10. 'I Never Wanted to Come Home': Skilled Health Workers in the South Pacific

John Connell

> I know I can't live away from Samoa for too long. I need a sense of roots, of home—a place where you live and you die. I would die as a writer without roots; but when I go home I am reminded that I'm an outsider, palagified (Albert Wendt, in Beston and Beston 1977).

Little has been written on return migration to the island states of the Pacific. More generally and despite its significance in many countries, there is a limited global literature on return migration, and even less that focuses on the return migration of skilled workers. This chapter traces the return migration of skilled health workers, in three Pacific island states (Fiji, Tonga, Samoa) and evaluates the rationale for and consequences of return and their contribution to development. As the short title—the words of a returned health worker—and the opening quotation from the distinguished Samoan author, Albert Wendt, indicate, there is both contradiction and ambivalence in the structure, nature and impact of return. Ambivalence and uncertainty are complicated within a more transnational world, through the flexibility and fluidity of more instantaneous physical and electronic communications and contacts.

The global rise in the migration of skilled workers has been perceived as a response to the accelerated globalisation of the service sector. Such professional services as health care are very much part of the new internationalisation of labour, as demand for skilled health workers in developed countries has remained high, seemingly paradoxically because of relatively low wages and poor working conditions in these destination countries (Connell 2008b). In the Pacific, as elsewhere, the migration of health workers is no new phenomenon. At least as early as 1989 a medical degree from the Fiji School of Medicine was regarded by some as a 'passport to prosperity'. However there have been few studies of any facet of this migration and those that have been done have until quite recently been largely qualitative (Naidu 1997; Rotem and Bailey 1999), while just as few studies in the Pacific region have examined other forms of skilled migration (cf. Liki 2001; Voigt-Graf 2003; Voigt-Graf, Iredale and Khoo 2007). In short, there is remarkably little information on the migration of skilled workers, let alone their return migration, in the Pacific region. This chapter seeks to help to fill this gap by addressing the significance of return migration of one small group of skilled workers in three island states.

Especially for small states, the migration of skilled workers has been seen largely as a one-way process, a critical component of the brain drain, and thus a major problem. Migration (and attrition) represent a costly loss of scarce and expensively–trained human capital. Loss of significant numbers of key health workers affects core national strategies for health sector development, creating problems for health care, and for human resource planning and development. Conversely, return migration in the Pacific is often seen as a migration movement dominated by retirees and those who have failed elsewhere: return has even been seen as an admission of failure (Maron and Connell 2008). Those who remained overseas were the success stories and though many of these publicly expressed intentions of return, in private they had moved towards permanence (Macpherson 1985). In other words, the returnees were apparently those least likely to make a significant positive contribution to their home countries. However, in the absence of detailed examination of return migration, such conclusions were largely drawn from anecdotes rather than ethnographic or survey data.

More recent studies, especially in the Caribbean, have gradually begun to recognise the diversity of return migration, alongside the diversity of reasons for return (Conway et al 2005; Gmelch 1992; Thomas-Hope 1999). Similarly for many Cook Islands migrants, the acquisition of new skills overseas was a contributing factor in the decision to return, particularly with the accompanying elevation of social status and income, hence there was a significant return movement of those who had succeeded elsewhere (Hooker and Varcoe 1999; Rallu 1997; see also Marcus 1981:60). Likewise in Tonga, returnees represented a cross-section in terms of age and employment, unskilled and skilled, including health workers, poorly educated and those with second degrees (Maron and Connell 2008). Yet in both these two national contexts there were relatively few such skilled migrant returns compared with the number of those who had left, and information on health workers is minimal.

At a global level, the situation is similar. The return migration of skilled health workers is assumed to be relatively limited in most places, though data are scarce, hence benefits from enhanced overseas skills—a compensatory brain gain—are considered to be few. Fragmented evidence from many parts of the world suggests that return migration of skilled health workers fails to occur largely for the same reason that migration previously occurred. Indeed, migrants are less likely to be tempted back by a system that they left, probably at least in part because of its perceived shortcomings. The extent of overall return migration of skilled health workers has been perceived to be so slight that Kingma (2005) has referred to the 'myth of return'.

Fiji, Samoa and Tonga

Samoa, Tonga and Fiji are all small island states. Fiji with a population of about 825,000 people is the largest in the region, Samoa has about 170,000 people, and Tonga 102,000. Both Tonga and Samoa have about as many ethnic islanders overseas as at home. By contrast, about 10 per cent of Fiji islanders live overseas. Limited land resources, few natural resources, isolation and fragmentation, weak infrastructure and governance all pose problems for administration and development, and economic growth has been weak in recent years. Most countries experience some problems of hardship and poverty of opportunity, and none have significant economic growth. Migration has consequently increased, mainly to the metropolitan states of Australia, New Zealand and the United States.

