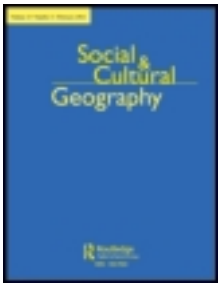

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Care work, migration and citizenship: international nurses in the UK

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Care work, migration and citizenship: international nurses in the UK

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Recent debates about nursing shortages in the Global North are part of a broader global nursing workforce crisis. Western governments have been increasing their recruitment of international nurses to fill their shortages, but this accelerates the global migration of nurses. The UK is a key node in global nurse migration. The increase in international nurse migration has profound consequences for both the sending and receiving countries, as well as implications for the health care system, and, of course, the individual nurses. In this paper, we explore recent trends in the UK's dependence on foreign-trained nurses. We use 1994–2012 data from the national register of nurses to track the admission of international nurses to the register and the countries they arrive from. During the early 2000s, there was an uptick of nurses from the Global South (notably several sub-Saharan countries, India and more recently the Philippines) and relative decline in traditional sources countries such as Australia and New Zealand. We draw on feminist care ethics to highlight the ways in which foreign-trained migrant nurses working in the UK are de-valued despite the UK's dependence on their labour and suggest rethinking citizenship in ways that are more clearly inclusive of care.

Key words: nurses, care work, migration, care ethics, citizenship, globalization.

> Nurses have become a highly sought after commodity. And like other commodities, the supply often goes to the highest bidder. National borders have become almost irrelevant as countries compete for nurses—even if they come from the other side of the globe. (Nelson 2004: 1743)

Roxanne Nelson, writing in *The Lancet* labelled the UK as a 'nurse poacher' because like many other Global North countries, the UK has turned to international nurses to staff hospitals, nursing homes and other health care workplaces. Often framed as a response to a nursing shortage, this is a part of larger trend towards a global health care economy marked by the international migration of health care professionals (Kingma 2006). One way to address the shortfall is to recruit nurses trained

abroad. Given its historical economic and political ties, the UK has looked to recruit nurses from sub-Saharan Africa and India, and more recently the Philippines. We pay particular attention to nurses coming from sub-Saharan Africa because of the ethical dilemma of recruiting nurses from regions that desperately need more health care professionals to address their own health care crises.

In this article, we analyse the migration of nurses in the context of transnational care work. By focusing on nurses, we move away from the usual focus on domestic workers in the care work literature to focus on trained professional care workers. Nurses have long worked both inside and outside of the privacy of the home in jobs supported and regulated by the state, providing care for strangers, communities and nations (Dingwell, Rafferty, and Webster 1988). This is our entry point into the debates on the commodification of care. We draw on scholarship about transnational care work to address the implications of importing foreign-trained nurses. Positioning international nurses as care workers follows Kofman and Raghuram's (2006, 2010) argument that many migrant care workers are skilled workers, broadening the focus of the debates beyond low-skilled work and work in the home (also see Yeates 2012). We begin with an overview of the themes in the literature that inform our argument. Then we turn to an analysis of the UK's register of nurses maintained by the Nursing and Midwifery Council (NMC) and trace the extent of nurse migration into the UK, identifying the source countries and flagging concerns about 'importing' nurses, especially from low-income countries into wealthy countries such as the UK. Nurse migration challenges ideas about citizenship—especially in the sense of belonging, and we explore that through a feminist ethics of care framework. The relational ontology of feminist care ethics means that we are each enmeshed in networks of care relations that have and continue to enable us to thrive. Using care ethics as our guide, we argue that the reliance on international nurses raises questions about the valuation of paid care work and also signals not only the interdependence of people, but of countries too.

Care work and international migration

As more women across the globe enter paid employment, gender analysis has become pivotal in understanding the interconnections and complexities of international migration (Kofman and Raghuram 2006, 2010). Global nurse migration is an important element in understanding the feminization of migration, since globally the majority of nurses are women (Kingma 2006). A sizable amount of literature has focused on paid care workers, a central theme for feminist scholars for some time. Initially care was understood as unremunerated activities occurring in the family home, but subsequently, given the tremendous expansion and commodification of care work, much recent attention has focused on paid care work occurring in a variety of settings. Increasingly, myriad carers are practicing paid care work in numerous sorts of private and public spaces. The expansion, redistribution and in many instances, marketisation of care work—particularly for the young, elderly and sick—involves the monetisation of care as care provision becomes waged work paid for either through government programmes or the commercial sector (Lister 2003). As a range of care services have become marketised, nurses provide a long-standing example of commodified care in the sense that they are paid to care for sick patients (who are usually

strangers in need of a time-limited intervention) and are often hailed as the pre-eminent caring profession (Dingwell, Rafferty, and Webster 1988). And in a context of publicly funded health care systems, nurses are an important part of health care as a public good and social citizenship right.

