

The Multi-step Migration of Nurses: The Case of Filipinos in the United Kingdom

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看護師の多段階的国際移動 —— 英国におけるフィリピン人看護師の事例 ——

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本稿の目的は、フィリピン人看護師の意志決定過程と英国政府の政策との相互作用に焦点を当てつつ、英国におけるフィリピン人看護師の移住行動を分析することである。1990年代後半以降、グローバルな規模で看護師の国際移動が急増したが、なかでも英国とフィリピンがそれぞれ受け入れ国と送り出し国として突出していた。1998年～2007年までの10年間に26,000人を超えるフィリピン人看護師が英国へ渡った。本稿は大きく2つの部分からなり、前半部分では、英国看護師登録簿の分析を通じて、英国労働市場へのフィリピン人看護師の参入のパターンについて考察する。それにより、英国へのフィリピン人看護師の移住が、英国政府の医療人材政策と密接に関連していたこと、英国がフィリピン人看護師にとって安定した受け入れ国ではないことが明らかになる。本稿の後半部分では、英国労働市場の拡大と縮小に対してフィリピン人看護師がどのように対応したのかを、多段階的国際移動の概念を用いて説明する。2008年7月に英国で行ったフィリピン人看護師12人に対する聞き取り調査をもとに、フィリピン人看護師の間で多段階的国際移動が観察されること、移住に関する意志決定が受け入れ国の外国人雇用・移民政策に大きく依存することを明らかにする。さらに、中継地の中でも英国が「ゲートウェイ」としての性質を持つがゆえ、多くのフィリピン人看護師にとって最終目的地とはならないだろうということも本稿で説明する。フィリピン人看護師にとり、英国は人的・社会的資源や資金の蓄積が可能な場所であるのみならず、一定の条件を満たせば市民権の取得が可能な国である。英国の市民権を取得することで、フィリピン人看護師は他の中継地や最終目的地でより良い待遇を得ることができるのみならず、いつでも英国に戻って就労できるという保証をも得るのである。

This paper aims to investigate the migration behavior of Filipino nurses in UK, with particular focus on the interaction between the decision making of Filipino nurses and the policies of the UK government. The Philippines and UK have featured prominently in international migration of nurses since late 1990s. From 1998 to 2007, more than 26,000 Filipino nurses joined the UK labor market. This paper consists of two parts. In the first part, we examine the entry pattern of Filipino nurses to the UK labor market through a macro-statistical analysis of the UK nursing register. This will show that the migration pattern of Filipino nurses to UK has been directly influenced by human resources for health policy of the UK government and that UK cannot be a stable destination for Filipino nurses. In the second part, we analyze Filipino nurses' responses to the UK market expansion and contraction and their high mobility by employing the notion of multi-step migration. Based on interviews with 12 Filipino nurses working in UK in July 2008, we argue that multi-step migration behavior can be found among Filipino nurses and their decision to move or stay in one country largely depends on the unpredictable foreign employment and migration policies of the destination country. Moreover, we show that for many Filipino nurses, UK is most likely not a final

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destination. Even among the transit points, UK stands out as an important “gateway” because working in UK not only allows the accumulation of human, financial and social capital but also, more importantly, entitles them to the UK citizenship. As migrants with the UK passport, they know they will get better treatment in their new destination and that they can always go back to work in UK.

Introduction

With the progress of globalization and the rapid aging of industrialized societies, international migration of nurses has intensified dramatically since late 1990s. Two countries featured prominently in this trend. They are the Philippines and UK. By 2000, the Philippines became a chief provider of nurses to hospitals, mainly but not exclusively, in the English-speaking countries such as US and UK [OECD 2007] and Middle Eastern countries such as Saudi Arabia and the United Arab Emirates (UAE). On the other hand, the expanding UK National Health Service (NHS) vigorously recruited foreign nurses in order to fill newly-created nursing posts in its hospitals. This paper aims to investigate the migration behavior of Filipino nurses in UK, with particular focus on the interaction between the decision making of Filipino nurses and the policies of the UK government.

The Philippines has been exporting its workers overseas in bulk from mid-1970s. It was a national development strategy to alleviate the problem of domestic unemployment and the associated problem of poverty. In time, a migration industry centering around recruitment agencies, financial institutions for overseas remittances and overseas freight services became well-established in the country. Family and social networks transcending national borders also developed, which contributed to sustaining and creating new flows of Filipino migration. Nowadays, the remittances from Overseas Filipino Workers, commonly known as OFW in the Philippines, are very important source of income for migrant households as well as to the country as a whole.

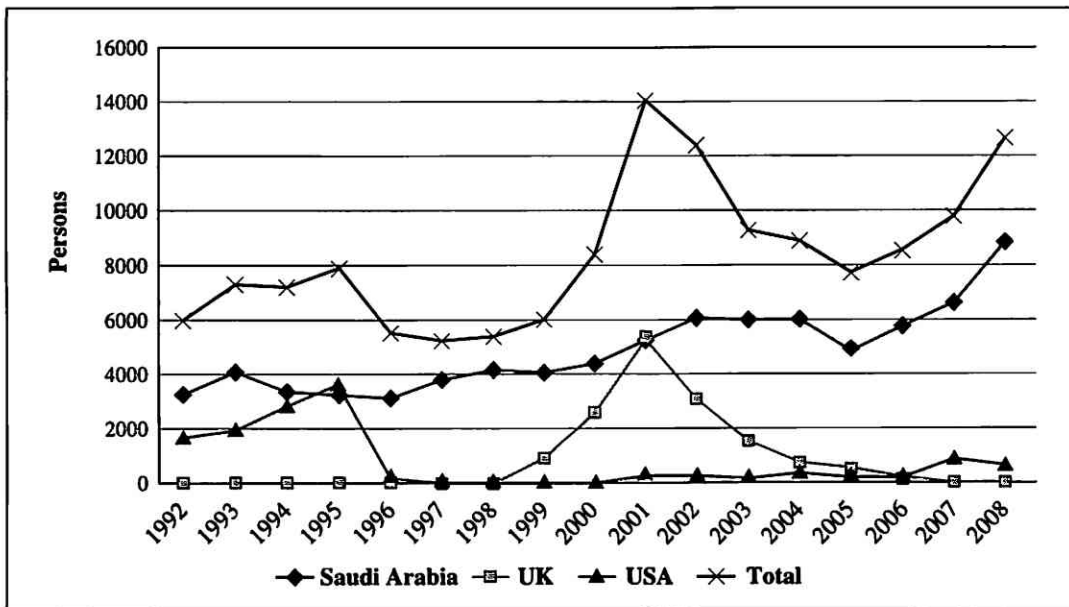
Migration of Filipino nurses dates back to late 1950s [Choy 2003]. At that time, their main destination was US, the Philippines’ former colonial power, and their number was limited as most of them went there through exchange programs. It was easier for Filipino nurses to work in US as nursing education curricula in the Philippines was based on the US nursing education program. In the 1970s and 1980s, Middle Eastern countries began employing Filipino nurses in bulk and they have remained important destinations (see Table 1 below).

The Philippine Overseas Employment Administration (POEA), a government body that markets and looks after Filipino workers overseas, produces official statistics on the number of Filipino nurses who go abroad through official migration process each year. However, the POEA statistics does not capture every Filipino nurse who goes abroad, as there are many nurses who find nursing job outside the POEA process. In particular, it is well-known that the POEA statistics of Filipino nurses who go to US is particularly under-counted, as there are several ways to bypass the POEA process. Still, the POEA statistics is a useful guide to capture general trends of Filipino nurse migration. Table 1 shows the number of Filipino nurses who went to the major foreign destination countries between 1992 and 2008, and Figure 1 shows three numerically significant ones among them.

