

Thinking UK's medical labour market transnationally

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The last few years have seen a range of theoretical insights that link people's activities and engagements across different places (Basch et al., 1994; Vertovec, 2004). Much of this literature can be included within the broad rubric of transnationalism, a mode of understanding that highlights the extent to which migration is not a simple or singular process but is marked by continued affiliations, networks and redistributions of resources and goods across space (Levitt, 2001; Levitt et al., 2003). The framework of 'transnationalism' offers us a way of understanding how the links between two or more places are maintained and of emphasising the agency of migrants who maintain these relations across space (Vertovec, 1999, 2004). However, as Bailey has argued much of the current literature on transnational migration has been 'agency-heavy' and 'structure-light' (Bailey, 2001: 421; but see for instance, Margheritis, 2007). Migrants' movements 'occur within a larger geopolitical context and global economy' (Hyndman and Walton-Roberts, 2000: 247) with both state and non-state actors playing a key role in organising migration, resulting in complex interactions and hybridised forms between global processes and the nation-state. In seeking to map out interrelationships that transcend states, researchers have focussed their attention on familial and kinship relations and networks (Boyd, 1989; Hondagneu-Sotelo and Avila, 1997; Yeoh et al., 2002). Yet there is little work that looks at the role played by migration regulations and labour markets in shaping this continuous engagement across place. British medical labour markets steeped, as they are in imperial history provide one site where this continuous and constitutive relationship between different places may be explored. In this chapter I aim to highlight some of the linkages and interdependencies that have shaped medical labour migration to the UK and to trace the tensions that become evident when this relationality is ignored or forgotten. The chapter is divided into four parts. The first section outlines some of the reasons why transnational theorising has not been applied in exploring the interdependencies of medical labour markets. The second section explores the history and nature of these interdependencies as they were established particularly through the second half of the twentieth century. The third section lays out some of the ways in which these historical linkages have been disentangled through the enactment of new immigration regulations. The final section suggests some of the implications of these moves for thinking medical labour migration.

National health, transnational connections

Transnationalism offers us a way of thinking about migration at scales other than that of the nation-state. One of the explicit aims of much of this literature has been to bring out an understanding of migration at local scales and to decentre the state, which has for long been the primary level at which migration, has been analysed (Guarnizo and Smith, 1998). Its ability to unsettle the methodological nationalism that dogged much migration studies has meant that it has become a valuable tool for

analysing migrant behaviour and experiences (Vertovec, 2004; Wimmer and Schiller, 2003).

The tensions between these modes of analysing migration that recognise the mobilities of individuals and the multiplicities of their affiliations comes undone when faced with the nationally based discourses around migration of health professionals. Unlike discourses of brain circulation that have been used to analytically capture the hypermobility of migrants in the IT (Saxenian, 2000) and financial sectors (Beaverstock, 1994) of globalizing industry, migration of health workers usually assumes and privileges a methodological nationalism and a commitment to nationally bounded populations (Lowell et al., 2004; Ray et al., 2006). One reason for this is that both the state and nationally organised professional bodies have considerable investment in provision of health training and delivery because provision of health is a central tenet of a welfare state. The frequent geographical conflation of nation state and welfare state in analysis of welfare (Clarke, 2005) alongside the constitutive nature of welfare provision to the identities of some nation states has meant that there is often slippage between health, welfare and nation. Secondly, the analytical significance of the nation in counting inequality has meant that most comparative datasets are produced by and within national boundaries so that the effects of health worker migration too are counted at and become accountable at the level of the nation state. This is despite the effects of such migration being much more spatially variable across regions, urban/rural and class and gender divides (Stillwell et al., 2006). Moreover, the many globalising forces that influence health provision such as health tourism, commercialisation and entry of multi-national providers to health provision amongst others are also rarely brought into discussions of medical migration.

As a result of the overwhelming focus on the nation state for understanding health worker migration this is also the scale at which discussions of optimum migration (Commander et al. 2004), ethical policy (Department of Health, 2001) and surrounding debates around their efficacy (Martineau and Willetts, 2006) and notions of development (Buchan and Dovlo, 2004) are mobilised. The attachments to the multiple places through which doctors and nurses move and their transnational affiliations within a historically constituted transnational medical labour market and training provision are rarely recognised (but see some steps towards this Decker, 2001; McNeil-Walsh, 2004). The range of other places and processes that are implicated in the production of many aspects of this welfare are either ignored or forgotten.