Metropolitan countries have also traditionally been the destinations for tertiary studies, but both doctors and nurses are educated in the region: doctors (and most other specialised positions) from each of the countries are trained in Fiji and nurses in the home countries. Fiji has the largest health care system in the region, but it has been the most affected by migration since 1987, when ethnic tensions and military coups prompted a series of resignations and departures, and relatively few returns. The health systems of each of the countries have also been significantly affected by migration, particularly of doctors and more specialised occupations such as lab technicians and dentists, for whom human resource planning is more difficult. In all three states the migration of doctors is considered to be more significant than that of nurses in terms of proportions who had migrated, their impact on the health care system and the cost of replacement (Brown and Connell 2004). Since the 1990s, recruitment of Fijian nurses by New Zealand, the UAE, Palau and the Marshall Islands has further emphasised the evolving migration structure and external orientation of health workers.

While the scale of international migration is affected by the vicissitudes of the international economy, migration is primarily affected by uneven development, income levels and the desire for access to education and health services. Each of the countries has experienced significant recent migration both generally and of skilled workers particularly. Skilled workers, and especially skilled health workers, are a significant proportion of immigrants from Pacific island states to metropolitan states. Many developed countries, including Australia, the USA and New Zealand, have a particular shortage of health workers, especially in remote areas.

For each of these countries, but less so for Fiji, where there are distinct, local alternative economic opportunities, there is to a significant extent a 'culture of migration' in which migration is pervasive, based on historical precedent, and part of everyday experience; perceived as legitimate, not as either rupture or

discontinuity in personal and household experience, but as an integral part of life (Connell 2008a). Migration is normal and mobility, intermittent return visits and return migration are part of that. Moreover it is embedded in strategies for extended household development rather than simply the outcome of decisions taken by a small number of individuals. International migration has long had a critical and virtually uncontested role in island societies and economies. The migration and return migration of skilled workers is embedded in this broad context of continuity.

Migration of Health Workers

The present study was part of a detailed study of almost 550 health workers in nine Pacific island states and, to a lesser extent, in two key destinations: Sydney and Auckland. This chapter focuses on the three largest island states that are key countries of origin (Tonga, Samoa and Fiji), and on the small sample of the health workers who were return migrants. Overall, 64 of the sample were return migrants (see Table 10–1). More than two-thirds of the sample were nurses, about 95 per cent of the nurses were women, and about two-thirds of the doctors were men, all a reflection of the structure of Pacific health sectors.

Early migration of skilled health workers from the Pacific was primarily related to quality of life issues related to the employment context (poor working conditions, inadequate facilities, limited opportunities for research or career development); income (particular professional salary structures, costs of living) and a variety of social factors (educational opportunities for children, morale). In this century, wages and salaries were ubiquitously seen as inadequate. Two-thirds of all nurses and almost half (46 per cent) of all doctors are primarily motivated to migrate for income reasons, a conclusion that is common across countries and across migrant groups (Connell 2004). The specific significance of income is a function of income differentials between Pacific island states and metropolitan states; thus, Tongans were more likely to migrate than Fijians or Samoans because of greater wage differentials between home and international destinations (Brown and Connell 2004). Doctors are almost twice as likely to migrate as nurses, partly because wage differentials are greater but also because men tend to be the decision makers and most nurses are women. Migration occurs in an extended family context.

Economic and political problems in parts of the region have contributed to emigration, exacerbated by economic restructuring, reductions in the size of the public service and deterioration in local working conditions. Work can be difficult and challenging. As one Fijian doctor said:

> people need to be compensated for their hard work and after hours duty. At present, work can be very stressful for those who are trying hard to improve the standards of health care. Why would one put in extra hours

of work especially when they are underpaid? The 'good Samaritan' and 'Nightingale' days are over.[1]

Table 10–1: Returned Health Workers in Fiji, Samoa and Tonga

		Nurses		Doctors		Total	
Number of respondents		No.	%	No.	%	No.	%
	Fiji	10	31	8	26	18	28
	Samoa	12	36	8	26	20	31
	Tonga	11	33	15	48	26	41
	Total	33	100	31	100	64	100
Female respondents		No.	% of total respondents	No.	% of total respondents	No.	% of total respondents
	Fiji	10	100	3	9.7	13	20.3
	Samoa	12	100	5	16	17	26.6
	Tonga	11	100	4	13	15	23.4
	Total	33	100	12	38.7	45	70.3
Age (years)		Mean	Standard deviation	Mean	Standard deviation	Mean	Standard deviation
	Fiji	47.3	10	37.9	5.3	43.1	9.4
	Samoa	38.8	11.1	35.1	7.3	37.4	9.7
	Tonga	46.0	10.9	40.7	10.5	43.0	10.8
Number of years away	Fiji	2.9	2.0	3.3	2.8	3.1	2.3
	Samoa	5.3	4.5	6.8	3.3	5.8	4.1
	Tonga	4.0	3.7	8.9	1.7	6.9	3.6

Difficult conditions were also a key factor in influencing migration. Some health workers resented long hours of overtime, double shifts, working on the 'graveyard' shift or on weekends, for which income is not always properly supplemented. This was particularly so in remote places where few staff are available, hence overtime hours can be long. Like the patients, health workers disliked overcrowding, long queues, lack of supplies and inadequate facilities, and the fact they could not do their job effectively, and repeatedly pointed to problems with inadequate technology, favouritism, over-long working hours, lack of support and respect. In most workplaces, it is normal for some expectations not to be met, especially where workplaces are small (so that chances of promotion are relatively few), but there was abundant evidence of lack of 'good housekeeping' and management that supports skilled workers in inevitably challenging situations.