Table 1: Foreign Deployment of Filipino Nurses: 1992-2008 (New Hires Only)

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Saudi Arabia	3,279	4,202	3,332	3,249	3,071	3,794	4,098	4,031	4,386	5,275	6,068	5,996	5,926	4,886	5,753	6,633	8,848
UAE	271	47	270	94	137	209	279	378	305	249	424	267	250	703	796	616	435
UK	—	—	—	1	—	—	63	934	2,628	5,388	3,105	1,544	800	546	145	38	28
Taiwan	2	44	4	1	1	2	8	17	1	9	131	200	6	357	273	174	231
Ireland	—	—	—	—	—	—	—	—	127	1,561	930	210	191	297	249	127	35
USA	1,767	1,987	2,853	3,690	270	11	5	53	91	304	322	197	373	229	202	933	649
Kuwait	320	139	455	59	269	25	143	53	133	192	108	51	408	193	354	393	458
Singapore	6	47	85	162	549	586	371	214	418	413	338	326	166	149	86	276	667
Qatar	7	7	6	10	6	14	29	12	7	143	213	243	318	133	141	214	245
Others	426	835	166	688	1,174	604	403	280	245	288	696	236	441	275	529	349	1,022
TOTAL	6,078	7,308	7,171	7,954	5,477	5,245	5,399	5,972	8,341	13,822	12,335	9,270	8,879	7,768	8,528	9,753	12,618

Source: POEA [2008: Table 23] for 2001-2008; POEA [2006: Table 22] for 1992-2000.

Figure 1: Trends of Deployment of Filipino Nurses: 1992-2008 (New Hires Only)

Source: POEA [2008: Table 23] for 2001-2008; POEA [2006: Table 22] for 1992-2000.

From Table 1 and Figure 1, we can observe three general features of Filipino nurse migration in the last 17 years. First, the overall volume of Filipino nurse migration doubled during this period. More than 50% of them went to Saudi Arabia, making it the most important destination country for Filipino nurses. Second, there are highly noticeable peaks in the US and UK lines, and third, these peaks significantly affected the total number of Filipino nurse migration in two specific periods. One is the small peak in the early 1990s in the US line, which suddenly dropped in 1996. Another is the higher peak in the UK line, with a sharp rise from 1998 to 2001 and equally sharp drop from 2001 to 2004. We notice similar ups and downs in the total number of Filipino nurses who went abroad during these two periods. In sum, while Saudi Arabia has been a stable destination for Filipino nurses for the last 17 years with the rapid increase in the last three years,

the total number of nurses who went abroad fluctuated due to the sharp expansion and closure of the US and UK labor markets for them. We explain the background of the sudden expansion and closure of the UK labor market for Filipino nurses, and examine how nurses from the Philippines responded to it.

In analyzing Filipino nurses' responses to the UK labor market expansion and closure and their high mobility, we employ the notion of multi-step migration. Multi-step migration pattern is a situation in which a migrant worker moves from one country to another (which we call here as the transit points or gateways) before reaching his final destination. One of the main aims of this paper is to examine the multi-step migration pattern/behavior of Filipino migrant nurses, and identify and describe the motivations for such behavior, with particular attention to the policies of the country of destination. We argue that multi-step migration behavior can be found among Filipino nurses and is largely attributed to the unpredictable foreign employment and migration policies of the destination country.

To test our hypotheses, we interviewed 12 Filipino nurses registered with the UK Nursing and Midwifery Council (UKNMC) in July 2008 in London and Birmingham. They were chosen through snowball method, with three key respondents who were acquaintances of the researchers. The interviews were conducted using a combination of Filipino (*Tagalog*) and English, which were recorded and later transcribed. We realize the limitations of this study due to the small sample size, but nevertheless, our findings can be useful in illustrating the trend of multi-step migration behavior of Filipino nurses in UK and how the UK policies affected such behavior. Table 2 shows the profile of Filipino nurses we interviewed.

Table 2: Profile of Respondents

Respondent	Age	Sex	Place of Work in UK	Arrival In UK	Current Immigration Status in UK
A	40s	F	Birmingham	2005	Limited leave to remain (5 years)
B	30s	M	Birmingham	2000	Indefinite leave to remain
C	20s	F	Birmingham	2005	Limited leave to remain (5 years)
D	30s	F	Birmingham	2005	Limited leave to remain (5 years)
E	30s	F	Birmingham	2000	Indefinite leave to remain
F	40s	M	Birmingham	2000	UK naturalized citizen
G	40s	F	Birmingham	2000	UK naturalized citizen
H	30s	F	London	2001	UK naturalized citizen
I	30s	F	London	2001	UK naturalized citizen
J	40s	F	London	2001	UK naturalized citizen
K	30s	M	London	2003	Limited leave to remain (5 years)
L	30s	F	London	2005	Limited leave to remain (5 years)

Source: Authors' fieldwork.

The respondents can be mainly divided into two groups, the first group whose members arrived in UK before 2002 and are now holders of the UK citizenship or an "indefinite leave to remain" (permanent resident) visa¹, and the second group comprising of those who arrived later and currently hold a "limited leave to remain" visa, which entitles them to stay (remain) in UK as

long as they have an employer who will sponsor their stay. It must be noted that the year of their arrival in UK and their current status are closely related since the UK immigration policy requires a certain number of years of stay in the country (currently five years) before qualifying to apply for a permanent visa or a citizenship.

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1. The UK Policy on International Recruitment of Nurses

Compared to the US and Middle Eastern countries, UK is a relatively new destination for Filipino nurses (see Table 1 above), and their entry into the UK labor market was a direct result of the policy decision of the UK government to recruit foreign nurses in order to expand public health services.

The Labor Party government that took power in 1997 set expansion and improvement of public services such as schools and hospitals as one of its policy priorities in order to consolidate its electoral victory. However, at that time, UK lacked skilled manpower to achieve this policy objective [Layton-Henry 2004: 298]. For the health sector, one of the reasons for the shortage of skilled professionals was due to the reduction of training places for nurses and midwives that was imple-

Table 3: Registration of Foreign Nurses in UK: 1993/94-2007/08 (Initial Entries Only)

YEAR	UK	EEA/EU	Other overseas	Total	UK as a % of total
1993/94	17,948	456	1,665	20,069	89
1994/95	17,411	798	1,654	19,863	88
1995/96	16,870	763	1,999	19,632	86
1996/97	14,210	1,141	2,633	17,984	79
1997/98	12,082	1,439	2,861	16,382	74
1998/99	12,974	1,413	3,568	17,955	72
1999/00	14,035	1,416	5,967	21,418	66
2000/01	15,433	1,295	8,414	25,142	61
2001/02	14,538	1,091	15,064	30,693	47
2002/03	18,216	802	12,757	31,775	57
2003/04	19,462	1,033	14,122	34,617	56
2004/05	19,982	1,193	11,477	32,654	61
2005/06	20,940	1,753	8,709	31,402	67
2006/07	21,388	1,484	4,830	27,702	77
2007/08	21,661	1,872	2,309	25,842	84

Source: Buchan, Baldwin and Munro [2008: 35] for 1993/94-1998/99, UKNMC for 1999/00-2007/08.

Note: In the UKNMC register, "foreign" means the place of education rather than one's nationality. However, we think it is safe to assume that most nurse registrants who were classified as "foreign" in the UKNMC register were educated in their own country, and thus their place of education is the same with their nationalities in most cases.

mente under the previous Conservative Party government. The UK Department of Health (UK-DOH) notes that the number of training places for nurses and midwives was reduced by 28% between 1992 and 1995 [UK-DOH 1999: 6]. The Labor Party reversed this policy direction, but it takes at least three years to train its own nurses. Thus, the UK government turned to foreign countries as a quick solution to realize staffing growth in the NHS [Buchan 2007].