One example of this is that in writing a narrative of health provision in the UK, it is easy to construct a national story because it is the singular example of a national health-provision system that is comprehensive, i.e. from the cradle to the grave as Aneurin Bevan famously said, and also free at the point of delivery. For many the NHS is therefore, an exemplary outcome of the welfare state. If the Chancellor of the Exchequer Gordon Brown is to be believed it is not simply a health provider but a very British institution. In his speech to the Fabian Society January 14, 2006 'A modern view of Britishness founded on responsibility, liberty and fairness' he called NHS 'one of the great British institutions – what 90 per cent of British people think portrays a positive symbol of the real Britain – founded on the core value of fairness that all should have access to health care founded on need not ability to pay.' As

Kyriakides and Virdee say 'the status of the NHS doctor largely reflects the importance of the British medical establishment as a guarantor of the moral order and the ideological resonance which 'humanitarianism' affords in the preservation of that order.' The NHS is thus a significant site where the 'best of Britishness' is mobilised.

Yet, there are many other sites and spaces that are required to produce this very British institution. For instance ever since its inception in 1948, a significant part of the workforce has been drawn from outside the country. To quote Kyriakides and Virdee 'migrant doctors from specific geographical locations have historically played a fundamental, but paradoxical role in the maintenance of the NHS: they are integral to its running but are not awarded the status that such a position would seemingly confer. The reception and occupational location of this crucial source of labour have reflected both the negative portrayal of migrants in wider British society and the specific institutional function that the NHS plays in safeguarding ideological identification through a sense of 'Greatness' from which the 'non-British' are excluded (p. 283-284). For the last quarter of a century they have formed between a quarter and one-third of all doctors in the UK. They have played a huge part in the less prestigious/lucrative parts of the health service such as geriatric medicine and in mental health (Bornat, 2004). Importantly many UK medical graduates too travel abroad for work experience, for elective options in international health during their studies and as part of international exchange programmes (also see Thomson et al., 2005). It is not enough to see this as a one-way flow. Medical training and practice in many different places are implicated in the provision of training and labour in the NHS. In the next section I aim to trace some of the ways in which these interlinkages have been embedded.

British medical labour market as a transnational field

In the UK the most significant change to the Health Service came through the introduction of the National Health Service in 1948 (Rivett, 1998). In creating a unified national health service there was a struggle to ensure that doctors who trained in the UK would not only have access to jobs in the NHS but would also not suffer unduly from loss of private incomes within the private sector due to the nationalisation of much of the health provision. Towards this limits were placed on the number of doctors who were annually trained in the UK and a close relationship between undergraduate medical training and medical 'manpower' was established. The pyramidal structure of medical training meant that medical staff requirements in lower grades were however greater than those who could achieve upward mobility into full-scale career posts. This service requirement was met through the deployment of migrant doctors who, it was deemed, would come to the UK to obtain training but would then return to their own countries. Like other trainees they were to be solely employed in the national health provision and in doing so would help to fill labour market shortages, especially in the lower rungs of the health service (Decker, 2001).

This dependence on migrant health workers was also facilitated by the historical links that commonwealth countries and their education systems had with the British health system (Pati and Harrison, 2001; also see Forbes, 2005). Even as far back as 1849 four medical students were brought from India to study medicine in the UK. One such student, Chuckerbutty (Fisher, 2004) completed his course and the Bengal government was asked to provide him with a post in Calcutta Medical College commensurate with his education 'so that he 'could have an opportunity of

communicating to his countrymen the scientific knowledge and practical acquirements attained by him in this country'. (p. 373). The migrant trainee doctor thus has a long history.

However, it was the 1886 Medical Act that first permitted migrant doctors to register to work in the UK (Kyriakides and Virdee, 2003). Through the end of the nineteenth century and into the beginning of the twentieth a number of colonial subjects came to the UK to obtain medical education as there were few centres for such education in the colonies. In India, for instance, there were only 4 medical colleges until 1900, of which two were established in the 1830s and 2 in the 1840s in the first flush of educational investment following Macaulay's infamous minute (see Bhabha, 1994 for a discussion of the Minute).