Much scholarship on transnational care workers addresses the experiences of migrant domestic workers and how the commodification of care in a 'private' domestic setting can increase exploitative conditions and conflicts around, for instance, what counts as 'overtime' (Cox 2006; Lutz 2008). However, as Kofman and Raghuram (2006: 297) point out, research into paid care work should:

> challenge the emerging orthodoxy of a simplistic representation of migrant women from the Third World as being almost exclusively incorporated into First World households... the presence of skilled women in global migrant streams (challenges) the dominant narratives for understanding women's place in contemporary global political economy.

In particular, they identify the international migration of nurses as contributing to that challenge. In a similar vein, Yeates (2009, 2012) argues that the concept of 'global care chains' should be expanded beyond the home and domestic workers to include other sorts of commodified social reproduction, especially nurses, and sites of paid care work beyond the home. She notes that '(n)urses capture global care chains involving more skilled care labour, working in health institutions involving public and private (commercial/corporate) agencies, provision and interests' (Yeates 2009: 176).

Thus, the migration of nurses offers a different view of the globalization of care work. First, as trained, professional workers nurses represent *skilled* migration. Second, unlike domestic workers, they are credentialed and are governed through professional bodies (such as the UK's NMC). To practice in the UK, all nurses are required to register with the NMC. Third, although some nurses do work in domestic settings, the majority of nurses are based in institutional settings, in hospitals and nursing homes (be they publicly funded or commercial). Fourth, nurses also have a much stronger position under labour law than domestic workers (who have curtailed judicial rights and limited coverage).[1] For instance, the UK Code of Practice (Department of Health 2012) states '(i)nternational healthcare professionals legally recruited from overseas to work in the UK are protected by relevant UK employment law in the same way as all other employees.' Nurses are visibly contributing to the care of others in the public sphere and public sector, unlike domestic workers whose care is individualized and usually hidden in private homes. They are, as Yeates argues 'the public face of transnationalising care (work) including the existence of looped circuits of connection from richer countries to poorer ones' (2012: 244).

Expanding the usual analytic category of care workers to include skilled care workers like nurses makes care visible and its necessity for individual *and* collective well-being evident. Reminding us that 'skill' is a contested concept, McNeil-Walsh (2008: 143) in her work on the migration of South African nurses to the UK, notes:

> Although skill operates on an individual level (the nurse) and embodies subjective and objective meaning, nursing skill is also important to society as a whole. The very nature of nursing, a profession that embodies a 'duty to care,' means that those skills are valued on a societal level and considered to be crucial to a society's well-being and ability to operate.

McNeil-Walsh makes this comment in relation to the ability of the governments of sending countries (like South Africa) to provide adequate health care for their citizens. But the importance of nursing skill to 'society's well-being and ability to operate' applies to the destination country too. The latter, however, is engaging in policy decisions that result in the active recruitment of international nurses as a means of 'solving' its care crisis, which potentially depletes the former of their nurses.

Kofman and Raghuram comment that 'the crisis in nursing and recourse to foreign nurses in many parts of the First World has meant that nursing now operates in a truly global labour market' (2006: 293). The migration of Global South-trained nurses increased substantially in the 1980s and 1990s amidst neoliberal economic policies in the West that cut funding to nurse education and health care provision (Kingma 2006). These cuts deepened the nurse shortage in many countries, particularly the UK and the USA, by limiting places in nurse-training programmes and making nursing a more demanding job. Burnout rates increased, and when coupled with stagnating pay and increased patient loads, the profession lost some of its appeal for 'home-grown' nurses (Kingma 2006).

The UK, the USA, Ireland and Canada have been significant players in global migration of nurses. Nurse migration patterns tend to follow paths of historical economic and colonial relationships (Aiken et al. 2004; Williams 2010). As Williams (2010: 388) notes: 'New migration paths superimpose themselves upon older colonial relationships, where, for example, Ethiopians go to Italy, Indian and African workers to the UK and South American workers to Spain.' Thus, the UK draws heavily on nurses from India, the Caribbean and sub-Saharan Africa (Hardill and MacDonald 2000; Ross, Polsky, and Sochalski 2005).

Nurses migrate for a range of reasons. They commonly cite better pay, but also the chance to travel, new learning and professional development opportunities and better working conditions. Remittance opportunities are important too, because they pay school fees, housing and household expenses of families 'back at home' (Connell 2008; Dovlo 2007; Likupe 2006; Smith et al. 2007). At the same time, poor health care infrastructures in many sub-Saharan African countries, including low wages and high workloads, along with the HIV/AIDS crisis and national economic instabilities, make emigrating more attractive (Aboderin 2007; Aiken et al. 2004; Dovlo 2007; Hardill and MacDonald 2000; McNeill-Walsh 2008; Ogilvie et al. 2007).

