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Taylor & Francis Group
www.routledge.com
Printed in the U.S.A.

The International Migration of Health Workers — Connell — Routledge

The International Migration of Health Workers

Edited by John Connell

First published 2008
by Routledge
270 Madison Ave, New York, NY 10016

Simultaneously published in the United Kingdom
by Routledge
2 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

Typeset in 10 pt. Sabon Roman by IBT Global.
Printed and bound in the United States of America on acid-free paper by IBT Global.

Library of Congress Cataloging in Publication Data
The international migration of health workers / edited by John Connell.
p. cm. — (Routledge research in population and migration ; v.10)
ISBN 978-0-415-95623-9
1. Medical personnel—Employment—Foreign countries. 2. Medical personnel—Supply and demand—Foreign countries. I. Connell, John, 1946–

RA410.6.I578 2008
362.1072'3—dc22 2007048350

ISBN10: 0-415-95623-4 (hbk)
ISBN10: 0-203-93245-5 (ebk)

ISBN13: 978-0-415-95623-9 (hbk)
ISBN13: 978-0-203-93245-2 (ebk)

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2 Globalised Labour Markets and the Trade of Filipino Nurses

Implications for International Regulatory Governance

Rochelle E. Ball

Nursing is the one of the most feminised and increasingly globalised professions. A growing volume of nurses from developing nations, such as the Philippines, are using their portable skills globally, migrating to fill the demand created by real or induced shortages of nurses in a number of countries. This migration either as contract labour migrants or, for the more fortunate, as semi-permanent or permanent migrants, is fundamentally based on global inequalities in levels of development, income and opportunity. The massive migration of nurses from poor nations such as the Philippines is much more than a large migration of nurses, but it is also about development, fostering long-term underdevelopment of labour exporting nations (through undermining important areas of capacity building such as the health care system) within an unregulated global movement of highly skilled labour. The globalisation of nursing has resulted in an unprecedented and acute brain drain from major nurse exporting nations, evident early on in the Philipines (Joyce and Hunt 1985). Outcomes of globalisation may thus be divergent for nations at either end of the development spectrum.

The contemporary global migration of Filipino nurses is migration of the highly skilled. However, this migration in many instances exhibits the characteristics of contract labour migration—a concept most frequently applied to the global, temporary and contracted migration of the unskilled. Since the rise of institutionalized, state managed and promoted labour migration in the early 1970s, the Philippine state has played an aggressive role in seeking out international markets for all workers and particularly their nurse nationals. In the 1960s the brain drain of nurses from the Philippines occurred principally through permanent migration to the United States (Ball 2004). By the 1980s and 1990s the main nation of demand for Filipino nurses as contracted labour, often recruited and placed by the Philippine government, was Saudi Arabia—which accounted for two thirds of Filipino nurse migrants. Since the 1970s the supply of Filipino nurses has expanded both numerically and geographically, to the extent that about 250,000 Filipino nurses are employed globally. The development of a sophisticated system of

nurse export from the Philippines has been facilitated by government policy (Ball 1996, 1997, 2006) and the use of temporary employment contracts and visas.

Contemporary labour export has wrought massive changes on Philippines economy and society. The economic effects of the labour export industry, in terms of worker remittances on the macro economy of the Philippines, has been widely acknowledged (Ball 1997, 2006; Tan 2000; Tyner 2004). Above all, it is migration's tremendous hard currency earning capacity that has won it the active support of the state (Ball 1996, 1997; Piper and Ball 2001). The combination of a state policy promoting labour export, the country's economic decline, and a burgeoning international demand for a range of labour services, has inevitably had an effect on individuals and households in terms of their career decisions, labour market participation and survival strategies (Ball 2000). Relatively little research has been conducted on industry and labour specific sectors, or on skilled migration of Filipino women. What research has been done on women OCWs (overseas contract workers) has largely centred on the situation of domestic helpers and entertainers (Chant and McIlwaine 1995; Yeoh and Huang 1998; Pratt 1999; Barber 2000; Tyner 1996, 2004) This chapter analyses changes in the nature of skilled migration of Filipino nurses, by employing a 'supply' and 'demand' approach to explore the nature of international labour market relationships in the global nurse trade from a poor underdeveloped nation to two economic powerhouses in the global economy: the United States and Saudi Arabia.