Postgraduate medical training opportunities were non-existent in the colonies and were slow to mushroom in many parts of the postcolonial world. This lacuna meant that the former imperial centre could continue to recruit a range of ambitious doctors who wanted to use mobility as a route to furthering their training. Moreover, the mark of medical educational achievement in the British Commonwealth remained (and still at least in part remains) the qualifications offered by the Royal Colleges of the various specialisms and obtaining these qualifications required doctors to come to the UK to train. They provided accreditation that had an international reach for doctors. An award of a Fellowship of the Royal College of Surgeons or a Membership of the Royal College of Physicians continued to act as a passport to further mobility. Socio-economically, these degrees were not only a mark of human capital, of accredited skills and knowledge but also held cultural capital arising from the weight of the authority of hundreds of years of historical privilege. Geographically, these degrees helped doctors who obtained them to move to other countries, particularly within the commonwealth family of nations. The Gulf countries in particular rewarded doctors who stopped by in the UK on the way to the Gulf financial rewards several times that which they gave to migrant doctors who came directly from their home countries, without the stamp of approval that a UK training provided.

Through the decades a range of provisions have been introduced to ease and more recently to regulate the mobility of doctors who moved through the UK medical sector and the forms of regulation have varied within the overall framework of wider acceptance of immigration and the needs of the health service. The 1962 Commonwealth Immigration Act, the 1971 Immigration Act and the 1981 Nationality Act all resulted in limiting the range and scope of immigration of doctors, particularly from the new Commonwealth. The introduction of further stipulations on the maximum period that migrant doctors would be allowed to stay and practice in the UK (5 years) firmly pushed medical workers into the role of transient labour providers. At the same time the inclusion of the UK in the European labour market also helped to provide a vast new source of potential labour for the National Health Service (Coker, 2001).

Medical institutions and regulatory bodies too participated in the culture of suspicion of overseas-qualified doctors that came to be adopted through the 1970s. Under the garb of protecting the UK population from 'less competent' overseas doctors a range of measures were introduced to ensure that migrant doctors had equivalent competencies and skills to those who were UK qualified. Doctors from the old

commonwealth were however excluded from these regulations in consonance with the racial filtering that marked much legislation in the 1970s. This led to the withdrawal of recognition of degrees obtained from particular institutions and subsequently from all medical training institutions in countries such as India and served to limit the migration of doctors from the new Commonwealth in particular. Medical regulatory organisations established new sets of examinations to assess the medical and linguistic competency of doctors migrating from outside the spaces of the European Union. On the other hand the growing facilitation of equivalence procedures for European doctors' qualifications and new regulations to smooth the mobility of European workers increased the role that they played in the health service. The link between the possibility of replacing migrant doctors from the new Commonwealth with those from Europe was explicitly laid out in the Merrison Committee report of 1975 (Kyriakides and Virdee, 2003).

Despite this there has been a steady growth of overseas doctors working in the UK. Major increases occurred largely from 1953 when the number of medical posts were expanded but was followed by a cut in medical student intakes due to errors in 'manpower planning'. Emigration continued but with particular peaks between 1957-60 and again a decade later (Decker, 2001). Overseas doctors therefore play a paradoxical role in the maintenance of the NHS: they are integral to its running but were never awarded the status that such a position would seemingly confer. They played a crucial role in setting up new specialisms such as geriatrics (Bornat, 2004). Moreover as Kyriakides and Virdee (2003) have argued in their theorisation of the racially stratified National Health Service migrant doctors also played a crucial role in shaping British postcolonial identity.

The legacy of these layers of regulations - immigration and labour market - was that until early 2006 the conditions of medical migrants' entry into the country and into the labour force varied depending on country of birth, country of qualification and educational institution from which the qualifications were obtained (Department of Health, 2005). For career purposes migrant doctors were usually defined not by their country of origin or their right to residence but by their country of qualification. Regulatory bodies within the medical profession emphasised the place of qualification in their determination of who constitutes an overseas doctor. The NHS census thus differentiates between those who are UK qualified, European Economic Area (other EEA) qualified and overseas doctors (i.e. those who qualified outside the EEA, now usually called).¹ For example, the large numbers of medical students who come from countries such as Malaysia to study medicine in the UK were not considered to be overseas doctors.²

These differences in classification and data collection reflected the differences between doctors in terms of rights of settlement and the recognition of their previous

¹ Those who qualified outside the EEA are classified as 'other overseas' or International Medical Graduates or IMGs. These terms are used interchangeably in this chapter.

