Through the back door: nurse migration to the UK from Malawi and Nepal, a policy critique

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The UK National Health Service has a long history of recruiting overseas nurses to meet nursing shortages in the UK. However, recruitment patterns regularly fluctuate in response to political and economic changes. Typically, the UK government gives little consideration of how these unstable recruitment practices affect overseas nurses. In this article, we present findings from two independent research studies from Malawi and Nepal, which aimed to examine how overseas nurses encountered and overcame the challenges linked to recent recruitment and migration restrictions. We show how current UK immigration policy has had a negative impact on overseas nurses’ lives. It has led them to explore alternative entry routes into the UK labour market, which can lead them into vulnerable and inappropriate employment. Stringent immigration policies mean that it is harder for nurses to return home from the UK because of visa uncertainties, combined with financial challenges and unfulfilled aspirations. We propose that a more sensitive and versatile border control policy would greatly assist overseas nurses to return home and would benefit individuals, the UK healthcare system and low-income nurse-sending countries.

Keywords
International migration, nurse migration, human resources, Nepal, Malawi, migration policy, brain drain, return migration, circular migration, globalization

KEY MESSAGES
• Following a period of unprecedented, active, international nurse recruitment, recent migration restrictions in the UK have had consequences at both the policy and individual levels.
• Despite increased restrictions, in Malawi and Nepal, the appetite for migration to the UK remains high. Nurses have used alternative entry routes into the UK labour market, which can lead them into vulnerable and inappropriate employment.
• Stringent immigration policies mean that it is harder for nurses to return home from the UK because of visa uncertainties, combined with financial challenges and unfulfilled aspirations.
• We propose that a more sensitive and versatile border control policy would greatly assist overseas nurses to return home and would benefit individuals, the UK healthcare system and low-income nurse-sending countries.
**Introduction**

The British National Health Service (NHS) has been employing overseas healthcare professionals, including nurses, since its establishment in 1948.\(^1\) In the early years of the NHS, both fully trained and trainee nurses, particularly from Ireland and countries in the Caribbean, were targeted for recruitment (Winkelmann-Gleed 2006). However, patterns of overseas nurse migration to the UK have fluctuated. Recruitment was halted in the 1970s and 1980s, but then rose in the late 1990s, peaking in 2001–02 and gradually declining (NMC 2009). The variability in the total number of overseas nurses entering the UK depends primarily on how many nurses are needed or how many nursing jobs are available in the UK (Buchan and Seccombe 2010, 2011). To manage the inflow of overseas nurses, various migration stimulation- or migration control mechanisms have been used by the UK government and the nurses’ professional regulatory body, the UK Nursing and Midwifery Council (NMC). Entry regulations are relaxed when the UK needs more nurses quickly to fill nursing vacancies and are tightened again when there is no immediate need for more nurses, a practice recently described as ‘turning the tap on and off’ (Parish 2006).

Although, in the peak years of overseas nurse recruitment (2001–02), several research studies [such as Aboderin (2007) and Allan and Larsen (2003)] documented the lives of nurses who migrated to work in the UK; few studies have examined the consequences of increasing migration restrictions on the lives of overseas nurses. This article aims to fill this gap and focuses on the latest wave of overseas nurse migration to the UK: the late 1990s to 2010. Based on the two independent multi-sited (Malawi, Nepal and the UK) studies, we highlight how individuals—caught between strict migration regulations and poor prospects in their home country—have been affected. Nurses provide an effective way of studying the impact of migration controls because of the global portability of the profession and the responsiveness of nurse migration patterns to global supply and demand for health workers which continues to change in response to population patterns and the economic climate. In addition, a comparison of nurses coming from Malawi and Nepal offers important insights into how regulations have affected nurses from two different (but in some ways similar) countries. (Both are low income and became new sources for nurse recruitment after 2000.) These two studies were conducted independently by two researchers in the period 2006–10. Researcher A conducted research in Malawi and researcher B in Nepal then A and B both independently followed up Malawian and Nepalese in the UK. After completion of the study, the researchers met to discuss what similarities and differences existed between the two research studies.