Table 3 shows the total number of new registrants at the UKNMC, as well as the registration of foreign nurses from 1993 to 2007. A number of observations can be made from this table. First, the number of UK-trained nurses was decreasing until 1997 when this trend reversed. By 2007, ten years after the Labor Party took control, the number of UK-trained nurses increased by 80%. However, from 1997 to 2001, the annual rate of increase of the UK-trained nurses was not significant. On average, it was about 5%. It was only in 2002 when the registration of new UK-trained nurses increased by 25% from the previous year.

On the other hand, the annual rate of increase of overseas (outside EEA/EU) -trained nurses was much higher from 1997 to 2001, averaging as high as 53% and peaking at 79% from 2000 to 2001. This means that the rapid increase in the overall number of new nurse registrants from 1997 to 2001 was mainly achieved by the increase of foreign nurses. While in 1996, 21% of newly-registered nurses in UK were foreigners (including EEA nationals), this ratio reached more than half (53%) in 2001. However, in 2002 when the number of UK-trained nurses increased by 25% from the previous year, the registration of overseas-trained nurses decreased by 15%. The percentage of foreign nurses also began to decline from 2002, and by 2007, only 16% of newly-registered nurses in UK were foreigners. Compared with the peak year of 2001, the registration of overseas-trained nurses in 2007 was cut down by as much as 85%.

With regard to the total number of new nursing registrants in UK, it increased steadily from 1997 until 2003 when this trend reversed. As the number of UK-trained registrants was relatively stable and incremental from 2002 to 2007, the reduction of new nursing registrants mainly took place among overseas-trained nurses. Moreover, the annual rate of decrease of new registration of overseas-trained nurses was more drastic than that of the total number of new registrants. It means that for UK, cutting down the annual intake of overseas-trained nurses was easy. It was done not only by tightening immigration policy as we discuss in the next section, but also by enhancing registration requirements for overseas-trained nurses. In September 2005, it became obligatory for overseas-trained nurses to take IELTS, an international English language proficiency test administered by the British Council, and undertake 20-day Overseas Nurses Program (ONP) in UK before they were allowed to register with the UKNMC. ONP made it difficult for overseas-trained nurses to obtain the UK registration. It increased the financial burden for overseas-trained nurses as they had to complete it before they start working as a nurse in UK. They also had to find a place at one of 35 higher education institutions that offered the program. Moreover, from February 2007, they were required to score at least 7 (out of 9) at IELTS [Buchan, Baldwin and Munro 2008: 34-35; Taylor 2008: 20].

Recruitment of foreigners in order to solve the problem of shortage of nurses was not a new strategy for UK. From 1948 up to 1970, the UK government relied on the new Commonwealth countries as suppliers of nurses. In particular it actively recruited nurses from the West Indies in the 1950s and most of them settled down in UK, comprising an important workforce in the NHS [Mayor 2002; Buchan, Seccombe and Hutt 2006: 12].

However, the aggressive recruitment of nurses from developing countries by the NHS hospitals in late 1990s soon became a controversial matter. Especially, African statesmen and politicians, including then South African president Nelson Mandela, also from member countries of the Commonwealth, heavily criticized the UK policy of international recruitment from countries which were also suffering from severe shortage of skilled health professionals. In response to criticisms of “poaching” talents from former colonies, the UK-DOH issued official guidelines in as early as 1999 that said that NHS should stop recruiting nurses from South Africa and West Indies [Buchan 2002: 2].

Unlike the governments of many African countries that expressed their criticisms and reservations on the UK recruitment of their health professionals, the Philippine government encouraged its nurses to go to UK. The UK-DOH document on official guidance on international recruitment of nurses reads that: “There are also countries . . . such as the Philippines, where nursing surpluses exist and where the national Government **actively support** recruitment by NHS employers” [UK-DOH 1999: 12; emphasis added by authors]. Thus, the UK government singled out the Philippines as an exception, which meant that the NHS hospitals were allowed to conduct large scale recruitment of nurses from the Philippines.

The UK policy of emphasizing “ethical” international recruitment of health professionals was developed into the Code of Practice in 2001. It prohibited NHS hospitals from active recruitment of health professionals from developing countries, unless the government of the said country agreed to it. The UK government made a list of countries from which the NHS should not recruit health workers. The Code was expanded in 2004 to cover recruitment agencies, non-permanent staff working in the NHS and private sector organizations that provided services to the NHS [UK-DOH 2004]. A similar code of practice on ethical recruitment was introduced among Commonwealth countries in 2003 [Commonwealth 2003]. Apparently, however, the process of drafting the Commonwealth Code among member states was highly contentious. In particular the issue of compensation from host countries to source countries often became the center of debate. Some source countries vehemently demanded compensation for the loss of their human resources for health, but the host countries refused, saying that it is not easy to calculate its monetary value. Also health workers sometimes migrate from one country to another, and again to another country. This raised the issue of which country - the intermediate or the final one - should pay the compensation [Interview with Vidot 2008].

There were several loopholes in these different Codes of Practices. For instance, the Code of Practice of UK-DOH did not prohibit passive recruitment or direct job application from foreign

health workers from the countries on the list. Moreover, the Code was more like a gentlemen's agreement and there was no penalty to the hospitals and nursing homes or recruiters that did not comply with the Code. As a result, these regulations on international recruitment of health workers did not completely stop migration of nurses from developing countries on the list to UK. The failure of these Codes should perhaps be understood to suggest that no stakeholder was really interested in halting the international flow of health workers. Nurses in source countries were looking for greener pastures, and even most of their governments that were critical about losing them to other countries knew that they could not stop voluntary migration, and thus instead they wanted to be compensated.

It should also be noted that other important elements of the UK government's guideline and the Codes of Practices on international recruitment were to protect migrants from exploitation by recruitment agencies as well as to ensure that migrant workers receive the same benefits as the domestic employees. Thus, the UK Code of Practice explicitly states that apart from basic expenses of obtaining passport and necessary visa to work in UK, a recruitment agency should not charge any fees from applicants seeking employment within UK; the cost of airfare to UK for a successfully recruited person should be borne by an employer; and the pay and conditions of newly recruited foreign workers should be consistent with those who were trained in UK [UK-DOH 1999: 23; UK-DOH 2004: 16]. However, the UK government's guideline could not really regulate practices of recruitment agencies in source countries and some nurse migrants continued to be exploited as one of our respondents illustrated to us (see below).

Another UK policy of regulating international recruitment of nurses was the formulation of bilateral agreements in order to turn nurse migration into mutually beneficial scheme for both sending and receiving countries. From late 1990s to early 2000s, the UK government signed bilateral agreements with several countries including the Philippines (2002), South Africa (2003) and India. Although these bilateral agreements were essentially "statements of principles and of broad objectives" rather than specifications of "the number of nurses or other health professionals that can be recruited", the content of bilateral agreements was different from one country to another [Buchan 2008: 46; Cornell 2008: 16].

For instance, the bilateral agreement between the UK government and South African government had a strong orientation for exchange of human resources for health for education purposes between these two countries. The agreement allowed South African health workers to work in the NHS hospitals for a certain period of time in order to gain professional training and skills and then return to the previous post in public hospital in South Africa without causing any disruption in their career path. The agreement also introduced a way for British health workers to work in South African public hospitals [Cornell 2008: 16]. According to South African Department of Health (SA-DOH), the bilateral agreement with the UK government had a positive impact of encouraging South African nurses in UK to go back home [SA-DOH: 2006].