² Given the fact that the data is based on country of qualification means that UK born doctors who qualified in other countries will be identified as overseas qualified and therefore for the purposes of this study as migrants. However, these numbers are likely to be few and should not significantly affect the analysis'

employment. Doctors who have qualified in the EEA have rights to enter and remain in the UK and their qualifications are accredited in line with regulations that have harmonised European qualifications (Directive 1993/16).

Doctors from non-EEA countries, on the other hand, have much more limited rights - either to work or to settle. Recognition of qualification varies along a number of vectors, primarily country in which medical qualifications were obtained. However, even applicants from the same country may find that their experience and qualifications are differently recognised based on the medical colleges from which they graduated or the hospitals in which they worked. Moreover, this recognition will also depend on the extent of labour market shortages in their speciality. As a result, for most non-EEA doctors the route to working in the UK is quite convoluted and complex.

The primary mode of entry for overseas doctors was through a permit-free training system that allowed doctors who had passed an English language exam as well as the exam conducted by the Professional and Linguistics Assessment Board (PLAB) to enter and stay in the UK (Raghuram and Kofman, 2002). The period of stay varied with the nature of training sought from a minimum period of 12 months for pre-registration House Officers through to a maximum period of four years for doctors working in other training grades, although applications for extensions were sometimes considered.

Some doctors entered through the International Fellowship Scheme and the Managed Placement Scheme, which recruited high level employees, usually consultants. The former was offered for a fixed period usually two years and was available only in specialities that had severe shortages, while the latter posts although initially offered on a temporary basis could develop into full-time permanent posts. Entry of doctors through both schemes was still relatively small. Recruitment through these schemes was more likely to be influenced by the Government's guideline for ethical recruiting, which restricted the countries from which the UK government is permitted to actively recruit (Department of Health, 2001). In particular, active recruitment from developing countries was not encouraged unless the government of the country had specifically permitted the UK to undertake a recruitment programme (p. 10).

Post-entry many doctors moved on to clinical attachments (unpaid observer posts) before they would be considered for training posts. Subsequent career pathways depended on whether they obtained training or non-training posts, and the level and nature of both training and non-training posts occupied (see Table 1 for details). Doctors who completed their permit-free training period often moved on to Work Permits if they were appointed to career grade posts (consultant and /or non-consultant career grade doctors such as Staff Grade and Associate Specialities (SAS) doctors³). Some doctors moved to the Highly Skilled Migrant Programme (HSMP) based on their eligibility. The former was utilised only for non-training posts while the latter has been more differentially used.

³ The expectation was that IMGs would acquire training in the UK and then return to their home country. However, a number of them were incorporated into sub-consultant career grade posts.

Between 1979 and 2001, overseas doctors without a right of residence in the UK were not allowed to enter General Practice and these restrictions were extended to assistant and locum posts in 1985.⁴ Furthermore, General Practice trainees were not allowed to enter under the permit-free training scheme so those aspiring to enter General Practice had to meet the requirements of other business people wishing to obtain a permit to work in the UK, including evidence of their ability to invest 200,000 pounds into their practice (MWSAC, 1997). This meant that there had been little intake of new migrants into this part of the medical workforce. However, these rules were altered in November 2001 and overseas doctors are increasingly entering General Practice training schemes. Trainee General Practitioners sit the qualifying examination to enter the Vocational Training Scheme (VTS) and undergo 3 years of training, also usually on permit-free immigration regulations. General Practitioners are considered as career grade doctors and are therefore either on Work Permit scheme or on the HSMP.

Notwithstanding these differential conditions of entry/stay for overseas doctors, the proportions of overseas doctors to total increased from 23 to 26 percentage points between 1995 and 2000. These were largely doctors who had qualified in countries of the Third World, particularly in the new Commonwealth, and who have for long dominated medical migration (Mejía, 1978). India was the largest source country for doctors in the 1970s (Mejía 1978) and continues to be important even today (Mullan, 2005, 2006; Robinson and Carey, 2000).