Some of the strongest influences on migration, however, have little to do with employment, or specifically the structure of employment in the country of origin, but much to do with attempts to improve the long term welfare and status of families. In each of the countries many people entered the health professions less out of altruism, or a particular interest in medicine, than through recognition that this might be a means to maximise or at least improve family incomes and welfare. Parents have encouraged their children to enter the profession for the same reason and increasingly so as familiarity with overseas circumstances

increases. Employment in the health system thus enables migration as much as being an instigator of it.

Skilled migrants make a substantial contribution to the economic wellbeing of those who remain at home, even compared with those unskilled migrants who profess the certainty of return migration. Remittances, notably in the case of Polynesian nurses, were sustained at high levels, and thus contributed substantially to the welfare of kin in the home country (Connell and Brown 2004). The creation of that income informs many family migration decisions and the use of the money within the home communities to benefit the extended family means that there is always some possibility of return migration.

Return

A significant number of health workers have returned to the Pacific island states, but not all of them return to work in the health sector. Indeed the majority probably do not (but because the survey data come from workers currently in the health sector, we cannot define this proportion). About one-third of the existing health workforce were returnees, though most of these had been overseas to train and were bonded to return, rather than having come back, usually later in life, for different reasons. In terms of reasons for return (see Tables 10–2 and 10–3), the substantial numbers listed as 'other' represent those who were bonded to return and thus had no real choice in the matter, while 'home country' in some cases was simply a more elegant way of indicating this bonding. More than half of the doctors and at least one-third of the nurses who had returned were bonded, and usually did so before significant overseas work experience. Again this indicates the small residual numbers who had specifically chosen to return. Two-thirds of the returnees were women, but that simply reflects the gendered composition of the nursing workforce. Among those who were not bonded, the returnees were not particularly young, but had largely returned in mid-career, suggesting their presumed ability to contribute to the workforce.

Beyond bonding, social reasons influenced return, for both doctors and nurses (see Tables 10–2 and 10–3), including the rather nebulous 'home country', but being with friends and relatives and accompanying a spouse home were highly significant. For a considerable proportion (even excluding those who were bonded), return was perceived as something of a duty rather than entirely an act of free will. Conversely, just one Samoan nurse claimed to have returned for 'higher wages and better jobs'. In other words, employment in the health sector, or good wages, were not incentives to return.

Table 10–2: Reasons for Return—by Country

Reasons for return	Nurses [1]		Doctors [1]		Total [2]	
	No.	%	No.	%	No.	%
Fiji						
Higher wages & better jobs	3	30	-	-	3	16
Less insecurity/discrimination	4	50	-	-	4	22
Home country	6	60	6	75	12	61
Due to Family members	5	50	4	40	9	50
Due to Spouse job	1	10	-	-	1	6
Due to friends & relatives	3	30	2	25	5	27
Other	2	20	6	75	8	44
Samoa						
Higher wages & better jobs	1	8	-	-	1	5
Better health and medical care	1	8	-	-	1	5
Less insecurity/discrimination	2	17	1	12	3	15
Home country	8	67	7	88	15	75
Due to family members	4	33	-	-	4	20
Due to friends and relatives	9	75	4	5	13	65
Close to retirement	-	-	1	13	1	5
Other	1	8	3	38	4	20
Tonga						
Home country	6	55	7	47	13	50
Due to family members	1	9	-	-	1	4
Due to spouse job	1	9	1	7	2	8
Due to friends and relatives	9	82	12	80	21	81
Other	9	82	14	93	23	88

[1] as a percentage of number of returned nurses/doctors of each country
[2] as a percentage of total returned respondents of each country

Table 10–3: Reasons for Return—Overall

Reasons for the returns	Nurses [1]		Doctors [1]	
	No.	%	No.	%
Higher wages & better jobs	4	5	-	-
Better health & medical care	1	1	-	-
Less insecurity/discrimination	6	6	1	1
Home country	20	25	19	28
Due to family members	10	13	4	3
Due to spouse job	2	3	1	1
Due to friends and relatives	21	27	18	27
Close to retirement	-	-	1	1
Other	12	16	23	55

[1] as a percentage of number of nurses/doctors who had returned to their countries

Migrants tended to return at key moments in the life cycle—after training for example, or when children had graduated—but at least as often when their parents had particular need of them. Thus many returned not necessarily at times of their own choosing or of their own volition, but in response to family needs or crises, influenced by the circumstances of others rather than themselves or their nuclear families. The repeated mobility of Tevai, a Cook Islands nurse, almost entirely in response to extended family needs (Hooker and Varcoe 1999, 94), is a typical if complex example of such a migration scenario, where Tevai and her family repeatedly balanced opportunities for income generation in Australia to provide economic support, with the need to be close to family in the Pacific to provide social support. Social obligations underpin this and other migration histories.