This chapter contextualizes the massive and ongoing export of nurses against the background of the phenomenal growth of international contract labour migration from the Philippines, and the economic impacts of remittances on the economy. The major impacts of this highly organized and ongoing global migration of nurses on the Philippine health care sector and labour markets over the last thirty years are then examined. The discussion first analyses how individuals and their families respond to both local and global labour market dynamics in the choice of nursing as an investment decision in a globalising world. It then examines the supply side nurse labour market in detail: the extent of nurse migration from the Philippines and its relationship to the local labour market, nurse–patient ratios, wages and condition of employment and the impacts of nurse migration on the Philippine health care system. The chapter then examines the demand side of the global nurse trade. Using the example of two major labour markets for Filipino nurses the chapter explores the differences in the nature of demand for nurses in the United States and Saudi Arabia. Finally, the chapter concludes by exploring how understanding the dynamics of these globalised labour markets provides the base from which we can identify potential areas for developing governance mechanisms between nurse exporting and importing nations that address the highly unequal impacts embodied in this trade.

CONTEXTUALISING NURSE MIGRATION: CONTEMPORARY DIMENSIONS OF PHILIPPINE LABOUR EXPORT

The Philippines is one of the major contemporary countries of migration—perhaps even the largest migrant nation—with Filipino migrants found in more than 181 countries. As a labour exporting nation the Philippines ranks second in the world, next only to Mexico (Carlos 2002:81). For more than 30 years since the OPEC oil crisis of 1973, the Philippines has been a labour exporting nation which has supplied workers to labour-deficit and/or capital-rich nations. While the export of labour was promoted by the Philippine state as a temporary measure, for more than 30 years it has both persisted and greatly expanded (Ball 2006).

The growth of the overseas employment industry has been remarkable. International contract labour migration from the Philippines has wrought substantial changes on Philippine society and economy. Exactly how many Filipinos are working abroad is unclear (Ball 2006). In 2004, the Commission on Filipinos Overseas and the Philippine Overseas Employment Administration (POEA) estimated that more than 8 million Filipinos live abroad. Of these the majority (3.6 million) are temporary overseas contract workers, followed by 3.2 million permanent migrants and 1.3 million undocumented migrants (such as overstaying tourists working illegally). Remittances from overseas workers are the premier foreign exchange earner for the Philippines, and the 'national' economy of the Philippines has become increasingly dependent on the hard currency remittances of migrants. Central Bank of the Philippines data reveal that in 2005, US$10.7 billion was remitted through formal channels; remittances through formal channels in 2003 (US$7.6 billion) accounted for 10% of GDP (ADB 2003). The remittances have contributed greatly to the country's foreign exchange earnings and were as much as 20% of exports and 5% of GNP in 1990–1998 (Tan 2001:380).

Gendered International Labour Mobility

Until the mid-1980s labour export from the Philippines was heavily dominated by men, primarily in the construction sector, but for more than two decades, it has been dominated by women (Tyner 1996, 2004). The economic contribution of women's overseas employment is vital: 'At the end of the twentieth century, Philippine gendered labour migration and its diaspora have become the primary means for servicing Philippine indebtedness' (Barber 2000:399). By the mid-1990s it was estimated that Filipinas working abroad contributed in legally and illegally remitted earnings nearly US$8billion yearly to the Philippines economy (POEA 1999). A decade onwards, these figure are even greater given the subsequent rapid growth of remitted income into the Philippine economy.

By the mid-1980s a combination of several key factors increased global demand for and employment of Filipino women: escalating economic decline in the Philippines; a rise in labour demand in the international service sector in both Asia and the Gulf; declines in (male) labour demand in the Gulf construction sector; and aggressive global labour marketing campaigns by the Philippine state (Ball 1997). Within a relatively short period the gender structure of the global Philippine migrant labour force was transformed. By 2001 Filipino women constituted 72% of migrant workers leaving the Philippines (POEA 2004). While male workers still typically dominate in the construction and shipping industries, Filipino women are employed in all tiers of service sector employment ranging from entertainment, prostitution and domestic service through to nursing, and in Southeast Asian, North American, European and Gulf labour markets (Barber 2000). Within the broad categorisation of 'service sector' there are wide-ranging employment vulnerabilities related to the intersection of occupation and country of employment. In addition, most Philippine women who are employed legally are generally overeducated for the forms of employment that they take on overseas, resulting in both a brain drain and a deskilling of the globalised and gendered Filipino labour market (Ball 1996, 2004, 2006).

