AND POLICY USES OF
A GLOBAL CARE CHAINS PERSPECTIVE

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Abstract: This paper examines the migration-social policy nexus in global context, using a ‘global care chains’ perspective to do so. Generally speaking, this perspective emphasises the centrality of care labour to livelihood strategies of households, be they located in ‘developed’ or ‘developing’ countries, as well as the internationalisation dimensions to these strategies and their socio-economic impacts at individual, household, community and national levels. It highlights that an asset-based approach to social policy must not only focus on formal and informal care labour but also analyse the transnational as well as national dimensions of social policy. The first part of the paper sets out the various analytical elements of this perspective, while the second part of the paper draws out its policy applications. In particular, through a focus on skilled and unskilled migrant care workers, the paper maps different policy approaches to the regulation of these workers in a variety of ‘host’ and ‘sending’ countries internationally and discusses the transnational dimensions and impacts of the various policies and practices identified.

Keywords: international migration; trade; nurses; global care chains; inequality

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1. Introduction

This paper examines the migration-social policy nexus in global context, using a ‘global care chains’ perspective. This perspective emphasises the centrality of care labour to the livelihood strategies of households, be they located in ‘developed’ or ‘developing’ countries, as well as the internationalisation dimensions to these strategies and their impacts at individual, household, community and national levels. Its particular strength is to highlight the need for social policy to focus on the contributions of formal and informal care labour to well-being and social development as well as the transnational and national dimensions to social policy and welfare. The first part of the paper sets out the underlying premises of the paper together with the analytical elements of the global care chains approach to social policy, while the second part draws out the applications of the approach to international migration. In this second part, the discussion focuses on the international aspects of health care worker migration, in particular nurses. It begins the process of mapping different policy approaches to the regulation of these workers in a variety of ‘host’ and ‘sending’ countries internationally and initiates a discussion of the transnational dimensions and impacts of the various policies and practices identified. The paper concludes by drawing out the main points of the discussion in the light of global care chain analysis generally and the Conference aims and themes specifically.

2. Care, social policy and social development: a transnational approach

Two premises about social policy and development inform this paper. The first of these is that social policy must be analysed at the transnational level as well as at the national level. Social sciences have tended to emphasise links, activities and processes occurring ‘within’ countries to the neglect of those that cut across them. This ‘methodological nationalism’ is increasingly being questioned as transnational processes, be they ‘from above’ or ‘from below’, institutionalised or non-institutionalised, formal or informal, have become more significant. To a large extent, this attention can be attributed to the emergence of ‘globalisation studies’ that emphasises the ways in, and degree to, which societies, economies and polities have become more ‘enmeshed’ as the spread of activities, links and ties beyond national borders has become more extensive, the transnational interactions themselves have become more intensive, and the speed of these interactions and processes have become faster (Held et al, 1999).
In the social policy context a transnational approach attends to the following: movements of capital, goods, services, people and ideas across international borders (as in international health, education and welfare markets, individual or household livelihood strategies; policy diffusion processes); institutions, policies and practices cutting across ‘the national’ domain (as in the extra-territorial reach of state policy and provision; as in social entitlements for nationals and non-nationals living abroad); the external effects and dimensions of government policy (be it international aid and development policy as ‘foreign social policy’ and/or the social dimensions of foreign trade policy); and the supra-national dimensions of social policy (as in the implicit and explicit social policies, provision and activism of governmental and non-governmental organisations operating at world-regional and global levels). Attending to the transnational context of social policy and development also involves foregrounding how ‘national’ institutions and structures are embedded in/linked to the global political economy. Much attention is being paid to how contemporary globalisation processes are reshaping national welfare states and provisions but there are also ‘rich pickings’ to be made from research into the ‘deep’ global links in the social policy sphere, such as how social policies were shaped by colonialism in both colonial and colonised countries alike, as well as by uneven development processes more generally.

The second premise of this paper is that social reproduction generally and care specifically is central to any discussion of social policy and development. Contrasting with psychological approaches to care-giving that emphasise individual motivations, emotional attachments and identities of care-givers, a prominent stream of social policy analysis conceptualises care-giving as labour, be this physical labour involved in ‘caring for’ another or emotional labour involved in ‘caring about’ another (Hooyman and Gonyea, 1995). Care labour can accommodate an incredibly wide range of social reproduction activities ranging from highly intimate social, health and sexual care services to less intimate ones (e.g. cooking, cleaning, ironing and general household maintenance work) offered on a waged and/or non-waged basis in domestic and/or institutional settings. Because of this diversity, a more restrictive meaning of care is used in social policy, referring to ‘custodial or maintenance help or services, rendered for the well-being of individuals who cannot perform such activities themselves’ (Waerness, 1985, in Hooyman and Gonyea, 1995: 3, emphasis added), typically ill, disabled, elderly and young people (Daly, 2002). The care services sector is highly diverse, embracing a range of groups with different ‘skill’
levels/occupational positions, working in different settings and under different conditions (Yeates, 2004a).

Questions such as who provides care, how much of it, to whose benefit and whose cost have been central to linking ‘private’, household-level arrangements with wider social/gender relations and the importance of public provisions and policies in mediating these relations. Typically emphasised is the close relationship between non-waged and waged labour: the work women undertake for wages outside the home often mirrors that which they undertake within it; women’s provision of unpaid care labour subsidises public expenditure savings; and because the provision of this labour negatively impacts on their availability for paid work it also shapes their access to the social wage and long-term socio-economic security (Pascall, 1997). One of the most useful ways of approaching the relations between care and social policy is to situate care labour within the gendered social relations of production. This approach emphasises household reproductive labour as a basic input into production processes and the importance of social policy in maintaining gendered household relations underpinning the production of surplus and its unequal division (Delphy and Leonard, 1984; Mies, 1986).

Given the focus of social policy on intra-national and national-level spheres it is not surprising that the transnational dimensions of formal and informal care provision have been relatively neglected. That said, there is growing interest in the implications of the internationalisation of health and social care services for social policy, though much of this is focusing on private corporations’ strategies to the neglect of governmental, NGO and household strategies. Moreover, although ‘care studies’ is fully conversant with the importance of domestic care economies and the divisions of paid and unpaid care work in the context of different national settings it has paid little attention to either the existence of an international division of reproductive labour and the repositioning of countries within it or to the ways in which transnational processes intersect with ‘internal’ social policies to mediate social relations of care and the distribution of resources within national settings. It is in this context that the global care chains perspective is proving useful.

3. The ‘global care chains’ perspective

The term ‘global care chain’ refers to ‘a series of personal links between people across the globe based on the paid or unpaid work of caring’ (Hochschild, 2000: 131). Hochschild’s focus lay

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1 This section derives from Yeates (2005).
with transnational transfers of ‘motherly’ labour, so she describes a global care chain as typically entailing

an older daughter from a poor family who cares for her siblings while her mother works as a nanny caring for the children of a migrating nanny who, in turn, cares for the child of a family in a rich country. (2000: 131)

It is worth spelling out the processes entailed by this phenomenon. The first process is the outsourcing of domestic care labour. This outsourcing occurs on both national and international scales; it entails mobilising labour supply through informal (kin) networks as well as through the market mechanism. It usually involves migration, be it on an intra-country basis (rural-urban migration) or on a cross-border basis (e.g. Mexicans to California) or on a trans-regional basis (e.g. Filipinas to US). The second process concerns household internationalisation strategies. For those households located in poorer (sending) countries, this strategy takes the form of the emigration of the mother to provide care labour overseas; for richer households it takes the form of overseas labour recruitment. Through these internationalisation strategies an international network of families is established. These networks are comprised of links amongst the same families through the formation of transnational households as well as links between different families through the employment nexus. These networks are not confined to adults, forging as they do ‘global links between the children of service-providers and those of service-recipients’ (Hochschild, 2000: 132).