In contrast, the main point of the bilateral agreement between the UK government and the

Philippine government was to ensure the continuation of recruitment of Filipino nurses to the NHS hospitals [Buchan, Baldwin and Munro 2008: 47]. However, the number of Filipino nurses who were newly recruited to the NHS hospitals began to decline in the same year when these countries signed the bilateral agreement. This suggests that the bilateral agreement between the Philippines and UK did not serve its purpose. Apparently UK unilaterally stopped recruiting nurses from the Philippines to the latter's surprise. Two countries exchanged another Memorandum of Agreement in 2004 which had more focus on educational exchange, but it was never implemented [Carlos, Sato and Caragay eds. 2009: 77-81]. In the next section, we turn to examine the migration trends of Filipino nurses in UK.

2. Filipino Nurses in UK

In the previous section, it was stated that the entry of Filipino nurses into the UK labor market from the late 1990s was caused by the UK government's policy of actively recruiting foreign nurses in order to quickly address the problem of domestic shortage of nurses. It was also stated that unlike other developing countries in Africa and Caribbean, the Philippine government was keen to send its nurses to UK. In this section, we examine the trends of Filipino nurse migration to UK since late 1990s.

Table 4: Top Five Nurse Sending Countries to UK (excluding EEA/EU)

YEAR	1 st	2 nd	3 rd	4 th	5 th	Total number and share of top 5 countries*
1998/99	Australia (1,335)	South Africa (599)	New Zealand (527)	West Indies (221)	Canada (196)	2,878 (81%)
1999/00	South Africa (1,460)	Australia (1,209)	Philippines (1,052)	New Zealand (461)	West Indies (425)	4,607 (77%)
2000/01	Philippines (3,396)	South Africa (1,086)	Australia (1,046)	New Zealand (393)	Zimbabwe (382)	6,303 (75%)
2001/02	Philippines (7,235)	South Africa (2,114)	Australia (1,342)	India (994)	Zimbabwe (473)	12,158 (81%)
2002/03	Philippines (5,593)	India (1,830)	South Africa (1,368)	Australia (920)	Nigeria (509)	10,220 (80%)
2003/04	Philippines (4,338)	India (3,073)	South Africa (1,689)	Australia (1,326)	Nigeria (511)	10,937 (77%)
2004/05	India (3,690)	Philippines (2,521)	Australia (981)	South Africa (933)	Nigeria (466)	8,591 (75%)
2005/06	India (3,551)	Philippines (1,541)	Australia (751)	Nigeria (381)	South Africa (378)	6,602 (76%)
2006/07	India (2,436)	Philippines (673)	Australia (299)	Nigeria (258)	Pakistan (154)	3,820 (79%)
2007/08	India (1,020)	Australia (262)	Philippines (249)	Nigeria (154)	Nepal (117)	1,802 (78%)

*Total number of nurses from top five countries/total number of overseas-trained nurses (excluding EEA/EU).

Source: UKNMC [various years].

Table 4 lists the top five countries, excluding UK and EEA/EU, from which newly-registered nurses at the UKNMC came from 1998 to 2007. We can make a few observations from this table.

First, the share of the top five countries among non-EEA/EU countries that sent nurses to UK during this period was consistently high. It always exceeded 75%, which suggests that a few countries dominated the supply market of nurses to UK. Second, the major sending countries to UK during this period were rather consistent, with Australia, South Africa, the Philippines, and India appearing recurrently. Third, it is noticeable that while the Philippines was the largest sending country from 2000 to 2003, it was replaced by India from 2004 onwards. Fourth, the Philippines was the only country during this period which managed to send more than 4,000 nurses in a single year, with the highest figure of over 7,200 in 2001. No country managed to send as high number of nurses to UK as the Philippines did in a single year.

However, migration of Filipino nurses to UK during this period was not a stable, long-lasting phenomenon. Table 5 shows that the number of Filipino nurses who started working in UK dramatically increased from 52 in 1998 to 7,235 in 2001 and then declined. In particular, the number of Filipino newly-registered nurses decreased to less than 1,000 in 2006 and 2007.

Table 5: Filipino Nurses in the UK Nursing Registry (New Registrants Only)

YEAR	Filipino (A)	Overseas total (B)*	A/B (%)
1998/99	52	3,568	1
1999/00	1,052	5,967	18
2000/01	3,396	8,414	40
2001/02	7,235	15,064	48
2002/03	5,593	12,757	44
2003/04	4,338	14,122	31
2004/05	2,521	11,477	22
2005/06	1,541	8,709	18
2006/07	673	4,830	14
2007/08	249	2,309	11

*Excluding EEA/EU.

Source: UKNMC [various years].

The declining number of newly-registered nurses was not a phenomenon specific to the Philippines, as it also applied to the total number of foreign newly-registered nurses as well as to other major source countries as shown in Table 4. Still, if we look at the proportion of Filipino nurses among foreign newly-registered nurses in UK, we cannot help but notice that the share of Filipino nurses declined considerably from 2004. While the share of Filipino nurses among foreign newly-registered nurses in UK in 2001 was 48%, it decreased to 22% in 2004, 14% in 2006 and 11% in 2007. We do not know why the share of Filipino nurses declined so dramatically. As we saw in Table 4, India replaced the Philippines as a top source country in 2004. Nevertheless, in terms of absolute number, the registration of Indian nurses has also shown a decreasing trend since then.

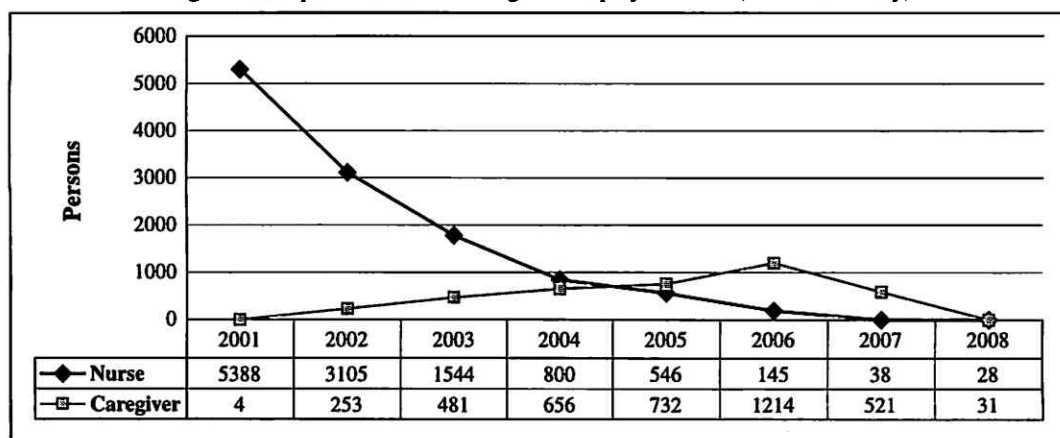
What is known is that the active recruitment policy of foreign nurses for NHS hospitals began to be reversed sometime in 2005, when some NHS hospitals reported financial problems due to over-expansion of its workforce. Buchan, Baldwin and Munro [2008: 24] cite a result of survey of 4,000 nurse managers, conducted for the Royal College of Nursing (RCN) in March 2006 that

45% of hospital-based managers reported reduction in nursing posts at their workplace by recruitment freeze and/or posts cut, in the last 12 months. The Health Committee of the UK government also concluded that the growth in staff numbers at NHS hospitals suddenly came to an end in 2005 and that “[t]he downturn in workforce expansion has created pressure to protect job opportunities for UK-trained staff” [quoted in Buchan, Baldwin and Munro 2008: 49]. In July 2006, it was announced that the number of general nurses is no longer in shortage in UK and therefore it was removed from the skills shortage list. This means that healthcare employers have to prove that no suitable person in UK and EEA/EU is found for the post in order to get a work permit for a general nurse from countries outside EEA/EU.