Nursing, service and entertainment positions are heavily dominated by women, with 95% of domestic helpers and entertainers and 92% of nurses being women (Ball 1991:97). Women also tend to dominate labour flows to particular countries. For example domestic helpers migrate mainly to Hong Kong, Singapore, Taiwan, Italy and the Gulf; entertainers migrate mainly to Japan (Ball 1996:72) and nurses work primarily in Saudi Arabia and the United States, followed by Libya, the United Arab Emirates and Kuwait.

THE TRANSNATIONAL LABOUR MOBILITY OF FILIPINO NURSES

The Philippines has had a substantive post-war history of international migration of health workers (Ball 2004). In its various phases this has responded to the dynamics of international demand, the success of Filipinos as individuals and the institutional apparatus of the Philippine government in responding to and meeting this demand. The Philippines leads the way in people thinking about global jobs and securing training just for that end (Ball 2000). The nursing component of the Philippine labour market has become particularly responsive to international labour demands and local stresses, and is no longer oriented to serving only national health care needs to the extent that the Philippines is now producing nurses overwhelmingly for international rather than national labour markets (Ball 1991, 1996, 2000).

Filipino women have had a long history of internal migration in search of employment, and are amongst the most domestically migratory women

in Asia (Trager 1984, Findlay 1987). The massive growth in international migration of nurses is an extension of internal labour migration trends, where women and daughters play a central role in household income generation. In the Philippines, individuals and families are choosing nursing as a profession, in clear response to the growing international demand for nurses. Feelings of responsibility and obligation to family, and strong family expectations that single adult daughters will financially contribute to their households, have underpinned the choice of nursing as a profession for the majority of a group of 640 Filipino nurses (Ball 2000). The family plays a central role in influencing the choice of profession as an investment decision, and the decision to educate daughters to become nurses is substantially influenced by concern for returns on that investment. Not surprisingly then, the choice of nursing as a profession was a decision made by daughters and families, which for a substantial number were strongly influenced by overseas, rather than domestic employment opportunities. Furthermore, most nurses do not intend to work as nurses in the Philippines after returning from working overseas. This has changed the focus of the nurse labour market in the Philippines away from local needs. The Philippine nurse education and labour market, since at least the mid-1970s, has essentially become a training ground for overseas employers and the international trade in nurses, with potential longer-term consequences for the Philippine health care sector and the quality of health care delivery.

The success of individual nurses in obtaining overseas employment has historically varied with the level of government intervention and regulation. The relatively unorganized international supply of medical workers as permanent residents to the United States in the 1960s and 1970s (Ball 2004) underwent massive transformation through the development of a state apparatus centred on labour export as development policy (Ball 1997, Ball and Piper 2002). As a result, the export of nurses expanded in volume, elaborate organisation, and destination, on a contract basis in the late 1970s and 1980s. While there is some overlap between this second phase of the brain drain (Ball 2004) and earlier permanent emigration of Filipino nurses to the United States, it was not until the early 1980s that private and public sector systems governing the temporary contract migration of Filipino nurses became well developed. This changed the status and conditions under which nurses migrated to the United States and other nations. The Philippines now supplies nurses to the United States, the Gulf, East and Southeast Asian nations, and to Britain and other European Union states as the major global exporter of registered nurses.

Contemporary Nurse Migration from the Philippines

The number of Filipino nurses that have migrated to work abroad has been extraordinary. Historical and contemporary data collection has been ad hoc, so it is difficult to assess the full extent of nurse migration from

the Philippines. The following statistics, however, reflect the enormity of this process. In 1985, 26,560 medical workers and 21,000 nurses (POEA 1986) were deployed for overseas employment, accounting for about 15% of all Filipinos finding employment abroad in that year. Since the 1980s, the annual exodus of nurses has fluctuated markedly (Figure 2.1), but has always remained substantial to the extent that the Philippines has consistently been the largest global exporter of registered nurses. For example, in the 1990s, the annual deployment of nurses had dropped from the levels of the 1980s and did not exceed 7,000 annually, but in 2001, 14,000 nurses left the Philippines (Baguioro 2002:1).