These processes embody major social divisions and inequalities. Most obviously, they reflect the social divisions of class, wealth, income and status, with richer households located in richer regions or countries outsourcing (part of) their care labour requirements to members of poorer households drawn from poorer areas within the same country or from a poorer country in the same region. These differences in class standing are also reproduced through the outsourcing process, since the employment of a domestic worker is a means of reproducing lifestyle and social status. Those at the end of the chain are too poor to be able to employ a domestic worker and their outsourcing takes the form of reliance on unpaid family labour.

Female labour is central to global care chains, with women supplying their own care labour while consuming other women’s paid and unpaid care labour. While the focus of global care
chains obviously lies with women, it is important to explain the apparent ‘absence’ of men in this process and more generally to situate global care chains within gendered divisions of labour in both the receiving and sending countries. Thus, Parreñas (2001, 2005) highlighted that women in the sending country undertook care labour mainly as a result of the male non-migrant’s failure to undertake care labour to replace the migrant mother’s labour. She found that fathers of all social classes tended to migrate to take up other work in the Philippines that enabled them to avoid providing such labour. In the receiving country, the ageing of the population, changes in family structure, the feminisation of the labour force, the masculinisation of women’s employment patterns, and a shortage of public care services make it difficult for female family members to perform reproductive work. For those able to afford it, the purchase of domestic labour relieves women from doing this work themselves and helps avoid generational and gender conflict over the division of domestic work (Andersen, 2000, 2001).

Finally, the outsourcing process is structured by ‘race’ and ethnicity (and caste) as well as by gender and social class, with migrant women and women drawn from minority ethnic groups brought in to provide care services. Thus, in the US context women to whom this labour is subcontracted tend to be Filipino or Hispanic. Employers reportedly seek nationals from countries whose populations are believed to express particular personality or behavioural characteristics. The low cost of this type of domestic labour is another factor, as is the control of this labour. Thus, domestic work in private households is an important sector of work for newly (legally and illegally) arrived immigrant women in the EU, and is often the only alternative to sex work. The option to leave an employer is further restricted by the fact that migrant workers’ family welfare is dependant on the remittances she sends home (Anderson, 2001).

This work on global care chains is one example of a large number of studies that have grappled with ‘globalisation’ processes through an examination of the international migration of female domestic workers, in particular nannies (e.g. Anderson, 2000; Chang and Ling 2000; Chin, 1998; Cock, 1984; Gamburd, 2000; Heyzer et al, 1994; Hondagneu-Sotelo, 2001; Lutz 2002; Momsen, 1999; Parreñas, 2001). This literature invariably points to the now buoyant global trade in domestic care services, with the massive and increasing demand for migrant domestic workers throughout wealthier countries of the world and the supply of domestic workers by a range of less wealthy ones. This trade is said to be increasing rapidly for childcare and elder care, as well as other forms of domestic and personal care services. In the US, for example, home health care and
cleaning are amongst the fastest growing areas within the care services sector.\(^2\) The workers of the ‘new’ service economy are increasingly sourced from outside the US, particularly from poorer countries, though this phenomenon is not confined to that country alone. Indeed, foreigners are over-represented\(^3\) in household services in the US as well as in certain other European countries such as Belgium, France, Germany, Greece, Italy, Luxembourg, Spain and Switzerland (OECD, 2002: 63).

This international trade in domestic care labour must be placed in the context of greater population movement in general and the feminised nature of international migration in particular, which are in part a response to the problem of uneven development. Through the income generated from work abroad, household internationalisation strategies are often key not only to the economic survival of the households concerned, the welfare of individual members therein, and the broader communities in which they live but also to the economies of the countries from which they emigrate. Thus, international remittances generated by migrant workers may be one of the few sources of foreign currency for some countries and can be as, if not more, important than overseas aid provided. In addition to being a major source of international financing for welfare, the international trade in migrant workers is central to the international politics of debt.

Having reviewed the general features of global care chains the discussion sets out the distinctive contributions of the concept. Most obviously, the concept draws on a value chains approach to international migration. Normally used by those studying the globalisation of production processes, a value chain approach generally aims to map the series of activities involved in the production and consumption of a manufactured product, the coordination of those activities by a network of agents and the distribution of risks, costs and profits along the chain (Kaplinsky, 2000). The value chain is used in a wide variety of approaches to the study of production but it has been primarily operationalised by global commodity chain analysts concerned with the emergence and consequences of a global manufacturing system (Gereffi and Korzeniewicz, 1994). Global commodity chain analysis maps the distribution and structure of manufacturing processes along three dimensions, as summarised in Figure 1. Focusing on a variety of sectors (automobiles, electronics, toys, apparel, agri-produce), global commodity chain analyses

\(^2\) Nearly 4 million beneficiaries of home health care services are served by over 10,000 home health agencies (International Trade Centre 1998), while ‘nursing homes employ more workers in the US than the auto and steel industries combined’ (Folbre 2002: 186).

\(^3\) The share of foreign employment in that sector is higher than the share of foreign employment in total employment.
have demonstrated how manufacturing processes exhibiting different patterns of organisation, competition and power relations allocate risks, costs and benefits differentially amongst chain participants, and how this produces different patterns of wealth distribution within and between countries and regions of the world economy.

**Figure 1 Elements of global commodity chain analysis**

<table>
<thead>
<tr>
<th>Inputs and outputs</th>
<th>Sequence of linked ‘nodes’ representing a specific production process in which each stage adds value to its predecessor (input acquisition, intermediate processing, manufacturing, distribution, marketing, consumption).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Territoriality</td>
<td>Geographical spread of networks of organisations (firms) involved in the production of a finished commodity.</td>
</tr>
<tr>
<td>Governance</td>
<td>Internal: relations between organisations in the chain; external: the wider regulatory context of production. Determines the allocation of financial, material and human resources within the chain.</td>
</tr>
</tbody>
</table>

Global care chains operationalises the value approach in two main respects. First, the international trade in domestic workers is approached as a series of spatially-dispersed, connected households. Generally speaking, global care chains start in poor countries and end in rich ones, sometimes passing via an intermediate country; others move from rural to urban areas within an individual country. The structure of each chain varies in terms of the number of links, the socio-geographical spread of the links and the intensity of their connective strength. Second, the global care chain concept attends to the (re)distributive dimensions of this international trade in care labour. While many accounts of international labour migration emphasise how uneven development frames the international trade in domestic labour, global care chains also attend to the reproduction of these inequalities: the extraction of (care) labour from poorer countries for consumption by richer ones constitutes a major drain on the resources of poorer countries with negative impacts on the development of those countries.