**Methods**

**Research with Malawian nurses: researcher A**

Research in Malawi focused on examining the lives of Malawian nurses, based on a timeline of key events. In-depth biographical interviews were conducted, beginning with a discussion about the start of the respondent’s career and ending with their thoughts about the future. A biographical approach was used because of its focus on the life experiences of an individual (Denzin 1989) and its ability to let a respondent lead the interview discussion and discuss topics they consider most important. Respondents were recruited through the ‘snowballing’ of existing contacts and community gatekeepers, a strategy that proved particularly important in the UK because of recruitment challenges. Forty-six nurses were interviewed (34 working in Malawi and 12 working in the UK) along with key informants such as nursing college tutors. These key informant interviews were conducted to verify information from the nurse interviews, and also to provide information on the Malawian cultural, historical and political context.

**Research with Nepalese nurses: researcher B**

Research in Nepal looked at the nursing education system in Nepal and Nepalese’ process of migration to the UK. A qualitative ethnographic style method was used. Socio-cultural context for international nurse migration was examined with a particular focus on how young women are trained to become nurses and how they prepare for an international move.\(^2\) The researcher then followed Nepalese in the UK. Over 100 Nepalese were met and in-depth interviews were conducted with 22 in the UK. Interview samples were generated by ‘snowballing’ techniques. Multiple sources were used to identify diverse participants from several locations in the UK and Nepal.

**Data analysis**

All the interviews were recorded onto a digital voice recorder and then transcribed solely by the researchers to allow for familiarity with the transcripts and to protect the anonymity of the respondents. The transcripts were then analysed using a ‘concrete thematic’ approach characterized by the identification of key themes or concepts within the interview texts (Merrill and West 2009). No superimposed thematic structure was used and the researchers drew visual ‘mind maps’ on paper to ‘brainstorm’ and organize the emerging research themes. These themes were then collated into Microsoft Word documents and related to other literature and existing theory. Findings presented in this article were examined and cross-checked by both researchers.

**Limitations**

Although we have tried to locate our research in its current and historical context, we recognize that it is just a snapshot in time and that we cannot over-generalize the results to all nurses from Nepal and Malawi. We have shown that although there are similarities between the experiences and pathways of nurses from two different countries, there are also inherent differences linked, e.g. to the home context of nurses. This suggests that we must also be cautious about extrapolating our findings to countries outside Malawi and Nepal.

**Ethical clearance**

Ethical approval was gained from the University of Edinburgh and University College London. In Malawi and Nepal, research permission was obtained from the Malawi National Health Sciences Research Committee, Nepal Nursing Council and...
individual institutions. In addition to institutional approval, informed consent was gained from all the research participants and any identified ethical issues were addressed. All our research participants are anonymous, and their real names are not used in this article.

Results and discussion
International nurse recruitment and the receiving context of the UK
As the experiences of the Malawian and Nepalese were grounded in the UK context, we begin our results section with a brief summary of the political climate of the UK after 1997, the time when nurses began to migrate from Malawi and Nepal to the UK. After the New Labour election victory in 1997, the Blair government, supported by a fertile economic environment, made a political commitment to expand NHS services in the UK. The main rhetoric concerned reducing hospital waiting lists. For this, there was a need to quickly expand the nursing workforce. Some NHS trusts began experiencing tremendous political pressure to achieve government workforce targets. They resorted to the international recruitment of nurses as a short-term measure, often through private recruitment agencies that also recruited overseas nurses to the private healthcare sector. As a result, in 2001–02, more overseas-trained than home-trained nurses entered into the NMC's UK register (NMC 2009). During this period, the pool of nurse-sending countries expanded from the traditional sources, such as India, the Philippines and South Africa, to include a suite of new countries, such as Malawi (in sub-Saharan Africa) and Nepal (in South Asia).

Both Malawi and Nepal are low-income countries, heavily reliant on foreign aid and technical assistance for infrastructure development, including the strengthening of their healthcare services. They also have links with the UK. Malawi, being a former British colony, inherited the English nursing education system, whilst Nepal, despite having no direct colonial link, had its first nursing school set up with the help of two British nurses in 1956 (Maxwell and Sinha 2004). Consistent with previous studies [as described by Winkelmann-Gleed (2006) and Kingma (2006)], our research found that nurses from both Malawi and Nepal have been (and remain) attracted to migrate to the UK by several factors. These include opportunities in the UK for further education and having a higher living standard, and improvements in salaries and working conditions. Language and training links resulting from colonial ties also contribute to the appeal of the UK (Young 2011).