The Philippine Nurses Association estimated that in the early 1990s, almost two thirds (61%) of the total number of trained nurses (which was 174,202 in 1990) were employed outside the Philippines (Ortin 1994:190). Manzano (2005) estimates that in recent years over 70% of the 7,000 Filipino nurses who graduate annually leave for overseas employment. This figure, combined with the migration of nurses employed in the Philippines, amounts to a yearly estimated supply of 15,000 nurses per annum to more than 30 countries. This outflow is more than double the average number of graduates from nursing schools (Baguioro 2002:1): a substantial brain drain. In a promotional statement, a major Philippine nurse recruiter has written:

> Filipino nurses can be found everywhere around the world—in the big cities of United States and England, in urban centers of Europe and

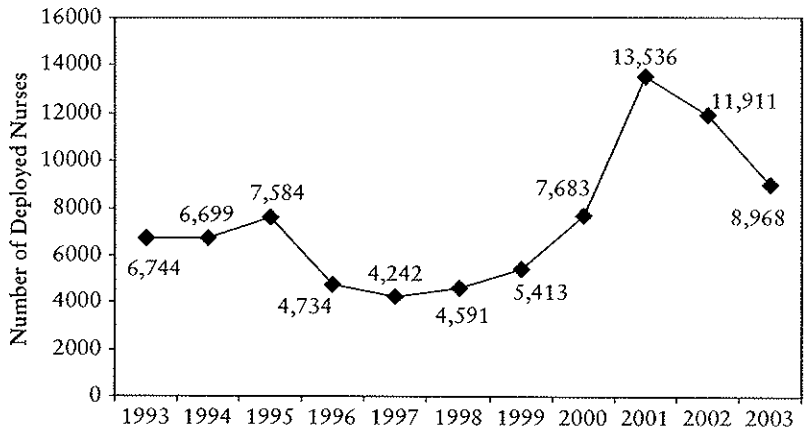

Figure 2.1 Overseas deployment of Filipino nurse professionals.

Source: POEA, cited in Manzano (2005:12).

Asia, in the far corners of Africa and South America, in remote desert clinics in the Middle East, in offshore rigs on the China Sea.

(http://www.abbapersonel.com/nurses.html)

The top destinations of Filipino nurses are: Saudi Arabia, the United Kingdom, Kuwait, the United States, Ireland, and Singapore—the only ASEAN nation that is a primary destination (Table 2.1).

The labour migration of nurses from the Philippines is symptomatic of part of the overall shift of labour migration away from the migration of unskilled and semi-skilled workers, to skilled service sector workers that are used to sustain existing levels of development elsewhere. The dominance of the Gulf as the major nurse importing region increased in the 1980s when the United States' qualifying examination of the Commission for Graduate Foreign Nurses (CGFNS) was strictly enforced, resulting in fewer nurses being able to obtain work in the United States. Nevertheless, since then the

Table 2.1 Deployment of Filipino Nurses by Country of Destination, 1993–2003

		Country of Destination						
Year	*Number of Deployed*	*Saudi Arabia*	*United States*	*U.K. and Ireland*	*United Arab Emirates*	*Kuwait*	*Libya*	*Rest of the World*
1993	6744	3762	1987	0	19	121	661	194
1994	6699	3032	2833	0	127	454	11	242
1995	7584	3015	3690	1	46	59	380	743
1996	4734	2711	270	0	50	269	809	645
1997	4242	3171	11	0	189	25	175	671
1998	4591	3473	5	63	268	143	34	605
1999	5413	3567	53	934	367	53	13	426
2000	7683	3888	89	2615	295	133	17	646
2001	13536	5045	304	6912	243	182	9	841
2002	11867	5688	316	4004	405	108	411	935
2003	8968	5740	196	1751	226	51	52	952
Total	87808	46153	11521	16280	2455	1877	2828	7064

Source: Philippine Overseas Employment Administration 2004

Philippines has provided a steady flow of highly trained and experienced nurses to both the Gulf and the United States.