The rapid decline in the number of newly-registered Filipino nurses in UK certainly reflected changes in the UK policy towards international recruitment of nurses. Since the Philippines was not targeted by the UK policy of restricting aggressive recruitment of nurses from developing countries, we cannot establish whether the Code of Practice on international recruitment had any impact on the trend of migration of Filipino nurses to UK. It is also not easy to discern the policy impact of the bilateral agreement between UK and the Philippines, as the number of Filipino newly-registered nurses at the UKNMC began to decline in the same year when the agreement was signed.

However, there is an opinion that the demand for care workers, if not for nurses, in UK is still high and will increase with the further population aging of the UK society. The question is what kind of labor is needed in the UK health and care sector in the coming years. Unlike nurses, there is no single authority which records the number of care workers in UK and thus there is no available statistics to measure the number of foreign care workers in UK. Still Figure 2 suggests that while the number of Filipino nurses deployed to UK decreased since 2001, the number of Filipino caregivers² deployed to UK steadily increased during the same period, at least until 2006. We do not know how many of the Filipino caregivers who went to UK were in fact licensed as a nurse in the Philippines³. If UK is no longer accepting foreign nurses, but still needs care workers to look after its elderly population, Filipino nurses might choose to work as care workers in nursing homes in UK rather than stay in the Philippines without a job. In fact, during our fieldwork in UK in July 2008, we encountered such Filipino nurses in London who went to UK on student visa and worked in nursing homes as care workers (people like her are not counted in Figure 2, as they went to UK as students).

Figure 2: Filipino Nurses and Caregivers Deployed to UK (New Hires Only)



Source: POEA [2008: Tables 23, 25].

Note: UKNMC Register declares much higher number than POEA statistics on deployment of Filipino nurses to UK. This confirms that POEA figures are highly under-counted.

Whether to recruit and how to recruit foreign nurses in order to meet staffing expansion is only one dimension of understanding the international migration of nurses. Another important dimension we need to look into is the question of retaining foreign-recruited nurses. In fact, from the early stage of expanding NHS workforce through international recruitment, the UK health sector recognized the issue of how to “retain” foreign-recruited nurses as a policy challenge. A survey conducted by Buchan, Jobanputra, Gough and Hutt [2005: 15] of 380 internationally-trained nurses working in London for more than two years aimed at finding their general circumstances. One of the major points they discovered was that “43% of respondents reported they were considering a move” from their current workplace. What is most interesting and relevant to our study from this survey was that Filipino nurses scored highest (63%) among foreign nurses who were considering a move from their current workplace, and “nearly all the Filipino nurses who were thinking of moving reported that they were considering moving to the USA”.

Now our question arises. What do Filipino nurses currently working at UK hospitals plan to do in the face of the current UK immigration and human resources for health policy environment that has become more and more restrictive? If Filipino nurses are highly mobile, will they stay or go to another destination? What are the factors that influence their decision to stay or leave UK? Do they consider UK as a final destination or merely a transit point in their multi-step migration process? These are some of the questions we are going to explore through looking at Filipino nurses working in London and Birmingham.

3. The Motivations to Migrate to UK

Conventional economic theory tells us that given the freedom to choose among destinations, an expected utility-maximizing potential migrant worker will want to go to the country which gives the highest expected utility based on several factors such as expected income, living and

working conditions including opportunity for career mobility, and availability of social network, and taking into account the pecuniary and non-pecuniary costs arising from migration. Roy [1951] and Harris and Todaro [1969] argued that the main cause of migration is economic - migrants move because of difference in income (or its expected value) between the country of origin and the destination.

In previous studies specific to foreign migrant nurses, it was found out that low pay, poor working conditions, lack of resources in the workplace and limited career opportunities in the country of origin were potential push factors why nurses left to work abroad [Denton 2006]. In the case of foreign nurses in UK, financial enhancement and career mobility were presented as the two leading motivations [Buchan, Jobanputra, Gough and Hutt 2005; RCN 2002; Withers and Snowball 2003]. Larsen et al. [2005: 352] also emphasized that migrant nurses possess cultural migratory capital which includes “the emigrants’ familiarity with life in the destination country, language competence, family bonds in the destination country and a long-standing tradition among their countrymen of migration”.

In this paper, we found out that having previous migration experience or not influences the motivation to migrate to UK. To highlight this point, we divided the respondents into two groups based on their work experiences prior to migration to UK (see Table 6). Eight of those interviewed came directly from the Philippines, while four had previously worked in other countries, mostly in the Middle East. It must be noted that although these migrants had returned to the Philippines in between their jobs in different destinations, it was brief (less than one year) and the purpose was not to work but “to take a holiday” [Respondent G] or “expiration of employment contract” [Respondent H], both with the intention of returning overseas to work.

Table 6: Year of Arrival in UK and Work Experience Prior to Migration of Respondents

Respondent	Year of Arrival in UK	Work Experience Prior to Migration	
		Number of Years	Previous Place of Work
A	2005	8 years	Philippines
B	2000	3 years	Philippines
C	2005	2 years	Philippines
D	2005	5 years	Philippines
E	2000	2 years	Philippines
F	2000	5 years	Philippines
G	2000	2 years 5 years 1 years 8 years	Philippines Dubai, UAE Saudi Arabia Malaysia
H	2001	2 years	Saudi Arabia
I	2001	Not mentioned	Philippines
J	2001	7 years	Saudi Arabia
K	2003	Not mentioned	Abu Dhabi, UAE
L	2005	6 years	Philippines

Source: Authors' fieldwork.

3. 1 UK as the Destination for First-Time Migrants

Five of the eight first-time migrant respondents admitted that the main reason on why they wanted to work overseas was economic - “to search for greener pastures,” “for financial rewards,” and “to uplift financial status” [Respondents D, E, F, I and L], highlighting the economic plight of nurses in the Philippines. In this country, professional (licensed) nurses’ starting salary is about US\$200 per month in a government hospital and even less in many private hospitals, and graduates find hard to land a nursing job within the country. Therefore, it is easy to understand that almost any industrialized country, which pays much more than this amount⁴ and has relatively high demand for nursing services, can be a potential destination for Filipino nurses.

It is also noteworthy to mention that based on the interviews, the financial enhancement motivation did not mean economic security only for themselves but also for their families “back home.” Nurses are known to be loyal remitters. Eight out of the 12 respondents send remittances to the Philippines to pay for the daily expenses of their (usually extended) families and for the education of children and siblings. This finding is congruent with previous ones, like for example, Larsen [2005: 357], who argued that “financial ambitions were part of a general family strategy of financial survival and progression.”

Although career growth is often cited in the literature as another important motivation for moving to UK, this was enumerated only by respondent C. One of the probable reasons is based on their perception of being able to achieve career growth even in the Philippines. Most of our respondents had worked for reputable tertiary hospitals in the Philippines and held senior positions before they left the country. Also, career mobility in UK, in terms of skills acquisition, remains an issue for Filipino migrant nurses, as the president of the Philippine Nurses Association - UK commented that “there is deskilling of our nurses in this country (UK)” [Interview with Duque 2008].

In deciding to which country and when to go, the immigration and health (particularly the human resources for health) policies of the destination emerged as very important factors. These policies can ease or tighten the migration pathway and change unpredictably without prior consultation with the stakeholders, including the sending country’s government. For example, while US is the most popular destination targeted by nursing students [Carlos, Sato and Caragay 2009: 33] and nurses [*Inquirer*, 1 September 2008], it is also the most difficult destination to reach due to its unpredictable and restrictive immigration policy and numerous requirements for foreign nurses to be able to practice in the country. Respondents B and E who have already lodged their application to US under the immigrant-based petition system have been waiting for their visas for more than a year now. Such long wait can be attributed to the US’ immigration policy of setting a quota for the number of working visas that will be issued in a given period of time. The time of announcement of the quota is often unknown and unpredictable, and because of the large number of applications, the waiting time for processing and granting of visas can take years.