The rise in nurse migration to the UK from Malawi and Nepal
Prior to 2000, according to the NMC of Malawi, the movement of nurses out of Malawi was too low to warrant recording. A few nurses had left for further training overseas but then returned home. The surge of requests to the NMC of Malawi for permission to work overseas began after 1999 and corresponded with the rising demand for overseas nurses in the UK. The UK's active recruitment practice and the escalating presence of private recruitment agencies were well-timed. Discontent with nursing and with Malawi was growing. Nurses were looking for a way to leave and agencies responded by providing the means. During this period, around 633 nurses left Malawi, representing a significant proportion of Malawi's workforce (NMC Malawi, unpublished data). Many nurses were also drawn to migrate by the emails and phone calls from friends already in the UK. The sense of an 'exodus' was heightened by the swift exit of nurses, who often gave little or no notice of their imminent departure. A migrant nurse, Lindiwe, recalled being swept up in the excitement:

In Heathrow airport there would be millions of Malawian nurses coming... you go oh my God, all the nurses, who has stayed in Malawi?... Previously you would hear, oh so and so maybe ten people in a month... I think that most of the people at [nursing college] have actually come here.

Similarly, in late 1999 the news of nursing shortages in the UK very quickly reached Nepal through the Nepali Diaspora network. A few nurses came to work in the UK first. Their friends and colleagues left behind then showed an interest in coming to the UK. Within a few years it became the most popular career move for Nepalese and many started looking for any possible entry route to the UK. Nurse brokering agencies sprang up and they started facilitating the nurse migration process. International nurse migration from Nepal is a new phenomenon. Available records and information on ‘out of country’ movements of nurses from Nepal suggest that Nepalese started migrating to the UK mainly from 2000. As with Malawi prior to 2000, only a few nurses moved to the UK and other high-income countries for further education but then returned home. Some Nepalese migrated internationally as dependent family members, but the wider and organized nurse migration market that we see today did not exist. Research suggests that around 1000 Nepalese migrated to the UK from 2000 till 2008 (Adhikari 2011).

This loss exacerbated Malawi's existing crisis over human resources in health care. In 2008, after the largest wave of migration, the nursing vacancy level stood at 77% (Malawian Ministry of Health personal communication). The shortfall in nursing workforce, combined with a high disease burden including high levels of malaria and HIV/AIDS, made Malawi's health and social indicators to be amongst the poorest in Africa (Harrigan 2001). Although Nepal also experienced losses of nurses to international migration, it was affected differently. There has been a phenomenal increase in training capacity since the late 1990s—with job scope for the international nursing labour market—leading to a sudden increase in demand for more nursing teachers. When many senior and experienced nurses—Nepal's key nurse training and management resources—started making the international move (not only to the UK but also to the USA, Australia and New Zealand), Nepal's nursing education sector experienced a critical shortage of nurse lecturers (Adhikari 2008).

Many low-income countries, such as Ghana and Zimbabwe, faced a similar situation, and the out-migration of nurses from these countries became a major global public health- and political concern. High-income countries, particularly the UK, were criticized for actively hiring nurses from resource-poor
countries, which desperately needed their nurses, a practice heavily worded as ‘poaching nurses’ or ‘haemorrhaging healthcare professionals’. It appeared that this was the ‘poor subsidizing the rich’ and was considered totally unethical (Augustine 2005). In the late 1990s, Nelson Mandela (then South African president) requested the UK government not to recruit nurses from South Africa, as the country was facing an HIV/AIDS epidemic and urgently needed to strengthen its health service (Kingma 2006).

Barriers to migration: the emergence of the Department of Health Code of Practice on the International Recruitment of Healthcare Professionals and changes in NMC registration regulation

These criticisms led the UK government to consider reviewing its international nurse recruitment practice. Consequently, ethical guidelines for the international recruitment of nurses were drafted and finalized in 2004 (DoH 2004). The Department of Health (DoH) in England created a list of more than 170 countries, including Malawi and Nepal, from where nurses and healthcare professionals were discouraged to come to the UK (NHS Employers 2009). From 2004, NHS trusts stopped hiring healthcare professionals from countries on the list, although private sector employers could choose to ignore or adhere to this guideline. In early 2000, as nursing was listed as a shortage profession in the UK Home Office list to assist overseas nurses’ entry and employment in the UK healthcare system, employers could fast-track work permits for overseas nurses. Later, in 2006, when nursing vacancies were no longer an issue, the Home Office removed nursing from the skills shortage list, making work permits (essential for overseas nurses to gain employment) very difficult to obtain.