The result of these migrations can be traced in tables 2-8⁵. Based on analysis of the annual census of doctors in England taken in September of each year, the tables outline the large and continuing significance of International Medical Graduates, the increasing feminisation of all hospital doctors. The tables highlight the large and increasing proportions of doctors working in England who had their initial training outside the UK. They thus bear witness to the embeddedness of the British National Health Service labour markets in transnational medical training fields. However, this picture was radically altered in 2006 with new regulations limiting the entry and circulation of doctors who were citizens from outside the European Economic Area. This altered the landscape of medical recruitment in the UK. In the next section I outline some of these recent shifts and the impact of the bid for autonomy on IMGs in the UK.

Comment [PU1]: Due to the word limit I have not currently included any tables on the specialties in which these doctors are distributed but I can easily put these together if useful.

Rethinking the linkages

On 7 March 2006 the Immigration and Nationality Department announced a series of changes to immigration regulations summarised in the document '*A point-based system: Making migration work for Britain*'. The new regulations were based around a point system were to be phased in and were open to consultation (HMSO, 2006). However, alongside this much-publicised set of changes new regulations pertaining to the entry of doctors was also announced. They came into effect without much public

⁴ Locum posts are short-term temporary posts and this form of work can be compared with contract work. Locum posts are usually not recognised for experience or for training more formally but this is a complex field because there are also differences between locum appointments for training (LAT) and locum appointment for service (LAS).

⁵ The tables only present the data for England as equivalent data is not collected by Northern Ireland, Wales and Scotland.

consultation from 3 April, i.e. less than 1 month after they were first announced and have altered the face of health provision in the UK.

The new regulations involve bringing doctors into the 5-tier points-based system and the peremptory abolition of the permit-free training category through which most IMGs worked in the UK. Transitional arrangements were to be provided for those who are already in training posts in the UK, posts which will come to an end when the current training programmes on which they are enrolled finishes.

The implication of these regulation changes arise from their content, the ways in which they have been introduced and the ways in which they are being implemented. The short notice and the lack of consultation meant that thousands of IMGs were suddenly faced with uncertainty and often unemployment. Those who had written the PLAB exam and not yet entered a permit free training scheme were no longer eligible for jobs as they would not meet the requirements of the new points based system. Their investment in the exam (fees - £145 for each attempt at PLAB 1, and £430 for each PLAB 2 sitting) and costs of travelling to the UK to undertake the second part of the exam were wasted. The losses incurred by the many doctors who were in unpaid clinical attachment posts while waiting for their first paid job was even greater. This represented a huge unrecoverable loss of resources for many IMGs, as these amounts represented very large sums of money compared to the salaries they are likely to earn in their home countries (Attili, 2006). It may take doctors many years simply to pay back debts incurred in coming to sit these examinations in the UK. The British Association of Physicians of Indian Origin (BAPIO) estimated that several thousand Indian doctors were affected in this way.

For doctors who were already in post the retrospective application of regulations meant that doctors had to negotiate a system to which they never signed up. For instance, those who are in training posts were no longer able to complete their training as per the regulations of the system that they joined. Many were unable to complete their training in the UK. They were also not eligible to sit the membership examinations set by the Royal Colleges as they would not have the years of experience in the UK that are required by the Colleges. The new regulations meant that investments in time and money made by IMGs from relatively poor countries to come to the UK have resulted in their acquiring no transferable skills or qualifications.

The sudden shift from regulations that had been in place for decades meant that those applying the rules had little understanding of how to negotiate these changes. Doctors applying for posts which might entail applying for Work Permits found that the transitional arrangements had not yet been specified. Doctors who had switched to the Highly Skilled Migrant Program were subjected to the differential interpretations of rules by different deaneries (Narayan, 2006). In particular, the shift from country of qualification to residency/citizenship rights as a filter for jobs led to considerable confusion. For instance, some deaneries issued a notice that they would no longer shortlist non-EEA graduates, while others excluded non-EEA citizens. HSMP candidates who applied for jobs and who had signed a commitment to remain in the UK and to seek work in that country now found that many deaneries were treating them as equivalent to Tier 2 applicants on the basis that they were non-EEA citizens. Moreover, foreign students who had graduated from British medical schools also

found that they were no longer eligible to complete their specialist training in the UK (Tee, 2006).