The Effects on the Philippine Health Care Sector

The impact on the Philippine health care sector of large annual outflows of nurses cannot be underestimated. This massive out-migration of nurses has created an under-supply of skilled nurses to the domestic health sector in the Philippines that has weakened the country's healthcare system. Since the mid-1980s there has been clear evidence that the country has lost many of its highly qualified and experienced nurses in both private hospitals and the public health care system (Ball 1996, 2004). As early as 1985, 47% of hospitals complained of being inadequately staffed, and extreme nurse–patient ratios existed—even as high as 1:120 in some larger hospitals (Venzon 1985:86, Quesada 1985). These serious nurse–patient ratios have been compounded by high staff turnover rates, again since at least the mid-1980s. In both private and public hospitals in Metro Manila, estimates of nurse turnover rates were 60% to 80% per year (Ball 1996). Hospital administrators and chief nurses all agreed that the quality of nursing care had been seriously affected by the rapid turnover of both junior nurses and the most experienced nurses. One of the consequences of understaffing was higher nurse-to-patient ratios, resulting in undue stress and widespread fatigue for nurses who receive no additional income for their higher workloads. The massive migration of nurses also led to serious geographical imbalances in the distribution of nurses. Of the estimated 35,744 nurses currently working in the Philippines, almost half are employed by national government hospitals and clinics, while 15% work in provincial and rural based hospitals operated by local government units (Manzano 2005). The scenario described above is magnified in rural areas, as many nurses migrate to Manila prior to obtaining overseas employment.

Wages and Conditions of Employment

While the 1990s saw increased numbers of people undertaking nurse licensure examinations, the seemingly paradoxical situation of high overseas demand for overseas workers and domestic nursing shortages has not translated into improved wages and conditions domestically, as nurses are willing to endure poor wages and conditions in order to obtain the experience required for overseas employment (Ball 1996). Wage differentials between domestic and overseas employment (Table 2.2) indicate why nurses accept poor wages and conditions before seeking employment abroad. The average salary of nurses in the Philippines amounts to just almost P10,000 (US$215) per month, compared to the basic monthly salaries of Singapore (US$900), the United Kingdom (US$2600), and the United States (US$4600).

Table 2.2 Salary of Nurses According to Position and Level

Position	*Tertiary Hospital*	*DOH Retained Government Hospital*	*Local Government Hospital*	*Private*
Chief nurse	20,415	19,729	16,864	19,293
Assistant chief nurse/ division chief	17,334	10,739	15,009	16,542
Supervisor special unit	13,715	15,009	13,857	13,065
Supervisor ward unit	13,715	13,357	13,357	13,065
Head nurse	12,206	11,888	11,888	11,466
Staff nurse special area	10,863	9,714	6,502	9,220
Staff nurse ward	8,605	9,714	6,502	9,220

Source: Manzano (2005). Salary in Philippine pesos.

It is not therefore surprising that for the majority of Filipino nurses, the major influencing factor on the choice of nursing as a career was the opportunity it provided for working overseas (Ball 2000). The international demand for nurses is so great that it has critically affected even the medical labour market of the Philippines: It is not uncommon for doctors to retrain as nurses, and more are opting for nursing over other medical fields, which has led to a decreased supply in other professions. Since nurses are willing to accept substandard wages in the Philippines—this leads to a feedback system which works simultaneously to depress nurses wages and encourage migration at the earliest opportunity. In short, the advent of systematic labour export of nurses has produced acute nursing shortages, rapid turnover of nursing personnel, declining standards in nurse education and health care, and the underremuneration of nurses and nurse educators (Huno 1990; Ortin 1994; Ball 1996, 2004). With a global shortage of nurses becoming increasingly acute in the 1990s, labour market opportunities for Filipino nurses expanded into Asia and Europe to the extent that the Philippine Labor Secretary, Patricia Sto. Tomas stated that 'the country cannot comply with the industry demand for nurses abroad. There are simply too many job orders' (Dancel 2002).

The unparalleled 'success of the Philippines as an exporter of nurses,' has thus created a major crisis in health care delivery in the Philippines and raised serious questions over its long-term sustainability. Migration constitutes a massive loss of human capital: the Philippines bears the cost of training health professionals without fully utilising them for local needs (aside from the enormous revenues raised through remittances). The most junior and least well-qualified nurses remain in the health care system, hence the

migrant nurses are the best educated and most experienced, and include many nurse educators, few of whom intend returning to nursing after working overseas (Ball 1996, 2000). The Philippines has become a training ground for nurses for an international market that can afford to provide the wages and working conditions that the Philippines cannot. These issues have serious transnational policy implications and major developmental impacts on the Philippines.