The application of the methods and approach of global commodity/value chain analysis to care services brings with it a number of challenges. First, global commodity chain analysis is primarily concerned with the industrial production of ‘things’ within the sphere of market production, while global care chains are concerned with the reproduction of ‘beings’ and the social bonds between them, activities that encompass both market and non-market spheres. Second, the
focus of global commodity chain analysis on the contractual linkages between firms is problematic for care services since the majority of such services are not produced by for-profit firms, but by governments, non-profit organisations and especially households operating outside of the commercial sphere. Third, care services are highly complex, encompassing as they do services as diverse as domestic cleaning, family care, health care, sexual care, educational care and religious/spiritual care, provided in a wide range of settings such as the home, hospitals, hospices, churches, schools and brothels and in a wider range of contexts such as individualised private settings and institutionalised state and non-state settings. Fourth, a major difference between manufacturing and care services is that those participating in global commodity chains are motivated by the search for economic benefit (profit) whereas care chains are structured by factors that cannot be entirely understood within an orthodox economic framework, however broad. Here should be emphasised the importance of linguistic, religious, cultural and familial factors influencing migration (Yeates, 2004a, 2005). These differences between manufacturing and services together with the particular nature of human (care) services necessitate modifications to the focus of global care chains (Figure 2).

Perhaps the most obvious change of focus is the enhanced emphasis on labour, especially migrant domestic labour, in global care chains. Thus, the inputs/outputs dimension of global care chains becomes essentially focused on the recruitment and organisation of labour; on the dimension of territoriality the focus shifts from international relations between firms to transnational labour networks that mobilise and coordinate the supply of and demand for labour; the focus of governance lies with the regulation of labour by state and non-state bodies. Global care chains accord more recognition to the greater diversity of agents involved in care service provision and the fact that they operate according to different logics and in different contexts. These agents include recruitment and placement agencies, overseas job promoters and job brokers provided by commercial and non-commercial, governmental and non-governmental, bodies. Here it is worth emphasising that the state is integral to global care chains involved as it is in health care services provision as well as in the regulation of non-state actors. This centrality of the state to global care chains also means that the distinction between internal and external governance is not as clear in global care chains as in global commodity chains. Furthermore, there is the explicit recognition of households as central to global care chains. In orthodox global commodity chain analysis the household is reduced to the role of consumer of commodity goods, while in global
care chain analysis the household provides essential inputs at all stages of the chain. Thus, all care chains begin with the household which supplies the care labour that will be exported through the migration process as well as the care labour which is required to care for the emigrant’s remaining dependants (or other relatives) while she is abroad. Households mediate between migrant workers and international labour markets, form the infrastructure necessary for organised migration to occur and serve as organisational linkages between exporting and importing countries.

As noted earlier, the focus of early global care chain analysis lay with the transnational ‘nanny trade’, with international transfers of motherly labour and care labour provided in individualised, household contexts. Although nannies are the group most often researched in studies of the transnationalisation of care labour, the type of care they provide (social care), the social group to which they provide this care (children) and the setting in which they work (households) cannot be taken as typical of, or limited to, all migrant care workers. The restricted
application of the global care chain concept to this group excludes a range of other types of migrant care worker whose experiences, situations and work contexts are not only equally relevant and amenable to global care chain analysis but which could enrich our understanding of the complex relationship between international migration and care-giving. Previously I (Yeates, 2004a, 2004b) have therefore suggested broadening the present focus of the concept and have identified five ways in which this should be done.

(i) Supplement the focus on ‘unskilled’ migrant care labour (nannies and maids) by attention to migrant care workers of different skill and occupational levels to reflect the increase in skilled labour migration that has been a feature of contemporary migration.

(ii) Broaden the focus on married women with dependent children and one-parent abroad households to take account of the range of family statuses of migrant care workers (married/single, with/out children, with/out extended family), the variety of household types to which they belong and the care obligations they fulfil towards other family member (elderly parents, siblings, nieces/nephews) as well as their gender roles.

(iii) Extend the focus of global care chains to encompass health, educational, sexual and religious care as well as social care to reflect the multi-dimensional nature of care services as well as the significance of international dimensions of provision in these other domains.

(iv) Widen the current emphasis on care workers in individualised domestic/household settings to also include those in institutionalised settings (hospitals, schools etc), distinguishing between state and non-state care work environments.

(v) Historicise global care chains to understand the transformation of these chains over time and the confluence of factors that bear on that transformation. Thus a substantial transnational care service economy can be dated back to (at least) the nineteenth century when it contributed to industrialisation processes in both care labour exporting and importing countries (Katzman 1978) in ways that have been observed in the contemporary industrialisation strategies of certain Asian countries (Chin 1998).

Expanding the focus in these ways would better reflect the diversity of the care services sector in terms of the spectrum of skill and remuneration of labour, input intensity, organisation and regulation (Figure 3). It would also capture variations between global care chains. Thus, global care chains involving nurses working in institutional residential and non-residential settings for public authorities or commercial corporations can be expected to differ from those involving
nannies working in domestic settings and employed by individual households. We could also expect to find differences between global care chains involving care services organised and provided on a for-profit basis compared with those organised and provided on a not-for-profit basis. The analysis is further complicated by the various shades of il/legalitY involved in these care chains. Thus, the range of agents involved in the global care chain for professional nurses working in hospitals would differ from those involved in the legal trade in domestic care workers and from those involved in the trafficking of sexual care workers. Overall, we could expect to find differences among different groups of care workers working in different contexts, with these variations reflecting the structures of organisation and control within the chain. Finally, introducing an historical dimension would reveal how different countries been repositioned which global care chains over time.

**Figure 3 The care services spectrum**

<table>
<thead>
<tr>
<th>Labour skill/remuneration</th>
<th>Professional labour</th>
<th>Manual labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified, skilled, highly paid (doctors, surgeons)</td>
<td>?</td>
<td>Unqualified, ‘unskilled’, poorly paid (cleaners, care assistants, nannies)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensity of inputs</th>
<th>Capital intensive</th>
<th>Labour intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>High start-up and running costs; reliance on high-tech equipment for production of service (Hospital services)</td>
<td>?</td>
<td>Low start-up costs; production of service relies on constant attention (Cleaning companies)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Degree of organisation</th>
<th>Corporatised</th>
<th>Atomised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement of commercial sector (Hospitals, nursing homes, domestic services corporations)</td>
<td>?</td>
<td>Individual arrangements; care sub-contracted to informal networks (kin, neighbours, friends) and/or to commercial care service providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of Regulation</th>
<th>Most regulated</th>
<th>Least regulated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong institutional framework governing funding, regulation, and conditions of service provision; formal recruitment through government or commercial agencies (Nursing, doctors)</td>
<td>?</td>
<td>Sector is weakly regulated, work is precarious and often illegal; informal recruitment through friends, relatives</td>
</tr>
</tbody>
</table>

Source: Yeates (2004a)
The remainder of the paper examines international nurse migration from a global care chains perspective. Nurses are a specialised, and in many ways archetypical, group of migrant care workers: in addition to being a major category of migrant care worker, they are a major health care resource of any country in which a high level of investment has been made and are key to the social development of national populations. Nurses capture global care chains involving more ‘skilled’ care labour working in health institutions involving public and private (commercial/corporate) agencies, provision and interests. They are a group around which social policy issues of internationalisation of care such as how far they should be regarded as internationally tradable ‘commodities’ and the extent to which international trade should be socially regulated more generally are played out. In what follows, the global care chain framework is applied to the international trade in nursing. The discussion uses a range of country examples for illustrative purposes.