Our analysis echoes other research that shows how reliant the UK has been on Commonwealth countries to supply nurses to stem periodic nursing shortages. Of particular concern is the number of nurses coming from former colonies in sub-Saharan Africa, especially in the early 2000s. The post-colonial ties between the UK and the key sub-Saharan African nations ease the 'extraction' of nurses because their entwined history means nurses are already English-speakers and, at least historically, were part of special work permit schemes and immigration rules (McNeill-Walsh 2008; Ogilvie et al. 2007). As Yeates (2012: 245) points out 'care migration entails the extraction of resources from poorer countries and their transfer to richer ones. Deprived of human care labour these extractive processes export to poorer countries social problems created by rich countries' underinvestment in public care services'.

International nurses in the UK

In the late 1990s, the new National Health Service (NHS) Plan introduced under Tony Blair's Labour government (1997–2007) put in place plans and funding to rapidly expand the NHS workforce. Some funding went into increasing training opportunities for domestic student nurses. However, between 1998 and 2005, there was also an explicit and coordinated policy, especially in England, to ramp up the international recruitment of nurses. Indications are that over the last 15 years or so, the proportion of the UK's health care workers who are international has increased. Using Work Permits UK data, Salt and Millar (2006) found that the proportion of work permits issued to health care workers rose substantially after 1995, rising from 7.5 per cent to 22.5 per cent in 2000 and another rise to 26 per cent in 2005 (and most of these permits went to nurses and carers).

However, up-to-date statistics on the proportion of all nurses who were born outside the UK are surprisingly scarce. Yar, Dix, and Bajekal (2006) use 2001 Census data for England and Wales to show how dependent the health care system is on workers born overseas (given that it is Census data, it covers the NHS and private sector nurses). They found that one in six nurses (16 per cent) was born outside the UK, compared with 9 per cent of foreign-born workers in all sectors of the economy, and that nurses were much more likely to come from countries in Africa and Asia. And the 2007 Crisp Report indicated that according to the UK NHS data by 2005, 10 per cent of the NHS nurses had been trained abroad. While the NMC data we use are only available for the UK as a whole, the spatial distribution of nurses within the UK is uneven, international nurses are over-represented in England (which engaged in more active international recruitment in the first part of the 2000s; RCN 2009). For instance, Batata (2005) found that in 2004 the UK's foreign-trained nurses were concentrated in Greater London (24 per cent) with another 16 per cent in the south-east (compared with 11 per cent and 13 per cent, respectively, of UK-trained nurses).

A frequent theme in the literature is that there are inadequate data to track the international flows of nurses, the number of international nurses in individual countries and what jobs they hold. This makes effective monitoring of migration and workforce planning difficult. Kingma (2006: 130) observes that given repeated concerns about brain drain and nurse shortages 'one might expect that governments would have introduced effective data collection mechanisms over the last 30 years. Most have, however, lacked the political will to finance the establishment of effective information systems.' Perhaps then, it is not surprising that there is no data source that indicates both the total number of international nurses in the UK *and* the countries they arrived from. However, national registers of nurses can give a clue to the trends. In the UK, the NMC regulates nurses and keeps an annual register of nurses, midwives and community nurses able to practice in the UK.

Although it is difficult to track how many foreign-trained nurses work in the UK, at least their initial entry into the system is captured by the NMC data. The 'initial admissions' to the register includes information on the country of origin of those admitted in the previous year (to 31st March each year).[2] Figure 1 is based on these data: over this near 20-year period 128,200 international nurses were added to the NMC Register, representing 27.5 per cent of all new registrants. Figure 1 shows a distinct uptick in the numbers of international nurses