THE DEMAND SIDE: IMBALANCES IN THE INTERNATIONL DISTRIBUTION OF NURSES—THE UNITED STATES AND SAUDI ARABIA

Acute imbalances in the distribution of nurses have led to substantial segments of developing country nurse labour markets becoming globalised to address increased demand for nurses in the oil rich states of the Gulf and in much of the rich world. Global demand for health services has aggravated human resource imbalances between first and third world nations (Bui 1987:88). Since the mid-1970s, rapid economic development in the Gulf States has been accompanied by commensurate growth in the health care industries of these countries, prompting the import of physicians and nurses (Mejia et al. 1979:49) The oil exporting nations experienced a spectacular increase in their total stock of foreign health workers primarily from India, Pakistan, Egypt, the Philippines and Korea (Bui 1987:91). Developed countries exploit the push factors from poor nations such as the Philippines, which, as discussed earlier, include low pay, severe understaffing, poor career structures and opportunities for further education. The following discussion analyses the demand dynamics of the two principal global employment destinations since the late 1970s for Filipino nurses: the United States and Saudi Arabia.

The United States Market

The ongoing demand for nurses in the United States and much of the Western world is a complex combination of gender and labour market dynamics, the changing demography of the United States, and a restructuring of traditional methods of medical delivery. The United States nursing profession has experienced one of the most serious labour shortages since the 1980s. The national supply of registered nurses in 2000 was estimated to be 1.89 million, while demand was estimated at 2 million, or 6% more than needed, while demand grows at 1.7% annually (Anonymous 2002:24). The current shortage is more serious than previous shortages, as it is nationwide, is numerically greater, and affects all types of hospitals and nurses.

Explanations for the current and projected shortages included an 18% growth in the population, a growing population of elderly and medical advances. Widespread gender discrimination in nursing, as a female

dominated profession, has depressed the attractiveness of nursing as a career. The financial rewards of nursing are not commensurate with the level of responsibility. Other occupationally based disincentives for people to become or remain nurses included: burnout; limited opportunities for upward mobility; insufficient authority and autonomy; increased work demands; and lack of participation of nurses in management decisions. While entry-level salaries for registered nurses are competitive with other professions, compression of the wage structure and relatively flat earning power creates severe retention problems (Aiken et al. 2001). Increasing dissatisfaction with nursing as a profession is also due to poor occupational prestige, shifts and weekend work. Most women want to work during the day, and may choose less interesting, less skilled, and lower paid jobs in order to do so. Nurses also perform many non-clinical, administrative, and management functions in hospitals, and the ratio of support personnel to professionals is substantially lower than in other industries.

Because fewer younger people are entering nursing and enrollments in nursing schools are declining, a third of registered nurses in the United States are more than 50 years of age and that proportion is rising, while turnover within hospitals is at approximately 20% per year, through dissatisfaction with increased workloads, low wages, and limited upward mobility (Dworkin 2002:23).

Demographic changes have intensified demand on nursing services. A rapidly aging population has expanded the proportion of population requiring health care, and hospitals in places with higher proportions of elderly (e.g., New York City, Miami and Texas) have experienced serious nursing shortages. Elderly patients require more intensive, longer term and complex care, and more labour-intensive nursing services. Hospitals are bearing the burden of providing a wider range of services to the growing elderly population, creating the need for more nurses (Dworkin 2002).

Changes in the form and philosophy of health care delivery have created new types of labour requirements. Medicare policies discourage in-patient and long-term hospital based care, which has meant an increasing emphasis on primary health care, especially amongst the elderly, and a move to home-based patient care. By contrast, hospitalized patients are sicker and require more care because of the reduction in discretionary admissions and the shorter average length of stay. The rapid growth of community-based health care organizations (e.g., home care, and walk-in medical treatment centres) offer professional nurses other choices of employment that often do not involve some of the less desirable aspects of hospital work including shift and/or weekend work.