Nonetheless, those who had returned to work in the health sector earned significantly more than those who had never migrated and this was especially true for Samoa and Tonga (see Table10–5). Similarly, returnees in Tonga and Samoa, more than in Fiji, also generally received incomes that were greater than other households (Brown and Connell 2004). Correspondingly, the numbers and proportions of those who returned to Samoa and Tonga were greater. Nevertheless, these relatively high incomes are low compared with incomes that might have been, or were, obtained overseas and hence do not explain return.

Migration itself was less likely to occur where health workers owned a house or business in their home country; in other words they are well-established economically (Brown and Connell 2004; cf. Brown 1997). Likewise, returning health workers are particularly likely to establish a business on their return, having accumulated enough savings to make this possible, a pattern that occurs more widely among all returnees (Brown and Connell 1993; Maron and Connell 2008). There is, therefore, a key economic rationale for return migration outside the health sector, enabling a degree of individualism, independence and autonomy from that sector. As a result, many return migrants to the health sector become part of multiple income households.

Alongside individual choice, bureaucratic and structural obstacles may also hinder return to the health sector. Such obstacles include starting again at the bottom of the system (rather than gaining promotion by dint of new skills and experience acquired overseas) that cancel out any status or professional recognition gained from migration. Accrued benefits may also have disappeared and, even then, there may be jealousy from co-workers who have not had overseas experience (and may see returnees as seeking to lord it over them). Moreover, unless there have been changes to the health system during the absence of the migrants, the old flaws and failings are reencountered and perhaps made worse by overseas experiences had in invariably better functioning systems.

Predictably, returnees were often frustrated with the health sector, which usually compared poorly with those they had returned from and/or been trained in. Those who had been forced to start again at the bottom of the employment hierarchy were particularly frustrated. Most frustrations and complaints related to work conditions and lack of recognition of skills and knowledge, which sometimes amounted to at least perceptions of blocked promotion, though many returnees expressed satisfaction at working for the government with the prestige, reliability and stability that it provides. Others were less enthusiastic: 'I had expectations of promotion and a salary rise'; 'I am better qualified than anybody in the Divisional level. Since my return from Australia, I haven't been promoted. In addition what I am doing is nothing to do with my specialised area of epidemiology'; 'I am burdened with responsibility'; 'long hours'; 'decisions made from higher levels of the hierarchy and no say from lower levels'; 'I want to upgrade my knowledge but it is too difficult'; 'this is my first year as a junior registrar and I have been appointed to a post with a lot of responsibilities and been deprived of a lot of sleep: overworked and underpaid'; and 'overwork: surely no hospital in the world can employ someone over 32 hours?' More generally 'not having normal hours' and 'little separation of work and leisure time; we are always expected to be available', distinguished employment in the health system from that in other areas. Such responses characterised the most obvious dissatisfactions though, with certain exceptions, many similar problems might also have been experienced overseas.

Many complaints were directed at a seemingly uncomprehending and uninterested bureaucracy. An Indo-Fijian doctor who had returned to a provincial posting found it not only 'boring' but also,

> the Administration is very bad, very colonial, with an 'I'm the boss' mentality that does not encourage progress nor allow things to move ahead. The boss is very stubborn and does not listen to his staff, yet he constantly talks of reform.

He could not wait to leave, either to Suva or overseas. Somewhat differently, another doctor elsewhere spoke of 'male chauvinism within the Ministry of Health', and others reflected more broadly on the 'failure of the…government to prioritise health care' or 'the communication gap between the Ministry and the workers'.

Other returnees stressed nepotism and favouritism in island health care systems, particular problems in small health systems in societies where cultures centred on kinship remain important. Stability in a small workforce where there is limited turnover (or what is perceived to be limited turnover) may discourage innovation and change; younger staff found some frustration when trying to implement change and new ideas, especially where it works elsewhere. These kind of 'crab antics', that discourage innovation and ideas, are not unusual in many workplaces

in Pacific island states. One former nurse commented: 'nurses have no autonomy'. Others perceived a lack of respect and support for junior staff, entrenched in the generation gap. In many respects this is universal: in all workplaces some expectations will not be met, though there seemed to be no work climate where new innovations were valued.

