

## Chapter 12 Migration, globalization and health

### CASE STUDIES

#### Case study: migration of doctors and nurses from Ghana to the UK

Mensah and colleagues<sup>33</sup> have reviewed the migration of health service personnel from Ghana to the UK. Since the 1970s over 50 per cent of all doctors trained in Ghana have subsequently emigrated to elsewhere. In 2004 there were 293 Ghana-trained physicians and 1021 nurses working in the UK. Those health professionals that have migrated have done so in search of higher income, better working conditions, and new qualifications. Many of the nurses have been actively recruited by UK nursing agencies to work in the private sector. While many Ghanaian medical migrants do benefit financially from the move, and are able to send remittances back home, there are often negative consequences for them. These can include high living costs, strains on family relationships, and unpleasant experiences in the workplace, such as racism, abuse, bullying, undervaluing of skills, and lower pay rates. On a national level, this medical migration can also have serious effects, undermining the entire health-care system back in Ghana. Globalization has blurred the boundaries between the UK and Ghanaian medical systems,

leading them to become increasingly integrated with one another – but as migration is largely one-way, it is to the detriment of Ghana. They point out that although 'health care professionals who have migrated to work in the UK were trained in Ghana at Ghanaian public and private expense: the benefits of that training are being experienced elsewhere'. It is the UK National Health Service that is 'using resources it has not created through investment, to the benefit of its users'. Many of these resources come from poorer countries that have supplied the UK with migrant doctors and nurses. They estimate that it currently costs about £220 000 to train a doctor in the UK and £37 500 to train a nurse, so that this migration would imply a saving to Britain in training costs of about £65 million from the employment of Ghanaian doctors, and £38 million from the employment of Ghanaian nurses. Thus the savings to the UK are enormous and, in effect, a poor country is now subsidizing a rich one (but without being compensated for this). The authors see this as an example of aid in reverse, and that 'the subsidy is perverse and unjust, because it worsens the existing inequity in access to health care at a global level'.

#### Case study: Indian Ayurveda practitioners in Germany

Frank and Stollberg<sup>40</sup> studied the reasons for the growth and popularity of Indian Ayurvedic medicine in Germany since the 1980s. There are currently nine Ayurvedic health centres in the country, and approximately 100 medical doctors and 25 *Heilpraktikers* (non-medically qualified healers) who practice it, mostly within the Maharishi Mahesh Yogi organization. This rise partly results from Germany's long tradition of non-orthodox medicine, including naturopathy and homoeopathy (invented by a German physician, Samuel Hahnemann), and the relatively liberal attitude of the authorities. However, most patients in the study were drawn to Ayurveda mainly by their negative view of biomedicine, and its medications, especially their side-effects and limited efficacy. Most patients were recommended to a particular practitioner by close friends or relatives, but once they had consulted them they became 'converted' to Ayurveda. They generally had a positive experience of its gentle approach, pulse diagnosis (an 'utterly convincing, slightly magical experience'), special massages (*panchakarma*), nutritional advice and 'natural' plant-based medicines. They also liked its longer consultations (30–60 minutes), and its more personalised approach

that focused more on their individual needs, feelings and lifestyles than their biomedical physicians ever did. Overall, they saw Ayurveda as more 'natural' than medicine, and as 'strengthening' the body rather than just treating its diseases.

The authors suggest that Ayurvedic notions of 'purifying' or 'cleansing' the body (by dieting or massage) make sense to these patients, is because they resonate with traditional German ideas of *Entschlackung* or 'purification' – ideas that have been prominent since about 1900, and the beginnings of the natural healing movement (*Naturheilkundebewegung*). Despite this, they still chose biomedicine for medical emergencies, acute illness and surgical conditions. 'You should have a healthy mixture of natural medicine and biomedicine', one person said.

Ayurveda in Germany, however, is different from Ayurveda in India. In adapting to German needs and outlook, it has dropped some of its more drastic treatments such as violent purging. Thus, this process of adaptation to local forms ('glocalisation') means that such foreign healing systems 'do not cross geographic boundaries without being changed', and local cultural conditions always ensure that 'transcontinental diffusion involves transformation and hybridisation'.

### Case study: effects of migration on blood pressure

Cassell<sup>49</sup> in 1975 reviewed the research done on the effects of migration on blood pressure. In one study, the blood pressure of black migrants from the Southern USA to Chicago was compared with that of Chicago-born blacks. It was found that the longer the period of city life, the higher was their blood pressure. In another study, the blood pressures of inhabitants of the Cape Verde Islands (off West Africa) were compared with those of Cape Verdeans who had migrated to the eastern USA. The immigrants showed higher pressures at each age, and a sharper difference between young and old than did the islanders. Other studies showed higher rates of hypertension among Irish immigrants to the USA (32 per cent) when compared with their brothers living in Ireland

(21 per cent). In Cassell's view,<sup>49</sup> the findings of these studies are unlikely to result from genetic differences between those who emigrate and those who stay behind, but possibly may result from genetic differences in the susceptibility to environmental influences among individual migrants. These influences include physical factors such as caloric intake, physical activity and salt intake, and the absence of certain parasites and diseases in the host country that, in the country of origin, usually cause wasting, anaemia and a fall in blood pressure. However, psychosocial factors also play a part, particularly the disappearance of a coherent value system and its replacement by different values and different situations, where the migrant's traditional way of coping with life is no longer effective.