We need to emphasise before moving onto this subject that empirical research on it has begun only in the last decade and, in common with much of the data on international migration, the data on international nurse migration leaves much to be desired. Some of the gaps in the evidence are beginning to be filled by large international research programmes such as that currently being coordinated by the International Council on Nursing. However, much research on issues of fundamental importance to global care chain analysis, in particular relating to gender and family issues, including basic information on marital and family status of migrant nurses, remains to be undertaken. In this light, it is worth repeating the first two key recommendations made by the most recent international study of nurse migration: the absence of accurate data on the flows of international nurses which constrains effective monitoring and limits the ability to assess impact; and inadequate workforce data and planning capacity in source countries which renders it difficult to assess how much of a ‘problem’ outflow to other countries is in comparison to the numbers of nurses underemployed or unemployed in the country (Buchan, Kingma and Lorenzo, 2005: 29). As they note this absence of accurate data is at least partly due to the lack of common or “standard” data or even accepted international definitions of nurse (ibid: 3).

4. Overview of international nurse migration

While migrant health workers have been a constant source of labour for core country health services throughout the 20th century, international health worker migration appears to have
increased with the current phase of globalisation and has been of increased concern to policymakers at both national and international levels since the beginning of the 1990s. One major cause of concern has been the identification of a global nursing shortage. The direct reasons for this shortage relate to nurse training. Fewer nurses are being trained due to a shortage of training personnel combined with changes to health care provision such as a switch from acute to primary health care, shorter hospital stays, a growing proportion of health care costs being borne by consumers, all of which encourage cut backs on the training of nurses. In addition, fewer women are choosing nursing as a career option compared with the 1970s and of those who enter the profession significant numbers leave the profession after having qualified due to a variety of factors including low pay, long and stressful working hours, unfavourable employer (family unfriendly) policies and reduced time for patient care (Thomas et al, 2005: 14).

There is a need to exercise caution in attributing the primary cause of nursing shortages to nurse emigration. In the case of Ireland, for example, while there were 3,955 Irish nurses working abroad in 2003 and over 4,000 foreign nurses working in the Irish health service, there were a further 15,000 qualified nurses in Ireland not working in the health service for various reasons, many of whom would return to work if flexible and family-friendly working conditions were introduced (INO/Smurfit Graduate School of Business 2003, cited in Irish Times, 19/11/03). The implications of this are that importing nurses may be a means of circumventing the need to address the quality of health service working conditions, and that were governments to address training and retention issues they would not need to depend on immigrant labour.

A second aspect of policy debate is the direction of nurse migratory flows. For the host countries policy issues may relate to the integration of foreign nursing labour into national health systems and labour forces, but many host countries are beginning to address the ethical question of which countries it is justifiable to recruit from following increased attention to the possible deleterious effects of health worker emigration on the health care systems of developing countries and the negative redistributive effects of international nurse migration; specifically, this concern relates to the loss of expensively trained and skilled workers to developed countries, the value of investment in whom is lost to the training country, and the de facto subsidy of developing to developed countries’ health care systems that this loss entails. This latter concern has been part of the controversy over the ‘brain drain’ of highly trained and skilled workers from ‘developing’ to ‘developed’ countries. We need also to recognise that nurse migration has different meanings
depending on which part of the global care chain you are located in. There are differences between nurse migration from developed countries and nurse migration from developing countries. For the sending countries, the state may be more concerned with the loss of expensively trained labour that the health system can ill-afford to lose and with whether the state should be training its workforce for export.

Although data on international nurse migration is patchy, the research evidence that exists indicates that the major flow of migrants is from developing to industrialised countries. The broad picture of international nurse migration has not changed substantially since the World Bank reported on the issue in its 1993 World Development Report: the major flow of migrants is from developing to industrialised countries: more than 90% of nurses who migrate go to North America, Europe and the high-income countries of the western Pacific, while only about 7% migrate to developing countries (Sarfati, 2003: 120). These latter would include volunteer development workers (e.g. VSO or Peace Corps workers) and (Christian) missionary workers.

In the global nursing chain, territoriality is expressed in regional as well as global flows. While the general flow is from ‘periphery’ to ‘core’ countries, there are also distinct regional processes and divisions of labour. Thus, one significant destination area is the Middle East, and specifically the states of the Arabian Gulf, where the recent development of health services has mainly drawn on non-national labour forces, with the Gulf States’ need for health workers being supplied by migrants from the Philippines, Egypt, Bangladesh and India. More recently, health authorities in countries like Oman and Saudi Arabia have been attempting to reduce their dependence on foreign migrant labour by developing health workforces comprised of nationals of those countries. Another significant example of a regionally important destination area is South Africa which is a significant destination for nurses migrating from, for example, Swaziland (Buchan, Kingma and Lorenzo, 2005:11). Similarly for nurses from Zambia, although the UK is the second most important destination, South Africa is the most important one, demonstrating that a nearby regional developed country can be as important a destination as the northern developed countries of Europe and North America (Munjanja, Kiduka and Dovlo, 2005: 21). While out-migration from South Africa is mainly to the UK, Saudi Arabia, Australia and New Zealand (Buchan, Kingma and Lorenzo, 2005:13), in other cases nurses are migrating from developed countries to other developed countries.
Several countries stand out in the nurse trade literature as predominantly nurse exporters or importers. Regarding source countries, the Philippines has dominated international nurse emigration to a variety of recruiting countries, in particular the Gulf States (especially Saudi Arabia) and the US (Safati, 1993; Brush et al, 2004). While there is disagreement over whether an explicit government policy to encourage migration exists, it is nonetheless the case that ‘with persistent but fluctuating 10-year trends of health worker migration since the 1950s…[the Philippines] has become dependent on health human resource out-migration to address surpluses and other employment related issues’ (Buchan, Kingma and Lorenzo 2005:14). The Gulf states are consistently reported in the literature as major importing states; not only are they dependent on foreign nurses for the functioning of their health services but nationals constitute a minority of their nursing labour force. The reasons for these low levels of nationals in the health service are explained as follows: ‘Nursing has traditionally been an unacceptable career option for Saudi nationals. Few females study professional nursing. The reasons suggested are low image/status of nurses, traditional, cultural and social values, and inadequate financial remuneration’ (El-Gilany and Al-Wehady, 2001:31).

While much of the research on nurse migration uses a neat dichotomy to distinguish between sending and receiving countries, many countries simultaneously import and export nurses. In some cases out-migration of nurses leads to the need for in-migration of nurses to fill resulting staffing shortages. Australia, Canada, Ireland and the UK, for example, are all both significant importers and exporters of nurses. A recent review of the literature on nurse migration listed the primary nurse ‘donor’ countries as Australia, Canada, the Philippines, South Africa and the UK, while the primary receiving countries are Australia, Canada, Ireland, the UK and the US (Buchan, Kingma and Lorenzo, 2005:13). The UK simultaneously exports and imports nurses, with Australia consistently the top destination for nurses migrating from the UK. The following shows import figures relating to new entrants on the UK nursing register from the EEA and

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4 According to a 1993 WHO report 80% of migrant Filipino nurses migrated to the Gulf States, especially Saudi Arabia. In 1987, for example, some 23,000 Filipino nurses migrated to the Gulf and 3000 migrated to the US (Safati, 2003:122). The Philippines was the lead supplier of nurses to the US from 1969 to 1979, while ‘until the mid-1980s Filipino nurses represented 75% of all foreign nurses in the US nurse workforce. Their representation dropped to 43% by 2000 as more countries began sending nurses abroad’ (Brush, Sochalski and Berger 2004: 79).