Others were frustrated by a lack of adequate technology and there was a constant refrain about problems such as 'lack of equipment'; 'not enough money for medicines'; 'staff shortages' and even simply 'other nurses', all of which affected morale and were essentially related to insufficient investment. Some of the concerns of the returnees were not merely about the factors that made it difficult to do the effective and rewarding job that they sought to do for themselves and their patients, but went beyond that to issues affecting the whole practice of medical care. Many problems are generic to health systems the world over, notably inadequate equipment and medicines, night shifts and problem patients but ultimately, the greatest concerns were about what one nurse perceived as 'failures in the job', such as 'seeing loved ones die' or 'when one is unsuccessful in helping a patient to live'. By contrast, when patients survived against the odds there was the greatest satisfaction.

Somewhat less frequently, qualifications and skills are acquired overseas that are simply too specialised, notably in outer islands, small towns and in very small states such as Niue (Connell 2007, 2009), where a more general multiskilling characterises smaller workforces. Some careers and expatriate social lives are more demanding and fascinating and simply do not exist at home for 'high fliers'. Return would demand too many social and economic sacrifices and unacceptably constrained opportunities. As one returnee, who had moved out of the health sector before being attracted back, said:

> I never wanted to come back from Australia because it was not challenging enough but my husband wanted to return. It's not challenging. The case mixes are too few and it is not specialised here. I have to be a generalist and I don't like it. I'd like to go back there again.

Matching local needs and overseas skills is never easy.

Indo-Fijians tended to be the most critical of the circumstances that they found themselves in upon return, perhaps with reason; as did those who had returned to rural and regional positions, but there were no distinct national variations in satisfaction or otherwise.

While there were inevitable frustrations about work issues, many respondents were more positive and optimistic about the contributions that they had been able to make and more generally about the benefits for themselves and their families of returning home.

> I never intended to stay in Australia permanently, just to go there for study. It's been good to return to work and live in Tonga—the lifestyle is better here and my family are here…I'm comfortable. It's also good to come back and help an ailing health system (quoted in Maron 2001, 71).
>
> The knowledge that I gained overseas is invaluable. I have been able to return to work here and start establishing new changes in dental surgery. The experience that I gained overseas is good for Tonga's development (ibid, 78).

Consequently, despite frustrations with bureaucracies and facilities, there was also recognition that the health sector had some advantages in itself: 'the salary is higher than other jobs in Tonga, I gained prestige through my return and the work is appreciated by the people'. And 'I've worked in Melbourne but it seems that you are doing it for the money. Here you don't get much money but you feel that you're really helping people'. Inevitably, considerable satisfaction was attached to the ability to contribute to a more successful workforce: 'saving two lives of a mother and baby…and working as a team with other nursing, medical and non-medical staff'; 'looking after people and planning for the health of the community'. Sometimes that was directly attributed to migration, through the 'use of overseas knowledge and skills to benefit Tonga' but usually satisfaction was simply implicit in doing a good job. For one nurse, this amounted to 'the pleasure of living with my family, low expenses, working with my own people, and being able to contribute to the government, the country and the people'. It is perhaps true that, rather more than in almost any other sphere, returned health workers are able to believe, make and sustain such claims.

Yet fitting in again posed some problems. While returnees were usually able to readjust to island lifestyles the transition was not always easy: 'I had culture shock coming back into Tongan culture, but in the end I was glad to be back'. Challenges also involved the attitudes of patients where these did not fit 'western' medicine: 'frustration with elderly patients who rely on traditional Tongan medicine rather than western medicine'. Although 'my parents are here, it is more comfortable living in Tonga and the job is more flexible', that sometimes necessary flexibility was a problem for those who had acquired specialisations and disliked having to become generalists. Here, as in other contexts, some were able to readjust and reintegrate, others found it more frustrating and resented being able to use only a fraction of what they had learned and practiced overseas. Those who had returned for the sake of others were most challenged by return and envisaged future emigration.

Table 10–4: Intended Future Migration of Return Migrants—by Country

Reasons for future migration	Nurses [1]		Doctors [1]		Total	
	No.	%	No.	%	No.	%
Fiji						
Higher wages & better jobs	2	67	1	50	3	60
More education for self	-	-	-	-	-	-
Education of children	1	33	2	100	3	60
Desire to travel and gain overseas experience	-	-	1	50	1	20
Spouse can get a job	1	33	-	-	1	20
Others	1	33	1	50	2	40
Total respondents: Fiji[2]	3	30	2	25	5	28
Samoa						
Higher wages & better jobs	3	75	1	25	4	50
Good business opportunities	1	25	-	-	1	13
More education for self	3	75	4	100	7	88
Education of children	3	75	2	50	5	63
Have friends and relatives	-	-	1	25	1	13
More contact with developments in medicine	-	-	1	25	1	13
Institutional settings	1	25	-	-	1	13
Desire to travel and gain overseas experience	-	-	2	50	2	25
Research possibilities	1	25	1	25	2	25
Total respondents: Samoa[2]	4	33	4	50	8	40
Tonga						
Higher wages & better jobs	2	50	2	25	4	33
More education for self	1	25	4	50	5	42
Education of children	2	50	2	25	4	33
Better amenities	2	50	-	-	2	17
Desire to travel and gain overseas experience	-	-	4	50	4	33
Others	2	50	2	25	4	33
Total respondents: Tonga[2]	4	36	8	53	12	46
TOTAL RESPONDENTS: ALL [2]	11	33	14	45	25	39

[1] as a percentage of number of nurses/doctors (who had returned) of each country
[2] as a percentage of total respondents who intend to migrate of each country; for reasons of space categories that had no responses have been omitted.