The Saudi Arabian Market

In rapidly growing oil-rich Middle Eastern nations such as Saudi Arabia, acute labour shortages have arisen for several reasons. Firstly, rapid economic development has taken place without the growth of an indigenous labour force to sustain and fuel such an expansion. Until the mid-1970s, many Saudi nationals were unable to take up employment in the modern sector. A politically motivated desire excluded most Saudi Arabians from the 'immorality' of modern sector employment. Despite a change in government policy encouraging an increased participation of nationals in the modern sector as part of a policy of 'Saudization,' both economic and social forces continue to work against full participation of nationals, particularly women, in this sector. In the health sector, a large infusion of capital has resulted in the rapid growth of health facilities to the extent that Saudi Arabia today boasts of some of the world's most advanced and sophisticated hospitals. A policy of free medical services and treatment for all citizens was first introduced during the reign of King Faisal (1964–1975). This resulted in rapid development of medical facilities for both preventative and curative health care. However, the growth in health facilities has not been accompanied by a corresponding rise of Saudi nationals to staff the health care sector. At the start of the 1990s some 92% of physicians, 92% of nurses and 73% of the technical staff were non-Saudi (Berhie 1991:821) though these proportions have subsequently declined considerably. Egyptians, Indians, Pakistanis and Filipinos mainly staff health services in base level nursing positions, and North Americans and British in senior or administrative positions. Studies on medical staffing in major institutions such as the King Faisal Specialist Hospital and Research Center indicated widespread employment dissatisfaction reflected in high staffing turnover rate with the average tenure among non-Saudi physicians and nurses being 2.3 years (Berhie 1991:821).

The acute shortage of nurses is also attributable to little enthusiasm among young Saudi Arabians for vocational training, combined with cultural and religious barriers that restrict female access to education and employment, especially in professions that require contact between men and women. Despite government policies to promote female education, social restrictions remain considerable, such that about half as many girls as boys attend school, consequently employment possibilities for women remain severely limited. Not surprisingly, Saudi Arabian women have very low labour force participation rates with less than one in ten actually employed in the paid workforce, and few of these (7.5%) are employed as nurses in the Kingdom's health care system although the number has been slowly increasing. The Saudi Arabian government thus depends heavily on expatriate nursing staff.

GLOBAL IMBALANCES IN THE RIGHTS OF FILIPINO NURSES

Large imbalances occur in the international distribution of nurses. Sending nations tend to be Third World nations that supply capital rich nations with

nurses, a situation that has exacerbated pre-existing imbalances in health care services in labour exporting nations. In both the United States and Saudi Arabia, Filipinos and nurses mainly from other Third World nations fill positions that nationals of receiving countries are unwilling to do, or are prevented from doing. Employment for Filipino nurses in the United States, the Gulf and elsewhere means the occupying of marginalised and racialised positions in the labour markets of both major nurse-importing regions. The labour migration of nurses to the Gulf is structured according to a racialised hierarchy of labour. According to the Hospital Corporation of America, principals recruiting workers for hospitals in the Gulf, and particularly in Saudi Arabia, recruit their labour according to the following racialised division of labour:

Americans and Europeans: Senior hospital administrative, senior technical and supervisory positions, e.g., hospital administrators, doctors, head nurses.
Filipinos and Egyptians: Middle status positions e.g., registered nurses and technical staff not in senior positions.
Sri Lankans, Pakistanis: Low ranking positions—i.e., unskilled jobs, e.g., orderly and janitorial positions (Ball 1991:196).

Nurses, like other contract workers, are recruited and paid according to an international hierarchy, where more powerful and skilled positions are more readily accessible to workers from developed nations.

The degree to which Filipino (or any other) nurses employed in both nations have recourse to legal and institutionalised workplace practices to voice their concerns varies enormously between Saudi Arabia and the United States. In the Gulf, there are few mechanisms for nurses to lodge workplace abuse complaints, unless through the Philippine Embassy, which has little power to negotiate with employers on behalf of Filipino nurses. Nurses working in the Gulf are largely employed there due to their inability to obtain employment in the West, for financial reasons (such as recruitment costs) or due to the lesser quality of their qualifications. Filipino nurses often see their employment in Saudi Arabia as a mechanism to improve their practical and academic nursing skills as well as their financial capacity to sit the CGFNS or pay the recruitment fees necessary to obtain employment in the United States or more recently, in Europe. Employment in Saudi Arabia is simply a transition point to employment in western nations. Consequently, many Filipino nurses are willing to endure difficult, often abusive workplaces in order to accumulate the necessary capital and experience, and are much more reluctant to lodge complaints over racially based workplace abuse than they would elsewhere (Ball 1991).

In both major nurse-importing nations Filipino nurses report that they are often 'talked down to' by patients, colleagues and members of the public, and regularly experience racial abuse. They are more likely to be reprimanded

for a minor misdemeanour that would be ignored by a Western nurse. As a result, in the United States, the confidence and motivation of many Filipino nurses is reported to be waning, despite widespread evidence of the capability of Filipino nurses to run large nursing departments. By contrast, there is an increasing incidence of lawsuits and class actions against employers that are discriminating against Filipino nurses in wages, assignments and other workplace conditions. For example, at the end of the 1990s, a legal suit filed with the U.S. Equal Employment Opportunity Commission against a hospital in Kansas by 65 Filipino nurses claiming discrimination based on their national origin, was recently successful resulting in a $2.1 million compensation payment.