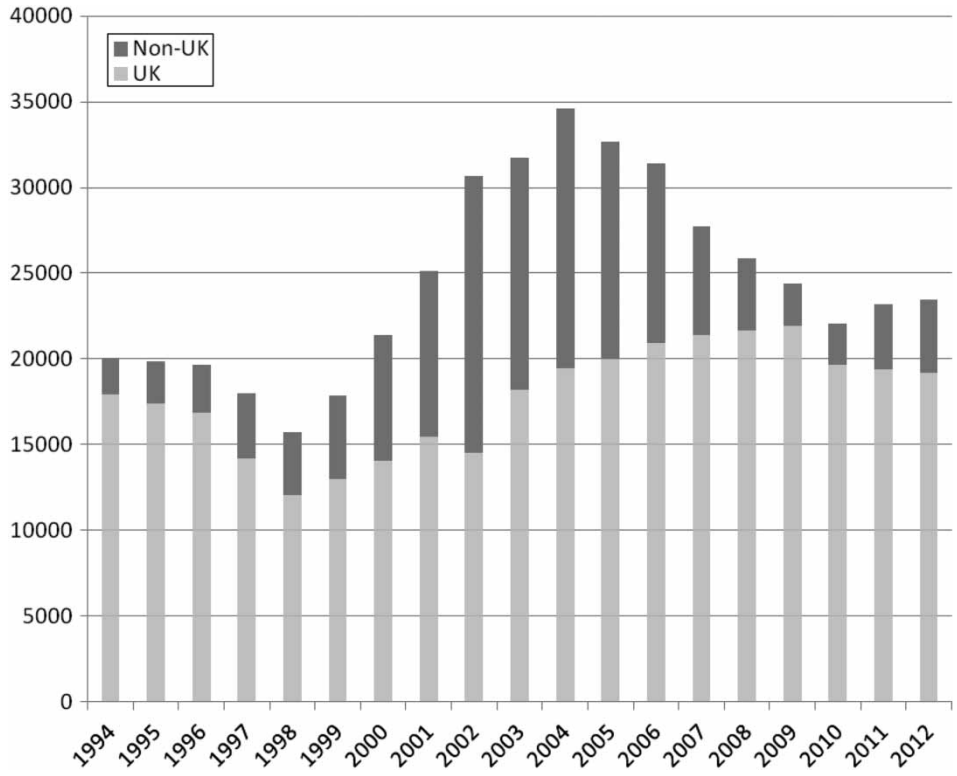

Figure 1 Admissions to the NMC Register from the UK and non-UK countries, 1994–2012. *Source*: NMC data, various years.

compared with 'home-grown' nurses accepted into the Register from the late 1990s to the mid-2000s, aligning with the Blair NHS Plan. In the 7-year period from 1999 to 2006, while overall 43 per cent of those 128,200 new registrants were added, that further broke down into 63 per cent of all the international new additions versus 34 per cent from the UK. Moreover, in some individual years the proportion of new registrants who were non-UK nationals was especially high: 52 per cent in 2002, 43 per cent in 2003 and 44 per cent in 2004.

Detailed information about the countries international nurses came from is only available from 1999 on. Figure 2 shows the break down between those coming from the EU/EEA[3] versus those coming from elsewhere (described by the NMC as 'overseas', a distinction we adopt in this article). The 'quick fix' of importing nurses is starkly evident, as is the drop-off after the mid-2000s. However, the numbers have risen again in the last couple of years, prompting some to ask if this is the start of another 'upsurge in international nurses' (RCN 2012: 13). Figure 2 also indicates that overseas nurses comprise the overwhelming majority of international nurses, but that in recent years those from the EU/EEA have been absolutely and relatively more noticeable (also see Table 1). While the number of all foreign-trained nurses currently

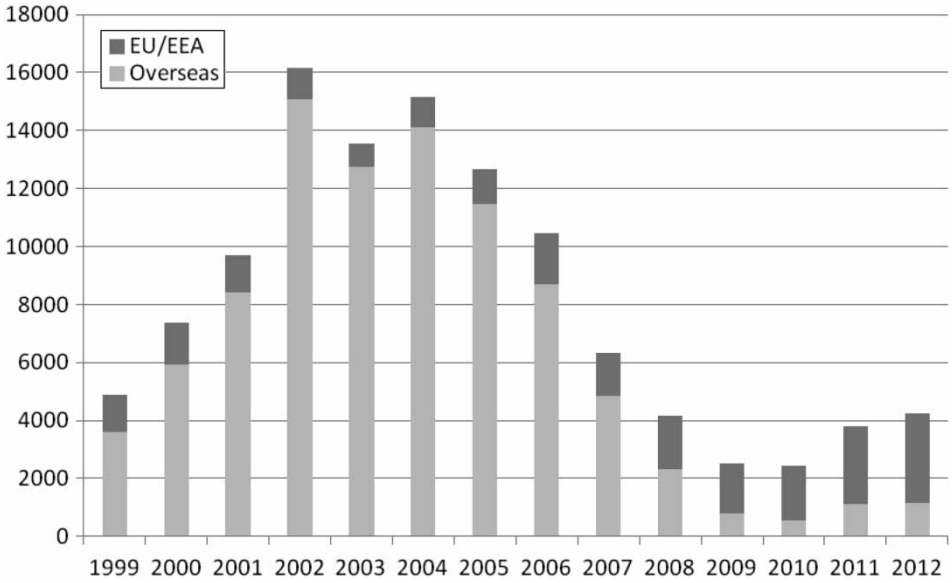

Figure 2 EU/EEA and 'Overseas' Nurses admitted to the NMC, 1999–2012.
Source: NMC data, various years.

in the UK (regardless of their arrival date) is not available, many of those who arrived in the 2000s (and before) are likely still employed in the UK health care system. Thus, the recent increase in new admissions of EU/EEA nurses does not diminish the importance of considering the situation of overseas nurses who still make up a significant portion of the UK's nurse workforce.