5 A 1993 WHO study noted that in Oman 85% of nurse were non-Omani, while of 1,160 nurses in Bahrain, only 27% were Bahraini, with 65% being Indian and 6% Filipino. (Safati 2003:122. In Saudi Arabia, only 11.2% of nurses were Saudi nationals in 1993, according to the Saudi Ministry of Planning (www.the-saudi.net/saudi-arabia/health-services.htm, accessed 9/11/2005).
overseas; export figure from the same source gives the number of verifications requested by overseas regulators of nursing.

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<td>Import</td>
<td>12,670</td>
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<td>Export</td>
<td>8,044</td>
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(Source: UK Nursing and Midwifery Council, annual statistical reports)

Shifts in the hierarchy of the international division of reproductive labour can also be observed. Just as countries develop in manufacturing by moving up the product ladder, so in the export of labour countries develop by moving up the skills hierarchy exporting increasingly skilled labour while importing less skilled or unskilled labour. Ireland constitutes an interesting example of this. Historically a major exporter of (nursing) care labour worldwide, and in particular to the UK, Ireland has also emerged as an importer of nurses in recent years. In the 1990s there was an increased reliance in the Irish health system on nurses migrating from the EU and the traditional direction of care labour migration between Ireland and the UK was reversed. This inward migration occurred alongside the continued outflow of Irish nurses to other countries, primarily the UK and Australia but also the US, Canada, South Africa, New Zealand and Kenya where they compensated for these countries’ nursing shortages. In effect, Ireland’s place in the international division of (nursing) care labour has changed, but the change accompanied the continuation of pre-1990s migration patterns by Irish nurses. That is, regional divisions of labour continued to operate alongside a changed global division of labour. In addition, recent international demand has been for Irish nurses with specialist skills, particularly in fields such as midwifery, intensive care and surgical operation and theatre work, and other peripheral economies countries are now supplying the general nursing labour that Ireland formerly supplied. One aspect of this nurse migration, then, is its exposure of the international hierarchy of countries, exemplified by which countries are exporting general nursing labour and which countries are exporting specialised/highly skilled nursing labour (Yeates, 2004b).

The year 2000 represented a further change in Ireland’s position in the international division of reproductive labour, when ‘developing to developed’ country migration began to be of increasing importance in sourcing nurses for care work in Ireland. The Philippines was targeted as a major reservoir of nursing labour, and Ireland quickly became a major destination for Filipino
nurses (in 2002 it was the third largest importer of Filipino nurses, after Saudi Arabia and the UK). Ireland still performs the function of global care labour reservoir, but it now also increasingly recruits from other global care labour reservoirs. It is worth noting that the links between the Philippines and Ireland are essentially of the same order as those that historically linked, and still link, Ireland to Britain, the US and many other countries. Just as American and British women enjoy better working conditions and career prospects outside of nursing, so Irish nurses can earn more in the immediate and longer term by working in these countries’ health systems; in the same way, Filipino nurses can also earn more by working in Ireland than in the Philippines (Yeates, 2004b).

5. Nurse migration: mapping territoriality and governance

This section maps the series of internationally dispersed activities involved in international nurse migration, and then focuses on governance issues when it examines how the migration is facilitated and/or impeded by government policies and recruitment agencies.

There is general agreement that the reasons behind nurse migration are in the first place economic. ‘Pull’ factors drawing nurses are mainly economic, with the lure of higher wages, increased promotional opportunities, higher standard of living and increased security in industrialised nations. Not all migration is premised on economic factors, however: in some cases, the desire for travel, adventure and a better climate are central, while the professional desire for wider experience, better and more specialised training and more autonomy should not be discounted. Conversely, low pay; minimal chances of promotion; unemployment and underemployment; low level of development of and investment in health services; low status and threats to personal security are key factors in emigration decisions.

Nurses’ migration decisions, the reasons for these decisions and the context in which they are taken vary depending on where in the chain they are located. One possible difference is that in developed countries emigration decisions are more individualised than based on family/kin considerations. There is a difference between migrating from a sending country in order to provide for the survival of a family/kin in a context where family members depend on remittances for

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6 The economic benefits are most obvious in the case of nurses from the Philippines migrating to work in the US: ‘In 2004 the US Department of Labour reported median annual earnings for RNs (Registered Nurses) in 2002 as $48,090; in hospitals and nursing homes where foreign nurses worked, earnings averaged $49,190 and $43,850 respectively. These figures contrast sharply with the $2,000-$2,400 annual salaries paid to nurses in the Philippines in 2002’ (Brush, Sochalski and Berger, 2004:80-81).
economic survival and where state social provision is minimal, and migrating from a country where family/kin are not dependent on remittances for survival and where state provision is, in global terms, extensive and generous. In the context of developing countries, these migration decisions can be the first stage of household internationalisation strategies. As Redfoot and Houser (2005: 20) argue with regard to India and the Philippines the selection of nursing as a career and the accompanying migration decision is a decidedly family affair, noting that ‘family networks are most important in financing nursing education – often with the expectation that the family investment will be returned by the remittances sent by migrating nurses. So family expectations of migration are often built into the decision to send a daughter to nursing school.’

Of course, migration must be understood in the context of structural factors such as geopolitical and –economic inequalities, global, regional and national labour markets and the influence of national policy not only in respect to health provision but in respect of economic and social development more broadly. Health is highly regulated so the institutional framework of national and supranational, state and non-state actors is of particular importance in accounting for the magnitude and direction of nurse migration. International nurse migration occurs inside a matrix formed by state policies and commercial, professional and labour interests.

Recruitment agencies and companies are important nodes in global nursing chains because they connect nurses with their eventual employers. There is a wide variety of these agents which may be private companies, specialist subcontractors, hospital associations, state or semi-state bodies. Often these bodies cooperate in partnership with one another, as is illustrated by the following examples. In May 1990, the New Jersey Hospital Association (NJHA), which represents seven hospitals (some of which are run by religious orders) in that American state, undertook a recruitment drive in Galway, Ireland, with support and cooperation from the Western Health Board. The NJHA recruitment drive involved a package of incentives including paid round trip airfare to the US, assistance in obtaining visas and appropriate state nursing licenses, housing and relocation assistance, tuition reimbursement, socialisation opportunities, and continuing education (Sunday Business Post, 6/5/90). These recruitment agents may also cooperate with trade unions. In September 2001, for example, representatives from a number of Irish Health Boards (semi-state organisations responsible for health care in geographical areas) and a number of Dublin hospitals visited Beijing and Shen Yang in China on a recruitment drive. The drive was facilitated by a Dublin recruitment agency, EuroCollege, which had taken advice from the trade union SIPTU and
the Irish Department of Health to agree salary scales for the fully registered staff nurses and nursing assistants being recruited in advance of their arrival in Ireland. The operation was also facilitated by the fast-track nurses visa scheme introduced in March 2000 as part of the Irish governments’ international nurse recruitment strategy (Sunday Business Post, 10/9/01).

The international nurse recruitment industry is a thriving one. Several US nursing executives reported in June 2002 that it may cost $10,000 to recruit an international nurse (Stringer, 2004). With costs this high, obviously the profits are considerable. One example is provided by Global Healthcare Recruitment, a Wisconsin-based agency set up in 2002, which had hired 250 Indian nurses for Wisconsin hospitals by the end of the year and expected to recruit an additional 500 nurses by 2004, pushing expected 2004 profits to in excess of $5 million (Brush, Sochalski and Berger, 2004: 83). For England, costs of recruiting a foreign nurse are between £2,000 and £4,000. This is considerably less expensive than the Department of Health estimated cost of £40,000 for recruiting (advertising and appointing, including securing a temporary replacement for) an experienced home-grown nurse (Padarath et al, n.d.).