Due to the difficulty of going to US directly, Filipino nurses choose to go to other countries

that will accept them at the time when they decide to migrate; they make “stops” along the path to the final destination. Two first-time migrant respondents in our sample [Respondents C and F] mentioned that they originally wanted to go to US but the job offer in UK came first so they “grabbed the opportunity”. Respondent A noted that “once the decision to move was made, I wanted to leave as soon as possible, and fortunately, UK was open at that time (2005).” Apparently, with UK’s active recruitment policy at that time, going to this country was easier and faster than to US. “In US, we needed (to pass) the NCLEX (nursing licensure exam in US), while in UK it was not necessary. (At that time, it was) easier to go to UK rather than US. Some nurses are here in UK to wait for the result of application in US” [Respondent E]. It is also worth noting that UK at that time was perceived as the “best” option among the countries that were actively recruiting nurses like Singapore and the Middle East. “(At that time) it was the country that accepted (Filipino) nurses. US was closed, the Middle Eastern (countries) did not have a good reputation” [Respondent B].

The “easy” migration of foreign nurses to UK circa 2000 was facilitated by a well-organized recruitment system involving the local recruitment agency registered with POEA, the counterpart recruitment agency in UK and the employer, usually an NHS Trust or a private nursing institution. The following is a typical process for recruitment and deployment to UK in circa 2000 as narrated by Respondents B, E, F and G who came in the same group or “batch”. The initial screening of applicants was done by the local recruitment agency by administering scholastic aptitude and psychological examinations. The names of those who passed the initial screening were forwarded to the prospective employer through the recruitment agency counterpart in UK, who came to the Philippines to interview the prospective nurse applicants and administer its own aptitude examination. The applicants were informed of the result within a few days, after which the employer applied for a work permit in UK. Upon approval, the nurses were sent the air ticket and documents for presentation at the UK port of entry. The entire process took about three months.

While the procedure was essentially the same for all first-time migrant respondents, coming to UK in later years was more difficult. Many NHS hospitals stopped recruiting nurses directly from overseas as part of their staffing reforms. In fact, the respondents who arrived in Birmingham in 2005 described themselves as the last batch of Filipinos recruited by their NHS Trust. Those who came later paid more for recruitment and took longer time to be deployed. While those in the earlier batch (2000) paid only about 15,000 pesos (about 200 British pounds as of December 31, 2000) to the local recruiter and were able to leave the Philippines in less than three months, those who came in 2005 had to pay at least twice as much, with one respondent ending up paying 380,000 pesos (about 4,159 British pounds as of December 31, 2005) on the promise that this would also cover the tuition fees for the Overseas Nurses Program (ONP). The longer waiting time of at least six months up to two years for those who came in 2005 was partly due to the need to study and take the IELTS.

In summary, our findings that the primary motivation for Filipino nurses to leave the

Philippines and work overseas is economic, that is, for financial upliftment for them and for their families back home, is congruent with other previous studies. In addition to this, we must also emphasize that for the first-time migrant nurse respondents, UK's policy on human resources for health, through its effects on the ease of migration to this country, was a very strong deciding factor **to choose this country** as their destination. UK's active foreign nurse recruitment policy provided the "opportunity" that the Filipino nurses thought was the best one at the time of migration.

3. 2 Filipino Nurses Coming to UK from Other Destinations

Of the 12 respondents, four had previous experiences working outside the Philippines before coming to UK - three in Saudi Arabia (one of them also worked in UAE as well as Singapore and Malaysia) and one in the UAE. We term these countries as "transit points" or "stops" along the migration pathway⁵. This implies that the nurse migrant reviews/reassesses his choice of destination from time to time, making him decide periodically on whether to stay or leave the current destination and move to the next one. The latter gives rise to multi-step migration path or process in which a migrant moves from the origin to country "A" to country "B" to country "C," and so on, until he reaches the final destination, which can be another country or the origin.

Respondent G's migration history helps us understand a Filipino nurse's decision on the choice of destination through time. After getting a nursing license and working in a Philippine hospital for two and half years, she migrated to Dubai to work in a government hospital as a staff nurse at a neonatal ICU for three and half years (1986-1990). After finishing her second contract, she spent a few months in the Philippines for "vacation" before moving to Saudi Arabia in October 1990. However, she did not like working in Saudi Arabia because of its strict rules and regulations towards foreigners and women, so she resigned and went to Malaysia, again, via Manila. While working in a pediatric hospital ward in Malaysia, she learned about the job opening in UK in 1998 and applied for a UK nursing registration from there. Since 2000, she has been working in the same hospital in Birmingham as a neonatal specialty nurse. Although she returned to the Philippines in between each assignment/destination, her purpose was not to work but to take a holiday, with a plan to go to the next destination country.

To analyze the process of multi-step migration, the crucial questions are: (1) how do migrant nurses choose the transit and final destinations and sequence them along the migration path; and (2) how do policies on migration and human resources for health of the destinations affect the migrant's decision.

Based on the interviews, while for first-time migrant respondents, good compensation and "grabbing the opportunity" to migrate played the leading roles in choosing UK, the decision making process becomes more complicated for those who came via a third country, as now they compare not only the conditions in UK with that of the Philippines, but also vis-à-vis their other previous destination(s). Three out of four respondents who came via a third country gave "better working and living conditions in UK compared to the previous destination" and "new challenge" as

reasons for moving to UK.

Apparently, the Middle Eastern countries have long been a leading destination for Filipino nurses, especially for those who are migrating for the first time. This is the result of these countries' (particularly Saudi Arabia, UAE and Kuwait) active recruitment policy and the Philippine government's institutionalized recruitment and deployment to these countries since the 1980s. Moreover, the basic requirements to practice nursing in these countries are easy to comply with.

However, although they are highly accessible as destination countries, the nurses are considered as "guest workers" whose employment contracts run for 2-3 years renewable subject to the "recommendation" of the employer. The nurses have to leave the country if they fail to renew their employment contract. No matter how long they have been living in the Middle East destination, they are granted neither permanent residency nor citizenship. Several factors enumerated by the respondents as reasons for leaving Saudi Arabia were: (1) its strict rules for women, based on Islamic law and traditions, (2) salary as low as US\$300 a month, and (3) discrimination against Asians, vis-à-vis local and Western nurses, in the form of slow career mobility and low salary for the same job. UAE seems to be preferred over Saudi Arabia as the former has "less" stringent rules especially towards foreign workers, particularly women [Respondent G].

Singapore was also mentioned as one of the potential transit points by the respondents. This country has been actively recruiting nurses from the Philippines since 1990s. Since the nursing profession is included in its Strategic Skills List, a foreign nurse registered in the Singapore Nurses Association (SNA) is granted an "S" pass, entitling him to earn a fixed monthly salary of at least S\$1,800 (about US\$1,270 or 114,000 yen as of September 30, 2009). This country is a popular destination among Filipino nurses because of its geographical proximity and similarities with the Philippines in terms of weather, food and culture. Moreover, SNA, in collaboration with potential hospital and nursing institution employers, administers the Singapore Nursing Licensure Examination in the Philippines, thus making the examination and the license more accessible to Filipinos. Those who pass this examination are allowed to work as staff nurses right away⁶. Otherwise, they come as enrolled nurses or health care attendants first and later take the licensure examination after working for a few months to a few years, but only upon the recommendation of the employer. The possession of a license to practice in Singapore entitles the Filipino nurse to apply for a permanent residency and obtain almost the same benefits and career opportunities as those of Singaporean nurses. Nevertheless, many Filipino nurses in Singapore choose to leave this country to work in another foreign country like Canada and UK [Interview with Ong 2008 and Chua 2008].