Other research indicates that during the 1990s, most overseas arrivals were from Australia, New Zealand, South Africa, the Caribbean and Canada (Bach 2003; Hardill and MacDonald 2000). That trend is reflected in the 1999 NMC data (bottom part of Table 1) which indicates that 37 per cent of all the new overseas registrants that year were from Australia, 16.5 per cent from South Africa, 14.6 per cent from New Zealand, 6 per cent from the Caribbean and 5.4 per cent from Canada (under 'Other countries')—thus eight out of ten came from just these five regions alone. Table 1 (top part) shows that whereas one in ten of all new registrants in 1999 were from Australia and New Zealand, after that point the per cent fell steadily and by 2012 the figure was only 1 in 100 (the Caribbean and Canada saw a similar drop-off). Starting in 2000 increasing numbers of new registrants came from Global South countries, including numerous sub-Saharan African countries: South Africa, Nigeria, Zimbabwe and Ghana (although not listed separately on Table 1, notable numbers also came from Zambia). Of the international nurses added to the Register between 1999 and 2008, 24.5 per cent were from sub-Saharan Africa. Fully 11 per cent came from South Africa alone. Also significant is that during the 2000s, the Philippines and India moved up to the top two countries for new overseas registrants: between 1999 and 2012, 30.6 per cent of overseas nurses from the Philippines were added to the Register, 19.5 per cent came from India and about 11

Table 1 Source countries for admissions to the NMC Register, 1999–2012

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
UK, total (%)	72.6	65.5	61.4	47.4	57.4	56.2	61.2	66.9	77.2	83.8	89.7	88.9	83.6	81.8
EU, total (%)	7.1	6.7	5.2	3.6	2.5	3	3.7	5.6	5.4	7.2	7.0	8.5	11.5	13.3
Overseas, total (%)	20.3	27.8	33.4	49.1	40.1	40.8	35.1	27.6	17.4	8.9	3.3	2.6	4.9	4.9
Sub-Saharan Africa	5.1	9.6	9.0	12.3	9.6	10.5	8.0	4.6	2.2	1.5	0.5	0.2	0.1	0.2
South Africa	3.4	6.8	4.3	6.9	4.3	4.9	2.9	1.2	0.1	0.1	0.1	0.1	0.0	0.0
Nigeria	1.0	1.0	1.4	1.4	1.6	1.5	1.4	1.2	0.9	0.6	0.2	0.1	0.0	0.1
Zimbabwe	0.3	1.0	1.5	1.5	1.5	1.1	1.0	0.5	0.3	0.2	0.1	0.0	0.0	0.0
Ghana	0.2	0.3	0.6	0.6	0.8	1.0	0.8	0.5	0.2	0.1	0.0	0.0	0.0	0.0
Australia	7.5	5.6	4.2	4.4	2.9	3.8	3.0	2.4	1.1	1.0	0.6	0.7	1.0	0.8
Philippines	0.3	4.9	13.5	23.6	17.6	12.5	7.7	4.9	2.4	1.0	0.4	0.6	2.0	1.5
New Zealand	2.9	2.2	1.6	1.4	0.9	1.0	0.9	0.7	0.3	0.2	0.2	0.2	0.3	0.2
Caribbean	1.2	2.0	1.0	0.8	0.7	1.1	1.1	0.6	0.0	0.0	0.0	0.0	0.0	0.0
India	0.2	0.4	1.1	3.2	5.8	8.9	11.3	11.3	8.8	3.9	0.9	0.3	1.0	1.7
Other countries	3.0	3.0	3.0	3.3	2.7	2.9	3.1	3.0	2.7	1.3	0.6	0.4	0.5	0.5
Overseas (%)	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Sub-Saharan Africa	25.3	34.7	27	25.2	24.0	25.8	22.9	16.3	12.7	16.8	16.6	9.7	2.6	3.9
South Africa	16.5	24.6	12.9	14	10.7	12	8.1	4.4	0.8	1.4	2.0	2.6	1.0	0.7
Nigeria	4.9	3.5	4.1	2.9	4.0	3.6	4.1	4.4	5.3	6.7	6.7	3.0	0.4	1.6
Zimbabwe	1.4	3.7	4.5	3.1	3.8	2.8	2.7	1.9	1.9	2.1	2.2	1.2	0.3	0.4
Ghana	1.1	1.2	1.7	1.3	2.0	2.5	2.4	1.8	1.4	1.6	1.1	0.2	0.2	0.6
Australia	36.9	20.3	12.4	8.9	7.2	9.4	8.5	8.7	6.2	11.3	19.6	28.0	20.5	16.3
Philippines	1.4	17.7	40.4	48	43.9	30.7	22	17.9	13.9	10.8	11.4	23.5	41.7	30.2
New Zealand	14.6	7.8	4.7	2.9	2.2	2.5	2.5	2.5	1.5	2.7	5.7	9.2	5.2	4.7
Caribbean	6.1	7.1	3.1	1.6	1.6	2.8	3.1	2.3	0.0	0.1	0.2	0.5	0.3	0.4
India	0.8	1.6	3.4	6.6	14.4	21.8	32.2	41.2	50.4	44.2	28.3	12.3	20.1	33.9
Other countries	14.9	10.8	8.9	6.7	6.6	7.1	8.9	11.1	15.2	14.1	18.2	16.8	9.7	10.6

Source: NMC data, various years.

per cent each from Australia and South Africa (see Ball 2004; Buchan 2008 for a discussion of the Philippines, and Raghuram 2009 on India). While the NMC data are not ideal as a data source, they do echo other data analysis. For example, Salt and Millar (2006) pooled work permit data for 2000–2004, and found that of permits for the health and social welfare associate professionals (most of whom are nurses) the vast majority came from India (32 per cent), the Philippines (17.6 per cent), South Africa (8.0 per cent) and Nigeria (3.9 per cent).