In addition to needing work permits, overseas nurses have to meet certain professional regulations to work as fully licensed professionals. After meeting these requirements suggested by the NMC UK, an overseas nurse would then be recommended by their British assessor for full registration, enabling them to obtain their NMC PIN and work as a licensed professional. A continuous inflow of overseas nurses to the UK from the 1990s created immense pressure on the NMC registration system. There were not enough training places (for overseas nurses) available in the UK and, at one point in 2005–06, there were as many as 37,000 overseas nurses waiting for a training placement (Smith et al. 2006). To control the inflow of overseas nurses, the NMC introduced the Overseas Nurses Programme in 2006, with a higher English language test score for nurses from outside the European Union (EU) (NMC 2012). It was widely believed that this new regulation was created mainly to tackle the huge backlog of overseas nurses waiting for full registration and as a way of restricting overseas nurses’ entry into the NMC-UK register. However, the NMC justification for higher English language competency was to raise nurses’ communication standards to ultimately raise care standards. However, this did not apply to nurses coming to the UK from non-English-speaking countries of the EU (a continuing point of controversy).

The consequences of strengthening barriers to migration

In 2008, the migration ‘exodus’ from Malawi had tailed off: whilst, between 2000 and 2002, between 90 and 111 nurses left each year, this declined to 23 and 28 in 2007 and 2008, respectively (NMC Malawi, unpublished data). Our research finds that this drop in migration is linked primarily to the three main policies that restrict overseas nurses’ entry into the UK (the DoH Code of Practice, tighter NMC restrictions and changes in the UK Home Office work permit system), rather than to decreasing interest in migration. The decline seen in Malawi is consistent with the NMC record, which shows that the total number of foreign registrants decreased after 2001 (Figures 1 and 2). Although nurses from Nepal were exposed to the same restrictive policies, the number of Nepalese entering into the NMC register did not decrease. In fact, the number of nurses entering into the NMC register appears to be consistent until 2008–09 (Figure 3). Our findings show that nurses began coming to the UK via alternative entry routes, including as a NVQ student or a Health and Social Care student and then stayed longer. Some came as dependent family members instead of work permit holders.

As migration routes changed from coming to the UK as a nurse to coming as a NVQ student, the process became costlier for nurses. Migration brokers, commonly known as ‘International educational consultants’ in Nepal, started charging more money for their services (Adhikari 2011). These new entry routes have been less-readily used by Malawian nurses and this may offer an explanation as to why migration from Malawi has declined when it has been consistent from Nepal. Another explanation may be the recent rise in alternative employment within Malawi, particularly within the expanding non-government organization (NGO) sector (Grigulis 2011). In recent years, the number of NGOs operating in Malawi, particularly in the field of health, has increased exponentially (there are currently 330 in operation in Malawi, CONGOMA 2010). High-paying NGOs are considered more desirable than the government service with its poor salaries, high levels of corruption and narrow career prospects (Anders 2002), even if nurses go into less-than-ideal, administrative positions (Grigulis et al. 2009).

Despite the migration challenges, the nurses we interviewed from Malawi and Nepal were determined to find work in the UK—propelled on by the burgeoning networks of nurses from their home country now working in the UK. Interviews with nurses from both countries revealed that there were persistent positive associations with migration, including high respect and unparalleled opportunities for financial gain. Many respondents firmly believed that, given the chance (i.e. if the restrictions were relaxed), more nurses would migrate. Although, from 2006, the NHS doors were closed for Malawian and Nepalese, this did not completely stop nurses coming to the UK, reflected in the high numbers of Nepalese entering the UK workforce and the few nurses coming from Malawi. Their entry was diverted to the private care home sector which did not, by law, have to sign up to the DoH ethical Code of Practice (DoH 2004), which prevented the NHS from employing Malawian and Nepalese. We did find that some nurses opted to work for care homes prior to 2006 because of greater employment flexibility.
However, after 2006, care homes became the only viable option for overseas nurses wishing to work in the UK. This is consistent with previous reports, which state that, increasingly, overseas nurses are entering the UK through private care homes as unregistered nurses (Pike and Ball 2007; Clews 2009), partly because of the availability of jobs and the easier entry process.