A study of the new forums set up to discuss the impact of the changes highlighted other forms of discrimination too. For instance, some deaneries failed to provide results for exams sat (such as among General Practitioners who sat the examinations to enter the Vocational Training Scheme) on the basis that applicants will not be allowed to take up a job later although the examinations had been taken under the aegis of earlier regulations. Moreover, if we endorse the shifting to a market-based economy as suggested by the new regulations, one could argue that applicants who paid fees and sat an examination are eligible to know their results.

Dismantling the permit-free training system that has been in place for over 20 years involved an emphatic disassociation from a commitment to facilitating the training of IMGs through special immigration regulations. The historical linkages around training provision are elided in the message put out by the Minister for Health on 7 March. He announced: 'We recognise that international doctors have made a huge contribution to the NHS since it was founded in 1948 and there will still be opportunities for overseas staff to come to the UK. We will continue to need small numbers of specialist doctors, who can bring their skills and experience to the NHS. However, increasingly the NHS will be less reliant on international medical recruitment' (Department of Health, 2006). The earlier system, which was based on a reciprocal relation between training and labour, was forgotten in these new regulations. The point-based system does not have the flexibility to incorporate the relation between work and training that underpinned doctors' migration. And these regulations were justified through a narrative of self-sufficiency and through evoking a picture of national labour markets.

The impetus for these changes came from a number of other changes in medical labour markets. First, the growth in number of doctors was part of the NHS Plan of drawn up in July 2000. 7,500 more hospital consultants, 2,000 more GPs were to be recruited by 2004 of which it was recognised that a number will be recruited from overseas (Department of Health, 2000). However, this was to be supplemented by 1000 extra undergraduates or a 31 per cent increase in home entrants to medical college between 2000 and 2005. Together these produced a rapid increase in the number of local graduates. At the same time the EU expanded to include 10 new member states and the UK decided to give migrants from these countries access to the UK labour market increasing the pool of labour available for filling medical training and career posts in the UK.

This increase in numbers happened at the same time that there was increasing pressure on hospitals to reduce expenditure so that staffing increases came to be increasingly scrutinised. Alongside these changes were a raft of changes to both medical training and service provision. Under the banner of Modernising Medical Careers the nature and structure of the medical workforce is being reorganised. The new regulations reduce the number of training posts and also tie these posts into a structured training programme. Ultimately they aim to reduce the pyramidal base of the training structure so that the number of specialist posts available will roughly match the number of entrants into training. The two exceptions to this will be a small number of fixed term specialist training posts and a number of career posts (approximately equivalent to current non-consultant career grade posts) which will

provide flexibility in numbers of specialists. The shrinkage in number of years of training (and hence of training posts) alongside the run-through training programme has meant that there is little flexibility to incorporate International Medical Graduates. The changes in immigration regulations pre-empt the shrinkage in job opportunities arising from this new modality of training.

Finally, these changes must be seen in consonance with wider changes in the NHS including the increasing commercialisation of various aspects of health delivery (Mackintosh and Koivusalo, 2005; Timmins, 2005). Whilst health provision is still free at the point of delivery more and more of the arrangement of this provision is being organised through public-private partnerships that take the form of independent sector treatment centres (21 operational in February 2006, of which several are owned by Swedish, Canadian and South African firms). Overseas contracting teams too have been recruited to attend to waiting list hot spots so that the nature of involvement of outside providers has been altered. So far, the Overseas Contracting Team has contracted work from France, Germany, Belgium, South Africa, Spain and Scandinavia. The number of professionals circulating through these means is admittedly much smaller than those involved in the NHS. However, the government is expecting to create an Extended Choice Network of Independent Sector providers with investment of approximately £3 billion expected to go into elective provision in the next 5 years (Department of Health, 2006; see also BMA, 2005; House of Commons Health Committee, 2006; Lethbridge, 2002a, 2002b). These new forms of provisioning within the NHS are creating novel labour relationships with a range of Scandinavian, South African and North American health providers as transnational health firms become the new merchants of labour (Connell and Stillwell, 2006; Kuptsch, 2006). New forms of medical migration are being opened up through these channels although there is little research on this thus far.