Table 1 also shows that the proportion of new registrants from the UK began to increase markedly after the mid-2000s, reaching almost 90 per cent in 2010. At the same time the EU/EEA numbers began to increase, while the overseas numbers fell. The expansion of the European Union means that increasing numbers of nurses come from the EU accession states (and so now have the right to 'freedom of movement'), and have registered with the NMC in the last few years (Nursing Times 2012). But there are also suggestions of active recruitment by some NHS Trusts from long-standing EU counties with high unemployment such as Spain and Portugal (Howie 2011).

The relative (and absolute) decline in overseas nurses being added to the NMC Register since the mid-2000s likely reflects a series of interconnected policies decisions at geographically different scales. As both nurses and immigrants in the UK, they are regulated by a professional body (the NMC) and the state, and, increasingly, international agreements and multilateral organizations. Starting in 2005, the NMC introduced additional requirements aimed at overseas nurses (i.e. from outside the EU/EEA). The NMC's Overseas Nurses Program introduced in 2005 requires a mandatory '20 days of protected learning time (which everyone must undertake), plus where appropriate, a period of supervised practice' (NMC 2008: 16). The 'protected learning' is intended to provide time for the adaptation of a nurse's skills to the UK's health care system and to safeguard patient safety. The additional 'period of supervised practice' (usually 3–6 months) is aimed at a nurse whose educational and practice experience does not adequately match the UK requirements for entry to the Register. In 2007, the NMC also introduced more stringent English language requirements for overseas nurses who are now required to reach a score of 7 (out of a possible 9) on the International English Language Test System before the NMC will accept their application (NMC 2008). At the government level, in 2006, the Home Office removed many lower grade nursing and general nursing occupations from the Skills Shortage Occupation list for work permits and subsequent changes now restrict the list to specialist nurses for operating theatres, operating departments and neonatal intensive care units (www.ukba.homeoffice.gov.uk). In addition, the 2008 shift to a points-based immigration system and the new 2012 work permit immigration rules further impact employers' abilities to recruit overseas nurses (RCN 2012: 13).

The expansion of the NHS workforce under Blair was also, of course, a period when the depth of the poverty and health crises in many sub-Saharan African countries became more apparent. It became clear that such countries lacked the funding and health care workers to move towards effectively and efficiently dealing with their own care crisis (Aiken et al. 2004). When paired with the incentives for nurses to migrate, the global nursing labour market/shortage sets up a perfect storm for perpetuating global inequalities in health care systems. With increased attention on these

conditions, the 'traditional' recruitment of sub-Saharan African nurses became politically unpopular. For instance, *The Observer* claimed there were more Malawian nurses in the UK than in Malawi (Renton 2007). Media portrayals of nurse 'poaching' and appeals from, for example, the South African and Ghanaian governments to the UK to stop recruiting their nurses underscored the practice as ethically questionable (Nelson 2004). In 1999, perhaps in an effort to counter such concerns, the Department of Health established guidelines that the NHS was not to directly target South Africa and the Caribbean for recruitment (Department of Health 1999). This was further strengthened in 2001 with the Code of Practice around the direct recruiting of nurses and was updated in 2004 (Aiken et al. 2004; Buchan 2008; Department of Health 2004, 2012).

However, as our analysis of the NMC Register shows, nurses were still coming from poor countries during this period. A 2005 article in *The Lancet* (Bevan 2005) based on evidence from South African Department of Health officials declared 'Britain accused of ignoring nurse recruitment ban' by circumventing the ban though the use of private recruitment agencies rather than the NHS directly recruiting nurses. In 2008, another piece in *The Lancet* provocatively asked: 'Should active recruitment of health workers from sub-Saharan Africa be viewed as a crime?' pointing to a variety of statistics including that '(i)n Malawi, for example, there has been a 12 per cent reduction in available nurses due to migration. In 2000, roughly 500 nurses left Ghana, double the total number of nursing graduates for that same year' (Mills et al. 2008: 685).

In 2010, the NHS realigned its Code once again, this time to fit with the global code of practice introduced by the World Health Organization that year. Employers are not to actively recruit from a specific list of about 150 Global South countries, unless there is an acceptable working agreement between the two governments, of which there were only a few (they include India and the Philippines). Now any recruiting agency (the NHS has an approved list of them) that supplies nurses to the NHS must adhere to the Code (Department of Health 2012). The Code covers some, but not all private sector employers and does not prevent other commercial recruitment agencies from targeting Global South countries (including those on 'the list'), nor are individual nurses prevented from migrating to the UK and then seeking work, and some hired by, for instance, private nursing homes may later move to work for the NHS.