Recruitment into the private care home sector
As the private sector is less regulated than the NHS, we found that nurses were more susceptible to poor working conditions and exploitation. Nurses from both countries reported being unprepared for what care home jobs entailed, mainly because of a lack of exposure to the care home sector. Neither Malawi nor Nepal has care homes, as elderly people are looked after at home by their families. Maya, a Nepali nurse explained:

...I did not know and understand the meaning of residential home. When I received a letter that said I was to work in a nursing and residential home, I asked both the agent who arranged the work and my friend who was already working in a residential home for a further explanation. It was then explained by my Nepali friend that residential homes are where people live, get looked after and fed, etc...

Lindiwe, a Malawian nurse, similarly described being shocked by what her care home job entailed. She explained how, when she arrived at her care home, she was made to paint the newly refurbished a job she felt was highly inappropriate. She left the job next day without officially resigning. She recalled:

I didn’t know the UK. That was my first time going to Europe, but I had to do it [resign]. I said no, I am not allowing this man to take control of my life like that.

The general consensus amongst Nepali and Malawian nurses was that care homes felt both unregulated and unprofessional, and that the tasks they were assigned to did not match their prior experiences and training or their expectations about what working life in the UK would entail. A few of the nurses from Malawi, and many from Nepal, reported that the jobs in private care homes were menial and repetitive in nature. Most nurses had ambitions to leave the care home sector to seek better opportunities in the NHS but found themselves unable to change job because their care home employment was linked to their UK work permit.

Deskilling
Migrant workers are often involved in ‘3D’ (dirty, dangerous and degrading) jobs (Castle 2000; Shelley 2007). The subject of professional migrants becoming de-skilled is a widely discussed issue (Allan and Larsen 2003; Kingma 2006). Working in the care home sector with very limited professional development opportunities has meant that many overseas nurses in the UK are becoming de-skilled. Our research provides another pertinent example of this, as many of the Nepalese working in the UK care home sector were highly experienced in intensive care nursing, theatre nursing and maternity services in Nepal. Similarly, the majority of the Malawian nurses who migrated were the most senior and experienced, some even coming from...
high-level academic positions. Many were losing their invaluable professional skills even though, paradoxically, some of these skills are highly sought after by the NHS. This is described by some Nepalese as a ‘trap’ in their dreams and aspirations and has led to significant skill wastage amongst the nurses. A Nepali nurse who had more than 20 years of experience in managing maternity services in Nepal, yet ended up working in a care home in rural England, stated:

When I started working here I found it [the care home] more like an hotel. I was supposed to be doing my adaptation training, but I was learning to set out the dinner trolley, offer and collect menus, serve food and feed elderly people, amongst many other things. It felt as if I was doing hotel management training, not learning any clinical nursing at all.

Nurses’ experience of racism and social isolation

Many nurses also felt managers and colleagues were able to get away with inappropriate practices: this included incidents of bullying and racism as well as lack of professionalism amongst colleagues. Julia, a senior nurse lecturer from Malawi who migrated to the UK, described how her more junior colleagues treated her:

There was so much hatred, [they would] ask: ‘why did you come to the UK? Don’t you have any jobs in your country?’ I said that there are, but it’s for education to travel and work elsewhere…It’s like you are going there to steal their money. You must look that you are desperate…It’s also a lack of understanding about what life is like in Malawi…This made me really to be so low.

Hema, a Nepali nurse, shared her frustration this way. She said:

…I had met some British people in Nepal and I thought that they all would be very polite, friendly, all very nice, very kind, and caring. But I found only 2–3% people like that. The rest are jealous, back-biting, dirty talking, swearing, racist, like that…I have this frustration. There are a few very nice people, too, but the majority of them are racist, some can be nice to your face but stab you in the back. If a local [white] makes any complaint against a foreign staff member, the manager would listen, the managers would listen to local whites [staff members], but, if a foreigner makes any similar complaint, they all get together and isolate the person who complained and gang-up against the foreign staff. So there is very little point to make any complaint.