Conclusions

In this paper I have briefly traced the recent history of IMGs in the UK in order to highlight the issues facing the reserve army of medical labour that these migrant doctors represent. In doing so, it is useful to remember that medical migration is shaped by a range of political, socio-economic (particularly educational and occupational) issues both in sending and receiving countries⁶. Historically migrant doctors have been an explicit part of the calculations of how medical care should be delivered in the UK. However, most recently the UK has decided to shake off its dependence on migrant doctors (particularly those from outside the European Economic Area) and to write a new script for medical provision in the UK. This was achieved through the selective disavowal of long-established forms of interdependence between institutions and practices scattered across many places and spaces.

The tendency to adopt nationalistic frameworks in thinking health service provision is somewhat short-sighted and elides a number of interdependencies and transnational linkages that shape medical migration. Firstly, in conjuring up the rhetoric of national labour markets they omit the impact that the UK's medical labour market has since many years been a European labour market. As part of the European political and

⁶ This paper has not focused on sending countries but see for instance Astor et al., 2005

economic space, the circulation of medical professionals has been enabled through the transference of accreditation across the countries of the Union. More recently, UK's decision to allow free circulation to members of the European Economic Area has expanded this labour market even further. This marks a significant shift from a dependence on Commonwealth countries, but for the most part it does only that. It does not (and cannot within the context of European agendas) mark out the boundaries for a national labour market that only locally graduated doctors can enter. Secondly, it ignores the interdependence between training and working that was a central pillar of medical careers. Working in the UK counted as training for examinations that international medical graduates took and provided one route through which doctors could obtain skills that were marketable both at home and in other countries. Thirdly, the immediacy of the strike for independence involves a disavowal of the temporal qualities of the interdependent relationships that have been established over centuries of co-production of health across different parts of the Empire.

Interestingly, the very strikes for autonomy by UK government have created new spaces of activism and produced new forms of lobbying. The British Association of Physicians of Indian Origin has been at the forefront of much of this activism, challenging the regulations in court and involving high-level politicians including the Indian Prime Minister in their cause. For the first time in the long history of Indian medical migration, the Indian government has become involved in the injustices meted out to its citizen medical professionals. It has pressed the case of Indian doctors with the UK government. At the same time, the Indian government has also recognised the transnationalism of its medical practitioners. It has facilitated their return to India by announcing in January 2007 that public sector medical posts will now be opened up to those who have taken up permanent residence in other countries. They have firmly placed Indian medical provision within a transnational Indian diasporic labour market. In doing so, they recognise and validate the contributions made by such diasporic Indians to private sector health provision in India, itself a generator of income for the country through the medical tourism that it has speeded up (Sahoo, 2003). It appears that just as the UK is withdrawing from its transnational allegiances to countries outside the EU, India is recognising its diaspora and engaging in state-led transnationalism (Margheritis, 2007). The Indian government, it appears, is recognising the multiple affiliations that migrants may have and the fluidity of the movements that individuals may have over their life-time. Moreover, it appears to be urging the British government too to recognise the multiple spatialities and affiliations within which migrants are embedded.

These political interventions suggest the tensions between nationalistic frameworks of analysis that often accompany social welfare provision and the transnational social fields within which the service is actually embedded. These tensions are heightened in the case of the National Health Service as this institution is considered to be emblematic of the success of the welfare state principle and a matter of national pride while at the same time enveloping in its folds a range of migrant workers whose labour is then devalued. Analytically, locating medical labour markets in transnational spaces will help to show the interlocking nature of medical labour markets across different places and spaces, including the new forms of transnational arrangements that commercialisation of health service provision is introducing in the UK. It will highlight the extent of interdependence that marks health provision and point out the

limits of the nationalistic frameworks of analysis often used in thinking medical migration.

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Table 1: Immigration Regulations and Career Pathways

Grade	Immigration regulation
Pre-Registration House Officer	Permit free for 12 months. Extension of stay for not more than 12 months
House Officer	Permit free for up to 3 years
Senior House Officer	Permit free for up to 3 years Extension of up to three years as long as not more than 3 years is spent at this or equivalent grade
Registrar	Permit free for 3 years with extensions, each of up to 3 years
Sub-consultant grade	Work-permit
Consultant	Work-permit

Source: This table was created from information provided in the Guide to Immigration and Employment of Overseas Medical and Dental Students, Doctors and Dentists in the UK.