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International migration of health professionals and the marketization and privatization of health education in India: From push–pull to global political economy

Margaret Walton-Roberts

School of International Policy and Governance, Balsillie School of International Affairs, Wilfrid Laurier University, 67 Erb St Room 216, Waterloo, Ontario N2L 3C5, Canada

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ABSTRACT

Health worker migration theories have tended to focus on labour market conditions as principal push or pull factors. The role of education systems in producing internationally oriented health workers has been less explored. In place of the traditional conceptual approaches to understanding health worker, especially nurse, migration, I advocate global political economy (GPE) as a perspective that can highlight how educational investment and global migration tendencies are increasing interlinked. The Indian case illustrates the globally oriented nature of health care training, and informs a broader understanding of both the process of health worker migration, and how it reflects wider marketization tendencies evident in India's education and health systems. The Indian case also demonstrates how the global orientation of education systems in source regions is increasingly central to comprehending the place of health workers in the global and Asian rise in migration. The paper concludes that Indian corporate health care training systems are increasingly aligned with the production of professionals orientated to globally integrated health human resource labour markets, and our conceptual analysis of such processes must effectively reflect these tendencies.

1. Introduction

The current period of health care globalization demands we adopt a conceptual framework that recognizes global integration and interaction between health human resource (HHR) systems across different jurisdictions. Literature on HHR global migration has been conceptualized through various perspectives, including push–pull, brain drain, global care chain, post-colonial, and more recently through perspectives informed by global political economy (GPE) (Kalipeni et al., 2012; Ansah, 2002; Prescott and Nichter, 2014; McNeil-Walsh, 2004; Yeates, 2009a). Increasingly scholars are converging in their calls for research that recognizes and interprets global or transnational intersections between professional training, health systems and the migration of health professionals (Yeates, 2009b; Prescott and Nichter, 2014; Zabalequi et al., 2006; Powell et al., 2012; Connell, 2014).

In order to contribute to this debate I examine the case of India to demonstrate how its health education systems are increasingly responsive to and shaped by international HHR circuits. I advocate for research that broadens migration analysis away from household and employment conditions (typically identified as the main 'push factors'), to the intersection of migration with education and training structures. This focus on education illustrates Powell et al.'s (2012, 256) wider observation that national skills formation policies respond to international goals and standards in order to compete, and that in effect; "Markets for individual investments in education and for skills among firms are increasingly transnational." More importantly focusing on the intersection of migration with education connects with wider debates on the changing role of education, which is increasingly constructed to serve: "the imperative to create hierarchically conditioned, globally oriented state subjects – i.e. individuals oriented to excel in ever transforming situations of global competition, either as workers, managers or entrepreneurs (Mitchell, 2003, 388).

2. Theorizing the international migration of nurses

To begin I briefly provide an overview of how global political economy (GPE) is useful for understanding how current HHR global migration intersects with educational system change. I then provide a short overview of four other approaches to the migration of

E-mail address: mwaltonroberts@wlu.ca.

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nurses (push–pull, brain drain, postcolonial and global care chain) to highlight how recent research on health worker migration is progressively detailing the emerging global and market oriented nature of the HHR training landscape.

2.1. Global political economy

While sometimes used interchangeably with international political economy, GPE is seen as less aligned with international relations and the discipline of Political Science, and rather is characterized as a more trans or multi-disciplinary approach (Palan, 2000 1–2). As with political-economy GPE examines public-private interaction in the allocation of resources (Ravenhill, 2014, 18), and focuses on the role of power (with reference to relational power and agenda setting) in state-non-state collaboration and co-operation. In addition, examining interactions between the state and the market, or the public and private sector, GPE also emphasizes interaction and integration between and across places and scales. 'Global' in this context does not refer to an apex scale of management, but rather the idea that 'national' processes are increasing comprised, altered and constrained by practices originating outside of the state (Betts, 2011). GPE's transdisciplinary nature is highly suited to the field of HHR migration, which is international in scope and engages multiple medical, policy and social science disciplines.