Our research findings support previous research which shows that migrant nurses commonly experience racism and feelings of isolation and vulnerability. Aboderin (2007) documented how Nigerian nurses in the UK found their white colleagues’ behaviour to be discourteous and domineering. Similarly, McGregor (2007), on examining the experiences of Zimbabwean care home workers, found that most were unhappy with their social life in the UK, particularly because exhaustion and antisocial working hours gave them little time to spend with family and friends.

Barriers to returning home

The majority of the nurses we interviewed believed that they would return home once they had achieved their objectives—in most cases, educational gain in the form of a Master’s qualification and education for their children. However, most felt unable to return just yet. In some cases, this was related to vulnerabilities linked to their migration status, especially if their visa was linked to their care home employment. This finding is reflected in a Voluntary Services Overseas (VSO) report, which documented that one-way migration flows do not mirror migrants’ own plans or aspirations (VSO 2010, p. 18). It reports that, although migrants wished to return home, they felt constrained by legal, financial and regulatory barriers. Our research finds that, despite having negative experiences in the UK, most nurses felt that they could not go back home. In particular, returning home without any financial or educational gain was perceived as failure and would bring shame to themselves and their families. This perception was supported by interviews with nurses who had remained in the home country, as the quote from Monica, a nurse who had remained in Malawi, illustrates:

You know a colleague went to the UK, and you know in the UK there is money, you wouldn’t expect her to come back empty-handed. You would want her to come back; for her to be better than you. They have to be different from the way they left, otherwise we people who stayed in Malawi would laugh at them. Why did you go to UK? What have you benefited? You left your family, how different are you? Either they have to go to school or they have to make some investments.

In addition, nurses from Nepal and Malawi felt that they had already invested a lot of money to make the initial journey, with the hope of getting further education and other life opportunities, which they would not want to waste. Nurses gave up their jobs when they left and the fact that they would be unable to return to their old job was another reason why they did not want to return.

Policy suggestions

Malawi and Nepal are losing valuable human resources for health, which has had a negative impact on health service delivery in these countries. Restrictive entry policies to the UK have been effective to some degree in stemming the tide of migration from low-income countries, as the NMC record (NMC 2009) suggests the overall number of non-EU overseas nurses coming to the UK has declined. However, we argue that restrictive entry policies have not been fully effective. We have presented findings which show that Nepalese have started using alternative entry routes or have gone to other destinations. Similarly, in Malawi, restrictive policies have not benefitted the nursing workforce. Nurses have either sought alternative employment in Malawi or have placed themselves in risky situations by entering the UK through the ‘back door’ of the private care home sector. Unilaterally created restrictive
entry policies have forced migrant nurses into vulnerable positions which negatively impact on migrant nurses’ lives. We make two policy suggestions to address this critical issue.

**Encourage and support circular migration for ‘brain circulation’**

Return migration is when migrants return home permanently and circular migration refers to their coming and going whenever desired. For circular migration to occur, migrants need to have flexible options (Haour-Knipe and Davies 2008). We argue that migrants will return home if they have the opportunity to move about more freely and have the open option to return to their desired destination countries. This has been evident within the EU where people have the freedom to move between EU member states. The BBC World Service published migration data in September 2009, which suggested that some European migrants—including Poles—were returning home from countries such as the UK during the current economic recession (BBC News 2009). Similarly, Nepal and India have an open border policy. Hundreds of thousands of Nepalis are currently working in India. Nepalis go to India as seasonal workers or some even spend many years there for education and work. Most Nepalese interviewed in the UK suggested that they would go back to Nepal only after they obtained an indefinite leave to remain (ILR) in the country. This would allow them to come and go whenever they wished. One Nepali nurse explained:

...once we have the permanent residency (PR) [ILR in another word] visa we can come and go in and out of Britain as and when we like. We have struggled so much and have come this far. Next I just have to wait until I get PR...

This type of freedom is vital for return and circular migration. Migrant nurses from Malawi and Nepal felt that, if they left before they obtained PR (or ILR), they would not be allowed to re-enter the UK and so were reluctant to go. They were prepared to endure the less-than-ideal working conditions while waiting for PR. It is evident that the current UK immigration policy is short-sighted and has been unfavourable for non-EU migrant nurses. Humphries et al. (2009) argue that immigration policies in Ireland similarly do not benefit migrant nurses working there. In their qualitative study on the retention of migrant nurses in Ireland, Humphries et al. (2009) showed that nurses were frustrated with the fact that procedures enabling them to remain in Ireland were not in place, such as naturalization, residency or immigration. These security measures were non-existent despite of the continuing Irish nursing shortage. They conclude that actively encouraging nurses to work in Ireland without having the policies or procedures to enable settlement is evidence of weak policy-making on the part of the Irish government.