Based on our interviews, the previous destinations can very well serve as a "transit point" or a "stepping stone" in the migrant nurses' migration pathway where they can accumulate human, social, and financial capital/resources. First, the previous destination allows the migrant to accumulate human capital in the form of license to practice and working experience that are preferred than those obtained in the Philippines. Respondent G said that her highly-specialized work as a

neonatal ICU staff nurse in Dubai and Malaysia was highly regarded by her current UK employer⁷. Employers and international recruiters also prefer to recommend those who have work experience in other countries, not only because they are already trained in an international workplace and standards, but also they feel less homesick [Interview with Duque 2008]. This explains why sometimes recruiters for placement in UK will prefer to conduct interviews and recruit Filipino nurses already working in Singapore rather than in the Philippines [Interview with Ong 2008]. In this sense, previous destinations function as a “filter” that screens Filipino nurses for deployment to UK.

Social capital can also be enhanced in the transit destination countries, especially in the more popular destinations for Filipino nurses, such as Singapore, Saudi Arabia and UAE. Their interaction with fellow Filipino nurses in these countries enables them to create a transnational network connecting several potential destinations. Respondents G and K obtained information about life and work in UK from colleagues who previously moved to UK. Spread by “word of mouth” about job openings in UK and job introductions among nurses were two reasons why many Filipino nurses in the Middle East “joined the bandwagon” (went to UK) in circa 2000 [Interview with Duque 2008]. Better internet infrastructure in the previous destination since early 2000 (compared to the Philippines in the same period) also assisted potential migrants in accessing information, processing their applications and even in undertaking interviews with employers in UK.

While theoretically, the relatively high salary obtained from previous destination compared to that in the Philippines improves the financial capability of the migrant, thus enabling him to pay for the recruitment and settlement cost for deployment to the next destination, this was not detected in the interview with the respondents. This is probably because, especially in the early 2000s, the recruitment costs to UK were not expensive and housing and settlement loans were usually provided by employers upon arrival in UK.

From the above, we can say that indeed, migrant nurses can have different motivations in coming to UK depending on their previous migration experience. For those nurses who had experience working only in the Philippines prior to coming to UK, the financial (economic) motivation as well as the “ease” in migration to this country as a result of its active recruitment policy were the main factors in choosing this country. On the other hand, for those who had work experiences in another destinations, factors in addition to those mentioned by the first-time migrants were also given, such as better working and living conditions in UK and improved chances of coming to UK from the third country, as working in these third countries allowed them to accumulate human, social and financial assets that were advantageous in finding a job in UK.

4. Is UK a Gateway or a Final Destination?

We have seen in section 3 that for some of the respondents, the previous destinations such as the Middle Eastern countries and Singapore served as “stepping stone” to migrate to UK. In this section, we ask: how do Filipino nurse migrants see UK - is it a transit point/stop or a final desti-

nation? What are the factors that encourage them to stay in UK or move to the next destination?

Given the higher salary compared to those in other potential transit destinations such as Singapore and the Middle Eastern countries, UK is a good candidate for a final destination. Our interviews, however, revealed that this is not the case. Of the 12 respondents, seven are already planning and/or preparing to move to another country while five claimed that currently, they have no definite plans yet of leaving UK (see Table 7). However, among the many “transit points/stops”, the UK stands out because working in this country for a certain period of time (at least five years under the current immigration law) allows them to obtain citizenship that gives more options (doors) as to destinations and better treatment, this time not as a Filipino citizen but as a British citizen. Therefore, we want to emphasize that the term “gateway,” rather than merely “transit point” is more appropriate to use in the case of UK.

Table 7: Current Immigration Status and Future Migration Plans of Filipino Nurses Interviewed

Respondent	Year of Arrival	Current Immigration Status in UK	Future Plans
A	2005	Limited leave to remain	No definite plan yet
B	2000	Indefinite leave to remain	Migrate to US
C	2005	Limited leave to remain	No definite plan yet
D	2005	Limited leave to remain	No definite plan yet
E	2000	Indefinite leave to remain	Migrate to US
F	2000	UK naturalized citizen	Migrate to Australia
G	2000	UK naturalized citizen	Migrate to Dubai, UAE
H	2001	UK naturalized citizen	Migrate to Australia
I	2001	UK naturalized citizen	Migrate to Australia
J	2001	UK naturalized citizen	Migrate to Canada
K	2003	Limited leave to remain	No definite plan yet
L	2005	Limited leave to remain	No definite plan yet

Source: Authors' fieldwork.

Like other transit destinations, working in UK allows the Filipino nurse to gain (1) better access to information about UK and other alternative destinations and (2) human, social and financial capital that can be used to move to the next destination. In terms of accumulating human capital, the UKNMC registration and work experiences at UK hospitals are recognized in other countries, particularly the members of the Commonwealth such as Australia and New Zealand. Two of the respondents (F and I) are planning to go to Australia because “there is no need to take an adaptation course or licensure exam as the UK registration is accepted in these countries.” Moreover, their work experience in UK is also an advantage as “the (Australian) employer knows that the nurse is familiar with the procedures,” (Respondent I) owing to the similarities in these countries' nursing standards. As a result, in recent years, nurses of other nationalities working in UK also aspire to work in Australia and New Zealand as well as in US [Buchan, Jobanputra, Gough and Hutt 2005].

Respondents F and I also noted that although the salary can be lower in Australia than that in

UK, they wanted to move to Australia because of its cheaper cost of living and better work-life balance (in terms of more relaxed environment, fewer working hours and feasible work schedule, good environment for raising kids, free schooling and other social welfare benefits for the family). This trend suggests that migrants' priorities - from getting higher salary to better quality of life and social welfare benefits for him and his family, can change overtime depending on his life course. That migrants, especially when choosing among advanced industrial economies, also consider welfare benefits and political rights was emphasized by Borjas [1999] in his welfare magnet hypothesis. According to him, "migrants, once they have made the decision to leave home, will seek out destinations that offer them the heftiest bundle of social services" [quoted in Leblang et al. 2006: 13]. The migrant's life course and differences in welfare benefits among destinations as decisive factors in his multi-step migration process, however, needs to be looked more closely in future studies.

Given the relatively high salary in UK, working in this country also allows the migrant to accumulate financial capital to pay for migration to the next destination. The nurses are able to save part of their salary in UK to pay for the cost of moving to the next destination. In the case of migration to US, the costs include reviewing and taking the necessary examinations like NCLEX and TOEFL [Respondent E], payment to the recruiter for those who are not direct hires, and actual cost of resettlement. Evidently, these nurses will find it much more difficult to raise such amount if they are in the Philippines or even in other destination countries, in which cases they will need to loan from the recruiter or foreign employer.

Another significant reason given by the respondents on why they want to move from UK was this country's recent reforms in its health-related policies, particularly that concerning human resources for health. Respondents B and E noted that the NHS Trust hospital where they work is currently understaffed because of the NHS "redundancy program" that includes a freeze on hiring and lay-off, resulting in increased patient-nurse ratio and thus more and harder work (and stress) to the nurses. This situation caused staff resignations and therefore much harder work for those who were retained or chose to remain. This program also creates job insecurity and apprehension to the Filipino respondents, inducing them to plan about moving to the next destination [Respondent F]. Here we emphasize the burden caused by the changing human resources for health policies of the destination country as a major factor that affects the nurse migrant's decision to move or stay in one destination.

An important finding from this study relates to the crucial roles that "length of stay" and "naturalization (obtaining citizenship)" play in the decision of the migrant whether to stay or leave the current destination. This study shows that we cannot automatically assume that the longer the migrant stays in one destination, the stronger the tendency to stay. Neither do we see among our respondents that becoming a UK citizen can substantially keep them from planning to work in another country.