The human rights position of migrant Filipino nurses varies. In Saudi Arabia, Filipino women occupy one of the lowest rungs on the ladder of racial tolerance: They are foreigners, Asian and women working in an industry which requires the crossing of major cultural taboos, such as contact between men and women outside of marriage. The vulnerability of Filipino nurses in this gendered and racialised hierarchy is mediated by the acute demand for nurses, which offers some non-institutionalised form of protection. Within Saudi Arabia there is a clear recognition of the need to retain nurses, hence greater attention has been given to job satisfaction and issues posed by the divergent backgrounds of nursing staff (Al-Ahmadi 2002). Such initiatives provide for the possibility of the development of institutional mechanisms that improve the labour and human rights of Filipino nurses and others from the developing world. In the case of the United States and other Western nations experiencing acute shortages of nurses, the fact that human and labour rights are integral to the rule of law, combined with the seriousness of nursing shortages provides a strong basis for increased institutional recognition of the rights of nurses. In addition, overseas Filipinos are well-known for their ability to network through NGOs and professional bodies within cities and through the internet, providing both the basis for information sharing as the basis for legal action, and the lobbying of Federal and State bodies responsible for regulating employment and workplace practices. The considerable divergence in the rights and ability to mobilize, alongside links with supportive NGOs (Ball and Piper 2002), emphasises the perceived hierarchy of destination states, and the particular distinction between the United States and Saudi Arabia.

CONCLUSION

Labour export and the use of foreign labour is, at its most general level, generated by the requirements of capitalist accumulation, and is highly selective. Even amongst the 'unskilled' it is the most able, highly motivated, fit and youthful workers that successfully weave their way through a myriad of obstacles to obtain overseas employment. International labour migration

and the large-scale movement of workers from less-developed countries to rapidly expanding economies have relatively recently been acknowledged as significant components of divergent globalisation (Castles 2000, Ball 2004, Ball and Piper 2006). The characteristics of the labour supply and the terms under which that labour is supplied reflect a sending nation's role in the world economy, the strength of its political ties and dependencies, and the degree of economic necessity to find employment for its nationals abroad. The contemporary global migration of Filipino nurses has intensified over the last thirty years to such an extent that there are now more Filipino nurses employed globally than within the Philippines. The scale of both the migration of Filipino nurses and its impacts on the health care system of the Philippines have increased to the extent that the Philippines government is challenged to control them. The Philippines is now producing nurses for an international rather than a national labour market, resulting in almost three decades of attrition of the Philippine health care system. While not ignoring the positive contribution of nurse migration for foreign exchange generation through remittances, this process of divergent development suggests the need for new dialogue between nurse supplying and importing countries.

This ongoing brain drain is also characterised by a weakening of the rights of nurses (as part of a global hierarchy of labour) in their contracted and globalised form. In both the two primary but very different nations importing nurses, Filipino nurses largely fill positions that for structural and cultural reasons nationals are unwilling to fill. This contributes to the marginalisation that many nurses experience, particularly in the Gulf, but also in the United States, where legal action is beginning to occur. However, there are no opportunities for legal recourse for nurses in vulnerable positions in the Gulf, hence broader transnational employment standards are required for international migrants alongside mechanisms for redressing institutionalised discrimination (see Ball and Piper 2002) for migrant nurses.

This expanding transnationalism of migration thus necessitates the parallel, but substantially belated, development of transnational methods of regulatory governance specifically oriented to improving equity between nurse labour supplying and importing nations in the terms of trade for nurses in the global labour market. Transnational regulations might include a continuum of approaches from intensive stakeholder dialogues, through persuasion to command and control mechanisms. Such regulatory governance to improve the developmental impacts and outcomes of labour migration can build upon existing models, frameworks and conventions that govern trade in commodities, refugee flows and regional multinational immigration systems. Multilateral organisations such as the WHO, the ILO and the International Organization for Migration are well placed to lead the way in addressing the hitherto unprecedented scale of migration of nurses and the global disparities it results in for nations such as the Philippines that are the providers of nurses, but not necessarily the beneficiaries of the process.

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