The real pleasure of return lay in the social context. This usually had little to do with the workplace but was about a 'more comfortable pace of life' among family and friends. Many of those who had moved back emphasised the climate, safety or the more relaxed pace of life, or simply the familiarity of the home country, indicating again how crucial social, political and economic stability is to return migration.

While return migration was for social reasons, reemployment in the health sector may even have been reluctant and others may have dropped out of the workforce, there is no clear evidence that those who had returned were 'failures' (though the methodology precludes their being recognised). Rather, it tended to suggest that returnees have contributed to national development and that even if some

felt that they had in some sense 'failed', many had made an effort and battled against stubborn bureaucracies and difficult conditions.

Of the returnees some 25 (29 per cent), about one-in-three nurses and one-in-two doctors (see Table 10–4 above) wanted to migrate again 'soon'. Although intent is different from action, at the very least some degree of ambivalence followed return migration, especially when that return was stimulated by the needs of others. Such a new phase of migration would be motivated by desire for better education and new experiences for the individuals and for their children, underpinned by higher wages and a better job (see Table 10–5). Poorly paid nurses tended to seek to move for higher wages and doctors for new education and training, but overall an economic rationale was significant. Even some of those who were aware that they were doing a valuable job and enjoyed it, found it difficult to balance this with their knowledge of 'higher wages and a better quality of life overseas' that presented a constant lure and temptation. Nonetheless, some strenuously denied any intention to go: 'If the worse comes to the worst I'd leave, but otherwise I'd rather stay here' and 'even in the worst situation I'd feel obliged to stay here'. Yet in the present climate of overseas recruitment and substantial demand for skilled workers, usually only older workers did not see migration, however improbable, as both temptation and possibility.

Table 10–5: Intended Future Migration of Return Migrants

Reasons for future migration	Nurses [1]		Doctors [1]	
	No.	%	No.	%
Higher wages & better jobs	7	64	4	29
Good business opportunities	1	9	-	-
More education for self	4	36	8	57
Education of children	6	55	6	43
Better amenities	2	18	-	-
Have friends & relatives	-	-	1	7
More contact with developments in medicine	-	-	1	7
Institutional settings	1	9	-	-
Desire to travel & gain overseas experience	-	-	7	50
Research possibilities	1	9	1	7
Spouse can get a job	1	9	-	-
Others	3	28	3	21
Total number reported[2]	11	33	14	45

[1] as a percentage of total nurses/doctors who had returned to their countries
[2] as a percentage of nurses/doctors who intend to migrate future

Those who intended to remain wished to stay, by contrast, because it was home and where their relatives and friends lived (see Table 10–6). In a wider sample of all health workers in Tonga, Samoa and Fiji, among those who had never gone overseas, income was even less evident as a reason for staying. This was especially so for nurses, whereas almost half of the doctors who had chosen not to migrate indicated that income was a factor in their staying, despite the fact that they earned about one-third of what they might have done overseas (Table 10–7). Alongside family ties, owning a house in the home country is a significant brake on leaving, whereas being trained overseas is a major influence on migration (Brown and Connell 2004). Returning and staying tend to be social phenomena, while leaving is an economic one; mobility is a constantly unfinished story.

Table 10–6: Reasons for Remaining—by Country

Reasons for remaining in home country [2]	Nurses [1]		Doctors [1]		Total	
	No.	%	No.	%	No.	%
Fiji						
Good job and satisfactory income	2	29	2	33	4	31
Close relatives and friends	1	15	2	33	3	23
Good house	4	57	-	-	4	31
Due to spouse preference and job	3	43	1	17	4	31
It's home	5	71	4	67	9	69
Others	2	29	-	-	2	15
Total reported: Fiji[3]	7	70	6	75	13	72
Samoa						
Good job and satisfactory income	2	29	1	25	3	27
Close relatives and friends	6	86	2	50	8	73
Good house	2	29	-	-	2	18
Due to spouse preference and job	1	15	-	-	1	9
Low level of crime and good security	-	-	1	25	1	9
Low cost of living	3	43	-	-	3	27
Many social activities	2	29	-	-	2	18
Difficult & impossible to get visa	-	-	1	25	1	9
It's home	5	71	3	75	8	73
Total reported: Samoa[3]	7	58	4	50	11	55
Tonga						
Good job and satisfactory income	1	15	1	17	2	15
Close relatives and friends	6	86	3	50	9	69
Good house	-	-	-	-	-	-
Due to spouse preference and job	3	43	-	-	3	23
It's home	4	57	4	67	8	62
Others	1	15	5	83	6	46
Total reported: Tonga[3]	7	64	6	40	13	50
TOTAL REPORTED: ALL	21	64	16	51	37	58