These recruitment agencies and practices can have strong links with specific countries. These links in part explain why certain agencies are set up, and why certain migration routes are created and/or consolidated. In some cases pure chance or contingency may be operating. One example of this is the case of PARC, a subsidiary of the state-owned Irish airline Aer Lingus, which had diversified into supplying and training airline staff for state airlines in developing countries. While in Zambia in 1978 on work for Zambia Airlines, the PARC representative was informed of an opportunity to recruit labour for mining companies in the Zambian copperbelt. Having successfully completed this project, PARC then turned its attention to nurses which it recruited for the hospitals the mining company operated. PARC later developed into a recruitment company specialising in the supply of Irish nurses to the Middle East and the US (Sunday Tribune, 12/8/86).

The migration process can be actively encouraged by sending countries through a policy of ‘producing nurses for export’. In the case of the Philippines, the government policy of nurse exports as a development strategy is highly significant. Adopted in 1974, this policy has made the Philippines a global nurse reservoir, and has resulted in over 85 per cent of employed Filipino nurses working outside the Philippines (150,000 nurses in all) (Buchan et al, 2003). This development strategy is supported by a number of specialist government agencies, such as the
Philippine Overseas Employment Authority (POEA) and the Office of Workers Welfare Administration (OWWA) which aim to facilitate the emigration of Filipino workers. The economic advantages of this to the Philippines have been immense, in particular in terms of remittances sent home by the migrant workers. Recent research suggests that migrant workers ‘make a major contribution to the economies of their home countries, which far surpasses the initial financial investment of educating the nurses’ (Buchan, Kingma and Lorenzo 2005:16). The Philippines has not been the sole state to follow this export strategy: Jansen (1974) reports ‘it has long been Egyptian Government policy to send a large number of trained nurses to Arab countries in need of hospital staff, particularly to Saudi Arabia and the Arabian Gulf.’ In addition, to an extent India and Cuba have also had a policy of export, while several other countries in the Caribbean, Africa and Asia are now considering the capacity to “train for export” of nurses as a regional economic diversification option (Buchan, Kingma and Lorenzo, 2005; Thomas et al, 2005).

Similarly, receiving countries can go out of their way to facilitate nurse migration through targeted policies of recruitment, such as in Ireland and the UK. One way in which receiving states facilitate migration involves the introduction of ‘fast-track’ visa systems. One example of a fast-track visa system was that introduced by the Irish Department of Enterprise, Trade and Employment in March 2000, which by September 2001 had issued permits to 1,430 Filipino nurses (Sunday Business Post 10/9/01). Alternatively, governments may simply allow market forces to operate, intervening only to validate the qualifications of the incoming nurse, such as in the US.

The terms and conditions of the contract between nurse and recruitment agency, including whether the agency charges nurses a fee, can vary widely. In the US, for example, international nurses contract to work for two or three years in the contracting hospital. In one case, Global Healthcare, the agency ‘agreed to fully refund the recruiting fee to the hospital if a nurse recruit failed to continue working past three months. The hospital was partially repaid if nurses fell short of their three-year commitment’ (Brush, Sochalski and Berger 2004:83). Another agency, Portland (Oregon)-based International Recruiting Network that recruits foreign nurses for local hospitals, intends to ‘collect a finder’s fee from the hospital and $3000 from the worker’s first-year salary’ (Stout, 2002). In return for the fee the company coordinates the nurses’ training, testing, certification, immigration and transportation.
A central concern in global care chains has been the unequal balance of power between female migrant workers (in particular domestic and sex workers) and their recruiters and employers. One key factor for the distribution of risks, costs and profits across the migration chain is the extent to which recruitment practices and recruitment agencies are regulated. The worst examples of recruitment, including trafficking and imprisoning sex workers, have emerged as a major concern for agencies combating transnational crime in recent years. In many cases women are recruited with false promises of legitimate jobs with good pay and conditions: when they arrive in the host country, the promises are revealed to be false and they are pressurised into sex work. Similar complaints where recruitment agencies misrepresent the pay and conditions the migrating worker can expect have been reported in the case of migrant care workers (Redfoot and Houser, 2005: 19). In the UK the Royal College of Nursing denounced some reported cases as a ‘modern form of slavery’. One example should suffice: ‘A recruitment agency in Marble Arch advertised in India for nurses in cardiac care, telling them they would get free accommodation, free uniforms, free meals and free flights. The fee for the opportunity was 32,000 rupees (£480). ‘We were told we were going to work in the NHS but when we got off the plane, we were told the NHS had no vacancies,’ said one of those who responded to the advert. Like the hundred other Indian nurses that followed her, she ended up working for a group of nursing homes in Nottingham and Leicester. They have to pay £20 a month for their uniforms and £30 a week to sleep three each in old hospital rooms that reek of urine. Rather than being paid £5 an hour as promised, they get £4. The nurses are threatened that, if they leave within two years, they have to pay a £3,000 fine to cover ‘training costs’ (Browne, 2001). In this case, the position of the nurses resembles that of bonded domestic or sex workers. Without denying the occurrence of such cases of exploitation, the more regulated nature of much nursing and the involvement of state and public institutions as employers, coupled with the increased status and value of nursing labour, militate against nurses being subject to some of the worst results of this unequal balance of power.

Although recruitment agencies are undoubtedly of major importance in international labour networks, informal networks, where family, kin or locality form the skeleton over which the network is stretched, are also of importance in mobilising and channelling nurse (e)migration (Thomas et al, 2005). In the Irish case, although state immigration laws and recruitment practices of British labour authorities have been significant in drawing Irish nurses to Britain, individual
hospitals still recruit ‘extensively in Ireland through formal means and informally, relying on contacts between existing staff and their home areas when need arises’ (Walter, 2001: 180-81).

A key factor influencing migration routes is the proximity of countries. An example here would be the fact that the number one destination for Swazi nurses migration is not the UK, but South Africa. Other factors owe more to historical ties between countries. Colonial ties are often of importance, for example in the traditional supply of nurses from Ireland to England. The choice of destination country also relates to the culturally available set of options and to a common language. Buchan et al note ‘it is possible to map out English speaking, Spanish speaking, French speaking and Portuguese speaking ‘zones’ within which much of the mobility of nurses between ‘source’ and destination country exists’ (Buchan, Parkin and Sochalski, 2003: 84). In other cases, routes may be based on historical connections, such as colonial or missionary connections, or training connections. For an example of the latter the growth of Irish recruiting companies to serve Middle Eastern markets arose to some extent from historical practice where Ireland, including the Royal College of Surgeons, was an acceptable place for training for Arab doctors, given its political neutrality.