The international migration of nurses has recently been conceptualized as a feminized labour export policy employed by Global South states to service flexibilized and globally integrated labour markets in the Global North (Valiani, 2012). The preeminent example of state-led nursing labour export is the Philippines, whose educational system was structured toward U.S. market demands under U.S. neo-colonialism (Choy, 2003). This global incorporation of certain national nursing labour markets is represented by Valiani as a new form of unequal exchange based upon "the re-intensified exploitation of female caring labour" (Valiani, 2012, 148). A GPE perspective informs Valiani's, (2012) work in terms of assessing how U.S. market demands penetrate the Philippines' health care training sector, with out-migration becoming the means of resource extraction. However, the increasing globalization of the health care sector in India problematizes a neat geographical distinction between 'core and periphery', since; "It is the advancement of health care in these countries that is, in effect, globalizing health care" (Crone, 2008, 117). Employing a North-South binary in terms of the directionality of HHR labour movements is also increasingly problematic because privatized health care has intensified service unevenness at all scales; local, regional and national (Smith et al., 2009; Reynolds et al., 2013).

International training has also contributed to reshaping the health sector. Levitt and Rajaram's (2013) research into different types of Indian health organizations suggests that the international experiences of health professionals are associated with neoliberal or market orientated forms of health care delivery. Levitt and Rajaram argue that the overseas educational experiences of professionals in the institutions they studied contributed to the adoption of neoliberal philosophy, further entrenching a market-responsive ethos (Levitt and Rajaram, 2013, 356). Levitt and Rajaram (2013) encourages a re-evaluation of the migratory process not as a binary balancing act between two separate national systems, but rather a circular process where migration is both cause and consequence of increasing globalization and marketization in health care systems. Explicitly focusing on how this power operates across multiple scales and sectors in the health-migration interface encourages researchers to attend to processes they may have implicitly recognized before, but not foregrounded in their analysis.

2.2. Push-pull

HHR migration has traditionally been seen through 'push–pull' migration, which tends to exhibit a dualist vision of migration where two separate systems are compared in terms of opportunity and then connected by migration (usually in a unidirectional manner). This approach is also evident in neoclassical gravity models which maintain that spatial difference generates migratory flows and propensities as part of an 'equilibrium recovering process' (Hart, 1975). However, after decades of Global South to North nurse migration (Organization for Economic Cooperation and Development (OECD), 2007) the inequalities between sending and receiving regions have not 'recovered equilibrium'. Traditional circuits remain, as new sources of oil wealth in the Middle East have created new and more diverse circuits of health professional migration. For example, in 2010 over 70% of the 12, 082 Filipino nurses who went overseas went to Saudi Arabia (Philippine Overseas Employment Administration, 2010). Migration, therefore, is not merely the accumulation of rational decision making units moving their respective systems toward some kind of equilibrium; rather migration is embedded within wider power and resource allocation structures. More recent analysis, while using the language of push–pull, has recognized that global political-economy factors shape HHR migratory flows (Kalipeni et al., 2012).

2.3. Brain drain

Resource reallocation and the interaction of states and markets in the health training process are also communicated in the concept of 'brain drain'. Originally used to characterize skilled professional migration to the USA in the 1950s (Ansah, 2002) brain drain was later used to reference medical professionals who moved from the Global South to service the Global North's health demands. By the 1990s this pattern of health professional migration was deemed a "perverse subsidy" (Mackintosh et al., 2006), that was impeding Global South health care systems from meeting their Millennium Development Goals (Willis-Shattuck et al., 2008). For example, Africa, with 25% of the global disease burden, retains only 3% of global health workers (Misau et al., 2010). Nevertheless, brain drain arguments have increasingly responded to changing patterns of professional migration by adopting the language of 'brain circulation'. Health professionals exploit the changing health care landscape and engage in expertise-building through international education and training. Such professionals may then operate as conduits to enhance international expertise and training capacity in their home countries (Hagander et al., 2013). From a GPE perspective skilled workers are important resources that countries compete for both as immigrants (Shachar, 2006), and as return migrants (Levitt and Rajaram, 2013; CODEV-EPFL et al., 2013). Skilled health workers represent a resource that can be allocated through the relative power of state immigration and private corporate attraction policies. This model of *circulation*, determined by various intermediating state and market factors, is more attuned to the current reality of HHR migration.

2.4. Postcolonial

Critical assessments of how power informs the HHR training and migration agenda are evident in research framed by post-colonial approaches. The postcolonial lens offers deeper awareness of global interaction while challenging state-centric analysis of migration and health systems (McNeil-Walsh, 2004). In the case of India, colonial practices are implicated in the nature of nurse training, which was heavily influenced by Christian missionaries as well as international agencies such as the Rockefeller Foundation,