### Case study: mental illness among immigrants in Manchester, UK

Carpenter and Brockington<sup>65</sup> in 1980 examined the incidence of mental illness among Asian, West Indian and African immigrants living in Manchester. It was found that the migrant populations had about twice the first admission rate to mental hospitals that British-born subjects had, especially those

migrants aged 35–44 years, and also Asian women. Schizophrenia was particularly common among the immigrants, especially with delusions of persecution, a phenomenon noted in many other studies of migrants. The authors hypothesized that 'social and lingual isolation... insecurity and the attitudes of the milieu are the explanations for the development of persecutory delusions'.

### Case study: psychiatric admissions to hospitals of foreign-born people in Bradford, UK

Hitch and Rack<sup>66</sup> in 1980 studied the rates of first admission to psychiatric hospitals in Bradford, and found that foreign-born people had substantially rates of higher mental illness than British-born people. The rates of psychiatric breakdown of a sample of Polish and Russian refugees in Bradford were measured 25 years after they had settled in the UK. While both had higher rates of mental illness (especially schizophrenia and paranoia) than the UK-born population, the Poles had a higher rate than the Russians. The most vulnerable group was the Polish females. The authors suggest that the difference between the immigrant groups was due partly to minimal cohesion among the Poles, and also to a strong sense of national, ethnic identity among the

Russians (many of whom were Ukrainians). This ethnic social support not only afforded protection against environmental stress, it also bestowed identity, though the Russians appeared to have maintained this identity more than the Poles. Many years after migration, though, both immigrant groups were especially vulnerable to first-time mental illness. The authors suggested that 'the combination of wartime experiences and culture shock may have been met with adequate coping mechanisms, but nevertheless rendered the personality vulnerable to later stress'. In middle age, when children have moved away from home and spouses or relatives have died, an immigrant who still speaks broken English and has no English friends will become particularly vulnerable to environmental stressors, with the consequent danger of mental or physical illness.

### Case study: attempted suicide among immigrants in Birmingham, UK

Burke, in three studies published in 1976, examined the rate of attempted suicide among Irish,<sup>67</sup> Asian<sup>68</sup> and West Indian<sup>51</sup> immigrants in Birmingham. His findings indicate that immigrants have a higher rate of attempted suicide than the populations in

their countries of origin, and this applies particularly to female immigrants. In Birmingham, those born in Northern Ireland or the Irish Republic had about a 30 per cent higher rate than the native population (as measured in Edinburgh), and higher rates than both Belfast and Dublin. Other indices of stress, such as the rates of alcoholism, drug addiction or mental illness, were also

raised in this immigrant group. Asian immigrants (from India, Pakistan and Bangladesh) had a lower rate of attempted suicide than the native-born population, but their rate was higher than that of their countries of origin, especially among females. Burke points out that language difficulties for women may play a major part in this, since Asian men have usually migrated several years earlier, and have had a greater opportunity to learn the language and familiarize themselves with English culture. Female immigrants are often expected to remain at home, and there is also some culture conflict for younger Asian women and girls between the values of home and those of school or workplace.

Among West Indians, too, attempted suicide was less common than in the native-born population, but West Indian women had a higher rate than women in the Caribbean; that is, the 'stresses that follow immigration and contribute to attempted suicide are more likely to affect women than men'. Part of the stress on young West Indians arises from the insecurity of low paid jobs, fear of not being able to cope financially and emotionally, housing difficulties, and the absence of the extended family in an urban setting. All of these 'may effectively reduce the tolerance of immigrants in withstanding these stresses'.

### Case study: suicide levels among immigrants in England and Wales

Raleigh and Balarajan<sup>69</sup> in 1992 analysed national suicide rates among 17 immigrant groups in England and Wales for the years 1979–83. Using mortality data on male and female immigrants aged 20–69 years, they found that many immigrant groups, especially Poles, Russians, French, Germans, South Africans, Scots and Irish, had much higher rates of suicide than the native population of England and Wales. The rates among Scottish and Irish immigrants aged between 20 years and 29 years were particularly high. Other groups, such as migrants from the Caribbean, the Indian subcontinent, Italy, Spain and Portugal, had much lower rates than the national

average. However, when the suicide rates of these various communities were compared with those of their countries of origin, they were found to be very similar. This was particularly true of male immigrants, but less true of females, especially from Ireland and Poland. The authors thus concluded that, as suicide levels in the immigrant groups differed less from levels in their home countries than from levels in England and Wales, 'the findings do not suggest that migration increases the risk of suicide'. Although they agreed that 'the economic and social changes associated with migration can often be stressful', they suggested that 'reaction to such stress is conditioned by the social and cultural attitudes inculcated in the country of origin'.