Bach argues that these historic ties may be lessening in importance:

Historical links and associated cultural ties play a role in explaining migration pathways between Australia, Canada, India and the United Kingdom. Similarly Portugal has links with Mozambique and the Netherlands has looked to former colonies such as Suriname or countries such as South Africa as a source of health professionals. Nevertheless, an important facet of the globalization of health labour markets is that these historic ties are loosening as destination countries become more utilitarian in encouraging migration primarily on the basis of economic requirements rather than historical or family connections. (Bach, 2003: 9)

Interstate agreements, whether bilateral or multilateral, have a decisive effect on nursing trade routes. Although there has been much attention to and in some quarters concern about the impacts of international trade agreements, be they at world-regional or global levels, these have a relatively insignificant impact compared with the existence (or absence) of mutual recognition of qualifications. There is little evidence of the impact of ‘free trade’ zones on nurse recruitment. Thus, while the EU has instituted a policy of free movement for nurses (and others) for EU
nationals, there is little sign of the development of increased internal migration within the EU. Such migration as exists is mainly linked to clusters of countries that share the same language (UK-Ireland; Belgium-France; Scandinavian countries) (Buchan, Parkin and Sochalski, 2003: 58). Indeed, mutual recognition agreements, for example, explain why Ghanaian nurses tend to migrate to the UK, as they don’t need to sit an exam, which they would need to do if they wished to migrate to the US (Buchan, Kingma and Lorenzo, 2005: 10). On the other hand, the need for certification can impede access to national health labour markets, as in the US where registration as a nurse requires that the applicant pass the National Council Licensure Examination. Some observers claim that the licensing process discriminates against foreign nurses in their attempt to gain access to the US market: in 2004, only 58.2% of foreign applicants passed this exam, compared with 85.3% of US-educated nurses (Redfoot and Houser, 2005:16).

Once nurses arrive in the host country, they can face a variety of work situations. Although the reasons cited for emigrating often relate to career advancement and skills development, emigration may result in deskilling. Qualified nurses may end up working as care workers in residential care homes if their nursing qualification is not recognised, or may be channelled into positions in health care institutions that are not concomitant with their skills. As one commentator notes ‘[m]any countries that rely on overseas health workers have traditionally employed migrants in low-skilled, low-paid work that is unattractive to host country nationals…Caribbean nurses who migrated to the UK in the 1960s were often channelled into non-career grades in unpopular specialities. Various forms of deskilling and under-utilization of skills have been documented’ (Bach, 2003:17). Similarly, ‘[h]ighly qualified nurses are often forced into menial, unskilled work. One eye specialist nurse was told she would work in Moorfields Eye Hospital, but when she arrived was told that she had to work in a nursing home instead. An intensive care nurse had to work in a laundry, doing 12-hour shifts in the laundry’ (Browne 2001).

Due to the possession of a globally tradable certified skill in the context of a global nursing shortage, nurses have greater options for international mobility and greater choice/freedom of action than other groups of migrant care workers such as domestic workers. This changes the balance of power between nurses and their employers. As a result of the skilled nature of their labour, nurses are able to make greater demands of their host countries. A central aspect of global care chains has been how internationalisation strategies create transnational families. Satisfying the demand for spouses to be able to work in the host country is an issue that is becoming central
to state strategies to retain migrant nurses though family reunification has always been a controversial aspect of immigration policies. For this group of care workers at least, they are permitted to be accompanied by their spouses and children. Here, whether the host state’s social policy facilitates the household internationalisation strategies of nurses by providing, for example, work permits to spouses is central to states’ competitive ability to retain migrant nurses. A comment by the director of nursing at the Mater Hospital, Dublin, illustrates the environment in which different countries compete to retain nurses: ‘We are going to be competing in particular with the UK and Australia for these nurses now, and the conditions of their visas are very attractive to the overseas nurses because they are giving their partners a work permit as well…in Australia, they provide guaranteed free education for their children. Obviously it’s very difficult for us to compete with countries where their partners get work permits’ (Irish Times, 12/7/03). This example highlights the importance of social provision for both the individual worker and their family members as a factor of international competition between states.

A key division between migrant nurses’ experiences concerns whether they work in public health care institutions (whether a hospital or long-term care home) or ones run by the private (commercial) sector. Related to this is the difference between strongly unionised state health sectors, as in OECD countries, and less unionised or non-unionised state health systems, as in the Gulf States. In OECD countries, at least, state healthcare tends to be highly unionised and hospitals are usually large workplaces and are more likely to be unionised so the trade union position on migrant labour is crucial to the recruitment, organisation and integration of health care workforces. Migrant workers entering unionised public hospital systems receive the same pay and conditions as their colleagues, and, with their union membership, have some possibility of protection against discriminatory pay and exploitative conduct that workers entering non-unionised private systems do not have (Bach, 2003). The involvement of trade unions and organised representation of workers is a major difference from the situation of care workers in individualised, household settings (e.g. nannies) who are often isolated, disorganised and powerless, having no organised support when negotiating terms of employment. This involvement of trade unions represents a major change in the balance of power between migrant care workers and their employers.

More generally, it is worth noting that the organisation of migrant labour forces has been of growing importance to trade unions in industrialised OECD economies. In some countries trade
union growth is now seen as being dependent on the unions’ abilities to organise migrant labour and major efforts have been made to extend trade union organisation to hitherto unorganised economic sectors where migrant labour predominates. One feature of this is the recognition that migrant workers need special services and for this reason, among others, some unions organise their migrant members separately. For example, the Irish Nurses Organisation (INO) established a separate section to represent and deal with overseas nurses. This form of union organisation can bring benefits which extend beyond the usual benefits or collective bargaining over pay and conditions. The INO’s annual report provides one example of the wider effects of this section: ‘The recent change in the legislation allowing the spouses of overseas nurses to legally work in Ireland was a clear victory for the section who untiringly lobbied for this initiative with other groups and with the INO itself’ (INO, 2004:46).

The difference between public and private employment is illustrated by the experience of Filipino nurses in the Irish Republic. A spokesperson for the INO stated that ‘[I]n the INO, we receive phone calls daily from overseas nurses whose rights are being abused. Many find the promises recruiters made are reneged on as soon as they arrive here. Rogue employers force them to work for long shifts in succession without appropriate breaks, and some nurses are not paid Sunday, bank holiday or night duty premium rates of pay.’ That the ‘rogue employers’ are based in the private sector rather than the public sector is made clear by the Irish-Filipino Association: ‘Generally, Filipino nurses get on very well in Irish public hospitals, although this is not always the case in private hospitals and nursing homes. They are not always advised of their rights as workers. They do not know that they have the same entitlements as their Irish counterparts, and are fearful that they can be deported if they complain or misbehave’ (Brennock quoted in Irish Independent, 9/7/01). Similarly, foreign nurses working in the private sector may be paid lower wages than nationals. The chairwoman of the Federation of Irish Nursing Homes confirmed in July 2001 that Filipino nurses were paid 30% less than the market rate for their first year working in Irish nursing homes. ‘It costs £3,500 to bring in every employee…they are paying back some of the cost of bringing them in’ (Sunday Business Post, 27/5/01). These observations are supported by an ILO Working Paper which observes ‘there are frequently differences between the experiences of employment in a nursing care/aged care environment compared to a hospital setting…It is in private nursing that some of the worst abuses have been documented’ (Bach, 2003:19).
6. Policy responses to international nurse migration

One regulatory response to nurse migration in the name of international equity has been the development of ethical codes of conduct by governments and nurses’ representative bodies. These attempt to regulate the import of nurses. The development of ethical codes has resulted from political pressure by developing nations concerned at the loss of valuable health care workers and also by development lobby groups concerned at the effect of this loss on the implementation of international social policy, in particular the Millennium Development Goals, and the ability of African nations to adequately respond to the threat posed by HIV-AIDS. One example was the call by Nelson Mandela in 1997 for the UK to cease recruiting nurses from South Africa. In response, the UK Department of Health issued guidelines in November 1999 calling on NHS employers to desist from actively recruiting from developing countries suffering nurse shortages, specifically citing the Caribbean and South Africa. Here the state healthcare system recruits migrant health workers, but from an agreed list of countries only. This list is developed as a result of consultations between the British Department of Health and the health departments/ministries of exporting countries wishing the UK to refrain from recruiting from their countries. This use of intergovernmental agreements is consistent with the position of the World Health Assembly which encourages the use of bilateral agreements to manage health worker migration.