At the same time, a central goal of international agreements and codes of practice, including the World Health Organization's Code on the International Recruitment of Health Personnel, is that health care professionals should be allowed to receive additional training and experience in the Global North and then return to their home countries to share that knowledge and expertise. However it is unclear to what extent that happens. Thus, it can be safely assumed that a goodly number of overseas nurses, including the many from sub-Saharan Africa who joined the register over the last 15 years or so, remain in the UK. Presumably this contributes to why the NHS and the Department of Health from time to time introduce policies aimed at accommodating a multicultural workforce with the goal of creating more inclusive workplaces.

Care work, citizenship and care ethics

Overseas nurses make up a significant portion of the UK's nursing population and their

presence raises questions about these nurses' work experience and sense of belonging once they are in the UK. Oftentimes, international nurses find their skills being devalued (both economically and culturally). In numerous studies conducted with international nurses (and specifically those from the sub-Saharan African countries) in the NHS and, especially, the private sector, nurses frequently talked of feeling underappreciated, experiencing deskilling and downward mobility in their jobs and social standing (see Aboderin 2007; Batnitzky and McDowell 2011; Likupe 2006; O'Brien 2007; Smith et al. 2007). Employers and the registration process exacerbate this by not allowing nurses to use their skills by placing them in jobs that do not match their skill-set or placing and keeping them at rankings much lower than their education, training and experience would suggest (Batnitzky and McDowell 2011; O'Brien 2007; Smith et al. 2007). Moreover, white international nurses were more likely to be given higher rankings than black African nurses. Devaluing both the qualifications they have earned and the care they perform can lead, almost inevitably, to a deskilling of previously highly skilled nurses (McNeil-Walsh 2008; O'Brien 2007).

The lack of adequate respect and recognition that international nurses receive for their knowledge, experience and skills suggests that they are not adequately valued for their work, which, after all sustains society and (daily) life. Contradictions abound in this situation. Not only are these nurses skilled professionals recruited from areas of the world that desperately need them too, but they come to provide public care services—labour which supports society and subsidizes social welfare provision (Kofman and Raghuram 2006, 2010; Yeates 2012). Although their professional qualifications set them apart from some other groups of transnational care workers, they are still disadvantaged by their locations in webs of power relations. As Widding Isaksen (2010: 15) points out:

> Unlike domestic workers, professional nurses and other care workers in welfare institutions have access to social citizenship and their own trade unions, and they are protected by labour laws. Their problems are related to discriminatory practices, differences in the acceptance of qualifications, and gender and ethnic hierarchies in welfare institutions.

Widding Isaksen's point is that nurses work in the public sector and are represented by professional bodies and unions, meaning they have fuller coverage in terms of formal citizenship (i.e. legal/judicial membership of nation-states through which rights can be claimed). But as she implies, citizenship is a multifaceted concept, thus the same person or group might be privileged in some aspects of citizenship, but not others (Lister 2007; Staeheli 2011).

Along dimensions other than formal citizenship—particularly the social practices, discourses and social identities that people engage with daily as they enact citizenship—international nurses may experience marginalization. These everyday acts of citizenship, sometimes described as substantive or ordinary citizenship (Lister 2003, 2007; Staeheli 2011), are associated with a sense of membership in and belonging to a community. To belong necessitates recognition by other members. International nurses' day-to-day experiences and their sense of belonging (ordinary citizenship) do not always match up with their expectations as they face issues of institutional and inter-personal discrimination and racism. For example, black African migrant nurses face discrimination and exploitation in everyday

practices, with discrimination both overt and covert, including blatant racism, xenophobia and deliberate strategies to exclude them (Alexis, Vydelingum, and Robbins 2007; McGregor 2007; Smith et al. 2007). Sometimes this is manifested as being passed over for promotion. When they actually do receive promotions, international nurses often have trouble asserting authority over nurses who have been discriminatory or exclusionary in the past (Smith et al. 2007). Another theme in international nurses' experiences is invisibility, partially as a result of their talents being overlooked, but also as a form of discrimination itself. For instance, some co-workers ignore their opinions and expertise when expressed; sometimes supervisors talk to other nurses about their patients instead of addressing them directly. Added to which patients' families may go around nurses of colour and those with accented English to find information from white British nurses (Alexis, Vydelingum, and Robbins 2007; Batnitzky and McDowell 2011; McNeil-Walsh 2008; Smith et al. 2007).

In the face of the ongoing globalizing health care economy, a more expansive understanding of citizenship would involve greater valuing of not only care practices but also the range of people providing that care. Drawing on her well-known formulations of care ethics as practice and politics, Tronto (2008: 199) offers a 'modest proposal' that engaging in activities of care is an act of citizenship. She remarks that:

> Citizenship reflects values. Western societies do not now, and never have, adequately valued care. Focussing on citizenship requires us to think about the most fundamental aspect of defining who is a member of a political community. It is a key way to begin to reframe the meaning of care as a public issue and to reopen the public debate about the nature of our responsibility towards others, both within our own society and around the globe.