In exploring the reasons why those who have worked in UK for a longer period of time

choose to leave this country, we cannot discount the fact that staying in the same country for a relatively longer period of time can make the migrant feel “bored,” thus inducing him to seek adventures and new challenges in another country, as pointed out by Respondent G. On the other hand, Respondents C and D who arrived in 2005 do not have plans of moving to another destination yet since they are “still happy and enjoying life in UK.”

The length of stay indirectly affects the migrant’s decision to leave or stay in UK through its connection with the naturalization policy of this country. From Table 7, we can see that there is a correlation between the time of arrival in UK (and thus the length of stay in this country), the migration status, and the desire to move to another country. Only those who have worked in UK for at least five years are entitled to apply for an indefinite leave to remain (permanent residency visa). Thus those who arrived from 2003 cannot apply for British citizenship yet at the time when this study was held. What is striking about the migration plan of the respondents is that those who have lived for more than five years and have already secured the right to stay and work in UK, whether as permanent residents or UK citizens, have plans of moving to the next destination, while those who are still on limited leave to remain (working) visa have no definite plan of migrating yet. Obtaining UK citizenship, instead of making them stay in UK, has influenced their decision to plan to work somewhere else, thus making this country one of the preferred “transit points” or “gateway”. Respondents F, G, H and I mentioned that obtaining British citizenship is “meritorious” and “convenient,” and the UK passport is an “asset” that provides them with “security” in UK and in the next destination in the following ways: As UK citizens,

- (1) While in UK, they will enjoy the same rights and privileges as UK nationals, such as being able to avail of social security benefits (education and allowance for children, free health consultations, retirement pensions, unemployment benefits, etc) and travel to almost any country without a visa - things that they will not be able to enjoy as a Filipino national.
- (2) Even if they leave UK, they have an option to return to UK anytime as a national and easily find work in this country. This “job security” in UK is important especially when they are not successful in the next destination.
- (3) In the next destination, they will enjoy the same rights and privileges as UK migrant workers. It must be noted that in many destinations such as Middle Eastern countries, holders of UK passport get better treatment in terms of salary and benefits, and less discrimination compared to holders of a Philippine passport. Respondent G mentioned that now that she is already a UK citizen, she wants to go back and work in Dubai because as such, she will get higher salary and higher position than the Filipino nurses there.

From the above, we can say that for the Filipino nurse migrant respondents, UK is seen more as a “gateway” rather than as a “final destination.” This is not only because in UK, they can accu-

multate human and financial capital, but also because by working in UK for more than five years and eventually gaining the UK citizenship, they can have better opportunities in other countries, this time as UK citizens.

Conclusion

This paper attempted to investigate the migration behavior of Filipino nurses in UK, with particular focus on the interaction between the decision-making of Filipino nurses and the policies of the UK government. Specifically, we tried to find out how the policy of the destination country influences the decision of the nurse to choose which country to migrate, and whether and for how long a migrant will stay in the chosen destination in the multi-step migration process.

The UK labor market opened to Filipino nurses in late 1990s. Although the Philippine did not have special ties with UK, it had a long history of sending nurses to other countries such as US and the Middle Eastern countries and it had a well-established migration industry. Moreover, unlike some African countries that criticized the UK government for its large-scale recruitment of foreign health professionals, the Philippine government was in favor of sending its nurses overseas. From 1998, the number of Filipino nurses working at UK hospitals increased dramatically, and in ten years, more than 26,000 Filipino nurses joined the UK labor market. Nonetheless, UK did not become a stable labor market for Filipino nurses. When UK began producing considerable number of its own nurses and the NHS hospitals began to feel the heavy financial implications of the over-expansion of the health workforce, the room for foreign nurses to join the UK labor market rapidly shrank.

What were the responses of Filipino nurses to this unpredictable and rapid contraction of the UK labor market? In our interviews with 12 Filipino nurses in London and Birmingham, we found out that economic/financial needs for them and their families back home were the main motivations for them to leave the Philippines. Especially for those whose first overseas destination was UK, the active recruitment for international nurses, brought about by the NHS Trusts' policy on human resources for health at the time of migration, emerged as a crucial pull factor in their choice of this country. On the other hand, the Filipino nurses who came from third countries like Saudi Arabia, Malaysia and UAE also emphasized the better working and living conditions in UK compared to these previous destinations, as a motivating factor to move to UK. Moreover, it was also found out that many of the respondents, especially those who have already gained the right to live in UK through naturalization or permanent residency permit, are already planning to migrate to another country. The better treatment that they expect to get in other destination countries as UK citizens as well as the recent reforms in the UK-NHS policy towards human resources for health have significantly contributed in their decision to leave UK to work in another country.

From these observations, we can say that indeed, the multi-step pattern of migration takes place among Filipino nurses. The "transit points" provide them with financial, human and social capital as well as easy access to more accurate information about the destinations. Based on

newly-acquired capital and information, the migrant nurses make decisions from time to time on whether to stay indefinitely in one destination, stay while waiting for the opportunity to go to the final target destination, or move to the next “transit” destination. Such behavior continues until they have reached the final destination, or perhaps until their retirement age.

Why is UK seen more as a “transit point” rather than a “final destination”? Similar to other transit countries, by working in UK, the nurse migrants can obtain financial, human and social capital and more accurate information about conditions in the destinations. More importantly, in UK, they can obtain permanent residency status and/or citizenship after five years of working and living in this country continuously. What was interesting and a bit ironical to us is that Filipino nurse migrants do not consider securing residency status in UK as a mere ticket to live in this country. For them, it has more value than that and rather contributes to their decision to leave UK and work in the next destination. In this sense, even among the transit points, the UK stands out as an important “gateway” because working in UK not only opens doors to more destinations but also, as UK citizens, they know they will get better treatment in terms of higher salary and career development in their new destination as well as “security” or “assurance” that they can always go back and work in UK.

Notes

- 1) Both status entitle the Filipino nurse to stay in UK regardless of whether he has an employer or not. The two holders of “indefinite leave to remain” visa, who are already qualified to apply for citizenship based on their number of years of stay in the country, did not mention the reason why they opted for this status. In this paper, since we focus on their status as workers and the timing of their arrival, we choose to include them in the first group rather than the second.
- 2) We use the term care worker as someone whose work is to take care of the elderly, either in the nursing institutions or home settings in UK. In the Philippines, these workers are commonly known as “caregivers”.
- 3) The Philippine Embassy in London estimated that by mid-2000s there were about 50,000 Filipino nurses in UK. Since only about half of this number (26,000) was registered with UKNMC by 2007, we can estimate that at least 24,000 Filipino licensed nurses were not working as a nurse in UK [Carlos, Sato and Caragay eds. 2009: 79].
- 4) For a comparison of average salaries of professional nurses across countries, see for example http://www.worldsalaries.org/professional_nurses.html (date accessed 21 October 2009).
- 5) Incidentally our sample corresponds to the estimate of the Philippine Embassy in London about the percentage of Filipino nurses in UK who came from a third country. The Philippine Embassy estimates that 1/3 of 50,000 Filipino nurses in UK in mid-2000s came from countries other than the Philippines [Carlos, Sato and Caragay eds. 2009: 79].
- 6) Currently, the only requirement to be able to take the Singaporean Nursing Licensure Exam is a Philippine nursing license. For details about Singapore’s regulations on foreign workers, check the website of Singapore’s Ministry of Manpower (http://www.mom.gov.sg/publish/momportal/en/communities/work_pass/s_pass.html).
- 7) The situation in US is quite different. One respondent mentioned that US employers value the work experience of a Filipino nurse in the Philippines, but are not particular with having a UK license or not. This is probably because the nursing standards in the Philippines follow that of US, and US has its own

licensure examination for nurses. Moreover, Respondent K did not think that his experiences in other countries were considered substantially by the employer.

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