Further codes of conduct have been developed over the last six years, by one further government (Ireland), one Australian state (New South Wales), one city (London NHS region), one international governmental organisation (Commonwealth), three professional nursing bodies (two regional (Nordic Northern Nurses Federation; Standing Committee of Nurses of the EU(PCN)), one national (English Royal College of Nursing) and two international (International Council of Nurses, Honor Society of Nursing, Sigma Theta Tau International)), one trade union (UNISON), and British and Irish independent health employers (IHA/VOICES/RNHA and Dublin Academic Hospitals) and health practitioners (WONCA) (Willetts and Martineau, 2004). One government (Norway) has precluded the need to issue a code of conduct by taking a policy decision to recruit only from developed countries (Buchan et al, 2003).

Although these codes are of relatively recent origin, their potential and actual effectiveness in regulating nurse recruitment has been queried. With regard to the UK code a number of limitations has been highlighted. First, it concerns only government recruitment and excludes
private sector health care providers and agencies. Second, the code has limited effects when
entrants come to the UK to study rather than to work. Third, although the code prohibits active
recruitment by governments it does not oblige governments to refuse to accept individual
applications from nurses from countries where active recruitment is prohibited. Fourth, its
guidance is weak and restricted and is, moreover, advisory rather than mandatory (Deeming, 2004;
Grondin, 2005). Indeed, despite the existence of this agreement over five thousand South African
nurses were registered in the UK between 2001 and 2004; this is more than twice the growth in the
number of nurses registered in South Africa in the same period (Redfoot and Houser, 2005: 20).
Furthermore, in a review of eight international and national codes of conduct Willetts and
Martineau (2004) concluded ‘support systems, incentives and sanctions, and monitoring systems
necessary for effective implementation and sustainability are currently weak or have not been
planned’.

An alternative approach to regulating international nurse migration is the attempt to restrict
international recruitment and migration. One form of this is to limit the possibilities for individuals
to emigrate. One method of achieving this is through bonding schemes. This approach is not
confined to nurses (it is used more widely for a range of health care workers) but requires nurses
to spend a certain number of years working in their national health services in return for the
investment of public resources in their education and training. Countries that use this method are
South Africa and Zimbabwe. Another bonding method introduced by Lesotho and Ghana requires
students to pay the full cost of their medical training (advanced as a loan by the government) after
graduation, either in cash or in public service (Padarath et al, n.d.). There are two limitations to
bonding schemes. First, emigrants who earn substantial salaries in overseas employment can easily
pay off their loan. Second, bonding focuses on newly-qualified professionals; it therefore affects
only junior staff, leaving senior staff to continue to emigrate unimpeded (ibid). Another approach
to restricting international nurse migration is to raise the costs to health providers of recruiting
nurses from developing countries. The aim of this is to remove the cost advantage of recruiting
foreign nurses. One suggested method is to force the recruiting body to pay the full cost of
educating and training nurses to the source country government (WONCA, 2002). An alternative
suggestion is that compensation paid should be channelled into the ongoing costs of the general
operation of the source country’s health care system (Mensah et al, 2005).
A third type of response is to improve the retention of nurses by addressing the most obvious reasons for leaving the nursing profession or emigrating to practise nursing abroad. This investment strategy includes ‘downstream’ and ‘upstream’ measures. The former include attempts to change the wages, conditions and status of nurses, including enhanced training and career development opportunities. Among African initiatives in this field are the offer of generous end-of-service payments, subsidised house and car ownership schemes (Namibia), the establishment of a prize fund to reward exceptional performance (Ghana), payment of long service awards (South Africa) and relaxing promotion criteria (Zambia and Ghana). Upstream measures might involve investing in health infrastructure to enhance professional performance and ensure personal security (Padarath et al, n.d.).

A further approach holds that, since migration is inevitable, it should be managed in the best interests of both sending and receiving countries while respecting the individual nurse’s right to choose their place of work and residence. The International Organisation for Migration advocates this approach, suggesting that countries should examine ‘schemes that aim at managing the movement of these professionals in a way that would benefit all partners, and would develop or strengthen capacity for provision of quality healthcare’ (Grondin, 2005). An example is provided by the programme of managed migration developed by the Caribbean Nurses Organisation in association with the Pan American Health Organisation. This programme involves a panoply of measures addressing recruitment and retention (advertising, mentorship), education and training (developing training capacity and distance learning programmes), utilisation and deployment (introduction of workload measurement tools), terms and conditions of employment (promotion of adherence to international (nursing) labour standards), management practices (leadership and human resource training) and policy development (research and evaluation) (Buchan, Kingma and Lorenzo 2005: 22).

7. Conclusions

What contributions can global care chain analysis make to the formation of socially-responsible policy responses to international nurse migration? At this stage, we can only offer a tentative answer but over the longer-term it is to be hoped that global care chain analysis can help identify points in the chain at which effective policy interventions can be made. To conclude, some general observations are offered and some policy tensions highlighted.
If one way to examine the distribution of risks, costs and benefits across the global nursing chain is to foreground costs to hospitals, profits to recruitment agencies and increased pay to migrant nurses in a consideration of individual cases of nurse migration, another calculation at the national-societal and global levels is not only possible but essential. In this view, the major benefits accrue to the health system of the host country, while the major costs are borne by the health care system of the country on the other end of the global care chain. These costs include not only the cost of educating and training the nurse involved, but also the health deficit caused by the migration of the nurse and the effect that a depleted health service has on the social and economic development of the sending country.

While there is some benefit provided to the sending country and individual households by the remittances sent by individual migrant workers, and there are recent examples of attempts to mobilise these remittances for general social benefit, more research is needed before it can confidently be declared that international nurse remittances balance the total economic and social loss involved in nurse emigration. It is in this context of the spread of costs and benefits across the global nursing chain at the individual, employer, governmental and societal levels that policy proposals calling for more effective governance of international nurse migration must be situated.

Of course, this raises the question as to what the overall aims of policy should be and how the competing interests of state, commercial, professional, labour and households can be balanced and whether they can be reconciled. This is complicated by the position within the chain, be it at the lower or upper end: how does one achieve a balance between the conflicting interests and needs involved here? How does the need for nurses to take care of older people in developed countries weigh against the need for nurses in developing countries to help provide care for people with AIDS? This goes to the heart of the problem: how far should international migration be regulated in the interests of public health and welfare? This can be seen as a subset of a more general question which has been taxing policymakers for some time now and has been a cause of much controversy globally: to what extent should international trade be regulated in the interests of social development?
References


(http://society.gu\rdian.co.uk/NHSstaff/story/0,7991,497983,00.html accessed 14/11/05)


www.cpc.paho.org/%5cfiles%5cdocfiles%5c60_121.pdf