[1] as a percentage of number of returned nurses/doctors of the country
[2] categories with no responses have been omitted
[3] as a percentage of total respondents who intend to remain in the country

Table 10–7: Comparison of Annual Income between Return Migrants and Never-Migrated Health Workers*

	Return Migrants				Non Migrants			
	Nurses		Doctors		Nurses		Doctors	
Total no. of respondents	33		31		96		14	
	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
Annual income	8273	6047	22554	31194	5754	2896	16312	8026
Annual household income	17565	20039	33175	36441	12354	6978	23825	8203
Annual per capita household income	3453	4089	8374	7844	2529	1579	6929	4469
Fiji	10		8		51		11	
Annual income	6674	2556	13867	3881	5473	1933	13327	5642
Annual household income	14285	9458	23176	11786	12305	7215	21986	7668
Annual per capita household income	2488	1576	6201	3205	2794	1728	6257	3987
Samoa	12		8		27		3	
Annual income	5330	3207	18529	5641	6380	4443	27255	5561
Annual household income	10818	5569	26540	14104	12832	7028	30569	7521
Annual per capita household income	2325	1867	6530	3404	2334	1508	9392	6226
Tonga	11		15		18		0	
Annual income	12790	7854	29334	44273	5614	2195	-	-
Annual household income	27609	31046	42048	50101	11778	6539	-	-
Annual per capita household income	5474	6257	10517	10552	2074	1091	-	-

* All income data are in Australian dollars

Conclusion: To the Islands

> My time overseas has made me more open-minded to new ideas and changes…and just about life in general (quoted in Maron 2001, 79).

At no time during the past quarter of a century has there been substantial return migration to Pacific island states, despite the centrality of an ideology of return. Return has been greatest where distances have been less and economic opportunities greater, and consequently, least in more remote islands and regions (Connell 2009). Limited return migration is at least partly due to the significant differences in income levels between the island states and the metropolitan periphery, but also to a host of social and economic factors.

Those who have moved back to the Pacific from overseas stressed that the factors that resulted in their return migration (other than, or alongside, bonding) included climate, safety and the relaxed pace of life, or simply the familiarity

of the home country and the presence of kin, where discrimination was less likely to be a problem—indicating how crucial social, political and economic stability is to return migration. However, they were unlikely to mention economic reasons for return. Few migrants returned because of conditions in the health sector or any great desire to return to work there. Where health workers returned to Pacific island states because of perceived economic benefits—such as the ability to open a store—these lay outside the health care system, which became, for some, mere supplementary employment. Returning workers within the health sector, though willing to contribute to the sector, were likely to resent the nepotism they found (which was quite different from the meritocracy of metropolitan states and hindered promotion and innovation), alongside a range of other problems, and stay for a relatively short period of time. Many migrants find return difficult, facing lower wages and standards of living, difficulty in establishing businesses and, simply, culture shock. Their success and their return were sometimes resented, both in the workplace (where they sought to make changes and introduce new ideas, etc.) and in local society (Maron and Connell 2008). The returnees had changed but, less obviously, so too had their homeland.

The skills drain is likely to continue, especially where there have been structural reforms that reduce public sector employment, where wages and salaries remain unequal, working conditions are difficult and hierarchical, international recruitment intensifies and many kin are overseas. For the health sector, the emigration of skilled workers has been widely seen as the most dramatic and significant example of the 'brain drain' from the Pacific islands, yet many do return. While relative numbers indicate that a considerable skills drain constitutes an imbalance, return migration is greater than might have been expected, where a general 'myth of return' has been suggested and where almost all migration from the Pacific island states has been of settlers rather than contract workers. While numbers may be small, their impact is significant for both social and economic development, in terms of gains to health services (through new skills and wider experience, and simply, additional labour) and to the economy for their (partial) investment of overseas-generated incomes. Most health workers who have returned have gained substantially in enhanced skills and experience overseas. Moreover, most have retained considerable local knowledge, education and expertise and are therefore in a position to integrate their new skills into the health system in a culturally sensitive manner (though this may not always be easy). Yet many are dissatisfied (for example, with the pace of life, hierarchical structures and their own inability to implement change), and return migration may be simply a stage in a cycle of continued migration, especially in the smaller states, where opportunities are relatively few and promotion prospects poor. Return migration, particularly of skilled workers, is therefore more problematic than for most other returnees.

On balance then, even for those who have established businesses or returned to good jobs, returning tends to be a social rather than an economic phenomenon. Indeed, given that many migrants return to look after relatives and thus may not have returned at times of their own choosing, their success is the more remarkable. Return migrants may be potential 'agents of change' but conformity is usually more appreciated than change.

> More commonly, it is return migration that slowly changes islands but, wherever and however it occurs, and especially on the smallest islands, migration and change incite resentment, envy, tension and new perceptions of identity (Connell and King 1999, 18).