The recommendation that policy-makers should implement measures that encourage circular migration is not a new idea. Several authors have presented the case for circular migration (Kingma 2006; Haour-Knipe and Davies 2008). Most recently, the VSO report on African health worker migration argued for the case of circular migration as a means of managing migration more effectively (VSO 2010). However, this article offers a fresh perspective on ways in which circular migration could benefit both source and destination countries and, most importantly, the migrants themselves.

In terms of sending countries, migrant nurses are potentially able to bring back to their country a whole suite of new skills and knowledge if they return. Their return could also help alleviate staff shortages, on the condition that they re-enter the systems in which they are needed most—typically the public health service—and that their skills are put to good use (Kingma 2006). Their return would result in additional manpower without a renewed cost to the government for training. Skills gained by nurses whilst overseas, such as cross-cultural communication skills, could also be put to good use to improve co-ordination between the Nepali and Malawian health services and the numerous international organizations which work to support these systems (these organizations often rely on costly overseas consultants to take on this role). All these are, however, dependent on nurses being suitably welcomed and integrated back into the health systems of their home countries, which may not be the case, especially if their skills are not recognized (nor particularly applicable) back home. This is also dependent on nurses, whilst overseas, being employed in suitable and challenging positions that allow them to develop new skills and knowledge. Currently, there is little quantitative data to support the qualitative evidence for return migration presented here. In her comprehensive examination of health professional migration to the UK, Young (2011) explains that she could not factor in the potential impact of return migration because of insufficient data on outflows. This suggests that this research area would benefit from further qualitative and quantitative work.

**Policy-makers should work with key stakeholders for an effective result**

Looking back at how restrictive policies were formed in the UK, we suggest that there is a need for UK policy-makers to work with key stakeholders from low-income nurse-sending countries to reframe UK immigration policy. "Turning the tap [of migration] on and off" has created an undesired result for many overseas nurses. As we have pointed out, these nurses are already in the UK and are not easily going to go back home for their home country to benefit from them. We suggest that UK policy-makers should use these highly qualified, experienced nurses to maximize the benefit to both the UK healthcare system and to overseas nurses. UK policy-makers should also work with policy-makers or counterparts in nurse-sending countries, including nurses’ professional regulatory bodies, respective governments and nurses’ trade union bodies, to avoid repeating similar mistakes in the future.

**Conclusion**

Our research has shown that changes in migration regulations have had significant consequences on the lives of overseas nurses. In this article, we argue that there is a need for the UK government to focus on more sustained and appropriate international nurse migration management strategies, especially taking into account the reality that nation states are becoming
increasingly interconnected in the contemporary global economic, healthcare and social systems. We have demonstrated that the implementation of the DoH Code of Practice on the International Recruitment of Healthcare Professionals, and consequent changes of work permit regulation in 2006, have not achieved the intended policy outcomes and have produced little tangible benefit for either Malawi or Nepal in terms of nurse retention.

We have illustrated that, to seek a better life, nurses from Malawi and Nepal have sought alternative routes or alternative destinations in the global healthcare market when one entry route is closed. This has led nurses into vulnerable and inappropriate employment, especially when expensive migration brokers are involved. These new entry routes have also meant that, once in the UK, it is harder for nurses to leave because of visa uncertainties, combined with financial challenges. Nurses are therefore more vulnerable to exploitation by brokers, private sector employers and to consequent ‘back door recruitment’ (Buchan et al. 2005). Migrant nurses from low-income countries, unlike EU migrants, can become trapped by UK border control regulations. A more relaxed, sensitive and versatile border control policy could greatly assist overseas nurses and other skilled professionals to return home. Such a situation would benefit individuals, the UK healthcare system and ultimately Nepal, Malawi and other low-income nurse-sending countries.

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Conflict of interest

None declared.

Endnotes

1 Throughout this article, ‘overseas nurse’ means a nurse who was trained outside the UK.

2 Nursing in Nepal is a ‘female only’ profession.

References