Return results in some degree of confusion and uncertainty about roles and identities, enhanced by the expectations placed on returnees by individuals and social institutions, their own recognition that they had changed, and their inability to meet others' expectations. Ambivalence is at the core of the Pacific 'culture of migration', where skills must be acquired overseas but dependent families remain at home. In a sense, Pacific islanders are similar to the Miskito Indians of Nicaragua who have been described as 'leaving in order to stay' and for whom migration has become a 'way of maintaining the family by leaving the family; and it is also a means of going away without leaving' (Nietschmann 1979, 20, 22). This is no less true of skilled migrants and emphasises how migrants are seemingly forever caught between two or more worlds as they strive to support their extended households while on journeys that are never complete in a transnational world.

References

Beston, J. and R. Beston. 1977. An interview with Albert Wendt. *World literature written in English* 16: 152–59.

Brown, R.1997. Estimating remittance functions for Pacific Island migrants. *World Development* 25 (4): 613–26

Brown, R. and J. Connell. 1993. The global flea-market: Migration, remittances and the informal economy in Tonga. *Development and Change* 24: 611–47.

—. 2004. The migration of doctors and nurses from South Pacific Island Nations. *Social Science and Medicine* 58: 2193–210.

Connell, J. 2004. The migration of skilled health professionals: From the Pacific Islands to the World. *Asian and Pacific Migration Journal* 13: 155–77.

—. 2007. At the end of the world. Holding on to health workers in Niue. *Asian and Pacific Migration Journal* 16: 179–98.

—. 2008a. Niue: Embracing a culture of migration. *Journal of Ethnic and Migration Studies* 34: 1021-1040.

—. 2008b. Towards a global health 'care' system. In *The International Migration of Health Workers*, ed. J. Connell, 1–29. New York and London: Routledge.

—. 2009. Bittersweet home? The return migration of health workers in Polynesia. In *Return migration of the next generations: twenty-first century transnational mobility*, ed. D. Conway and R. Potter. Ashgate: Aldershot.

Connell, J and R. Brown. 2004. The remittances of migrant Tongan and Samoan nurses in Australia. *Human Resources for Health* 2 (2): 1–21.

Connell, J. and R. King. 1999. Island migration in a changing world. In *Small worlds, global lives: Islands and migration*, ed. J. Connell and R. King, 1–26. London: Pinter.

Conway, D., R. Potter, and J. Phillips. 2005. The experience of return: Caribbean return migrants. In *The experience of return migration: Caribbean perspectives*, ed. R. Potter, D. Conway, and J. Phillips, 1–25. Aldershot: Ashgate.

Gmelch, G. 1992. *Double passage: The lives of Caribbean migrants abroad and back home*. Ann Arbor: University of Michigan Press.

Hooker, K. and J. Varcoe. 1999. Migration and the Cook Islands. In *Strategies for sustainable development*, ed. J. Overton and R. Scheyvens, 91–9. Sydney: UNSW Press.

Kingma, M. 2006. *Nurses on the move. Migration and the global health care economy*. Ithaca: Cornell University Press.

Liki, A. 2001. Moving and rootedness: The paradox of the brain drain among Samoan professionals. *Asia Pacific Population Journal* 16 (1): 67–84.

Macpherson, C. 1985. Public and private views of home: Will Western Samoan migrants return? *Pacific Viewpoint* 26: 242–62.

Marcus, G. E. 1981. Power on the extreme periphery: The perspective of Tongan elites in the modern world system. *Pacific Viewpoint* 22: 48–64.

Maron, N. 2001. *Return to Nukunuku. Identity culture and return migration in Tonga*. BA Honours thesis, University of Sydney.

Maron, N. and J. Connell. 2008. Back to Nukunuku: Employment, identity and return migration in Tonga. *Asia Pacific Viewpoint* 49: 168-184.

Naidu, L. 1997. *Contemporary professional emigration from Fiji*. MA thesis, University of the South Pacific, Suva.

Nietschmann, B. 1979. Ecological change, inflation and migration in the far western Caribbean. *Geographical Review* 69: 1–24.

Rallu, J.-L. 1997. *Population, migration, développement dans le Pacifique Sud*. Paris: UNESCO.

Rotem, A. and M. Bailey. 1999. Health personnel migration within Commonwealth countries in the Pacific region. Mimeo. Sydney: University of New South Wales.

Thomas-Hope, E. 1999. Return migration to Jamaica and its development potential. *International Migration* 37: 183–207.

Voigt-Graf, C. 2003. Fijian teachers on the move: Causes, implications and policies. *Asia Pacific Viewpoint* 44: 163–74.

Voigt-Graf, C., R. Iredale, and S. Khoo. 2007. Teaching at home or overseas: Teacher migration from Fiji and the Cook Islands. *Asian and Pacific Migration Journal* 16: 199–224.

ENDNOTES

[1] This and all other quotations are from health workers in the three Pacific island states unless otherwise stated.