Several points flow from Tronto's statement. Even as care work becomes marketised and commodified, and in the case of nurses, professionalised, it still gets marked by the 'stigma' of care and surrounded by discourses of devaluation. Scholarship on care argues that the market finds difficulty placing an accurate value on care work, as efficiency and profits are favoured over quality, compassion and relationships (Green and Lawson 2011). Thus, in a purely economic accounting frame, the transnational migration of nurses to the UK serves to lower the costs of social welfare expenditures. Their migration brings in a supply of 'ready-made' nurses, with the added benefit of externalising the costs of training to outside the UK. As a recent Royal College of Nursing (2011: 14) report put it

> (t)he attraction of international recruitment is obvious—it is a quick and cheap fix. The nurses have already been trained, so are available in weeks rather than years, and their training costs have been met by another government, or by the nurses themselves. (RCN 2011: 14)

Care then has become a pivotal category in the political and social policy arenas. Kofman and Raghuram (2010: 50) argue '(f)eminists have pushed care to the centre of social policy, pointing out both the invisibility and the universality of care (as ethic) and the importance of women in care provision around the globe.' Care ethics are based on *interdependence* as the basis of human interaction; this in turn problematizes neoliberal economised notions of independence, rationality, autonomy and individual self-sufficiency. The relational ontology of feminist care ethics means that as Tronto (2008) has it,

care should be seen as fundamental to human life. Thus, she urges us to think about the broader dimensions and practices of care in social, political and work life. Given the stronger presence of the welfare state in Europe compared with the American context that Tronto addresses, Sevenhuijsen (1998) reformulates citizenship to be more inclusive of caring needs and care work, bringing care into public debates. Similarly Williams (2011) makes the case for a public, democratic ethics of care based on care as concrete practices and as shaping the political values that underwrite social policy formation.

Recruiting international nurses to supplement the inadequate supply of 'home-grown' nurses exacerbates the care crises in those sending countries with their own astronomical health problems. Some argue that worsening health outcomes in poorer countries and widening global health inequalities are directly linked to nurse migration (Yeates 2012). Care ethics in this situation places in tension the health care needs of people in the UK against those in the countries that nurses migrate from. If, as Tronto and others implore, the significance of care in our lives is taken more seriously, including a more inclusive citizenship based on recognition and responsibility, the interdependence and the power relations undergirding care arrangements would be more apparent and thus less easily dismissed. Care ethics draw attention to the far-reaching consequences of policy decisions in the UK (e.g. the active recruitment of overseas nurses) for a web of interconnected people across the globe: the nurses, the patients in the UK hospitals, the patients in the 'source' countries and the families of these three groups, as well as various governments, employers and recruiting agencies and the UK-born colleagues of the international nurses (Williams 2011; Yeates 2012). Nurse migration makes visible the interwoven geographies of connection and interdependence between the UK and less wealthy Global South countries. Those geographies are based on and even further exacerbate global inequalities and asymmetrical geopolitical power relations.

Conclusion

Care ethics focus on interdependence and demonstrate how people *and* nations operate in socio-spatially embedded relational contexts. Even in its diminished form, the social welfare state nods to this spirit, providing and regulating collective services intended to meet basic social citizenship needs. Nurses are central to that provision. As paid care workers, they perform important, life-sustaining labour that is essential for social and economic systems to function. Nurses' location in public sector jobs makes apparent that care is a collective concern. We have explored the trends in international nurse migration to the UK and argued that many foreign-trained nurses experience discrimination in a combination of overt, covert and systemic ways that lead us to question the ways in which commodified care is valued.

Although recruiting international nurses may seem like a quick fix for the UK nursing shortage, it raises a whole range of additional ethical, political and policy issues; thus there are profound consequences resulting from the recruitment of international nurses. As our analysis of the NMC Register demonstrates, a sizable per cent of nurses in the UK are internationally trained and their presence demonstrates the health care system's dependence on them. Even with the recent decline in international nurses being added to the Register, the UK has a diverse (foreign-trained) nurse population, which reinforces the need

for understanding their experiences and finding ways to address problems, discrimination and human rights violations in the workplace. Feminist care ethics help to highlight and challenge these concerns by alerting us to the power inequalities in the care relation and prompting us to conceptualize activities and the consequences of particular choices in relational ways. Reading social policy through care ethics shifts the focus away from the cost-efficiencies-only goal of an economistic interpretation towards an ethics of interdependence, compassion and connection. At the same time, taking on board the consequences of the global interdependence of care bring new challenges as well as opportunities for refashioning social justice.

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Notes

1. In February 2012, the Home Office introduced restrictions to the Overseas Domestic Worker visas, including removing their right to change employers, their right to permanent settlement after 5 years and greatly limiting the possibility of having their dependents accompany them (www.ukba.homeoffice.gov.uk)
2. Summary statistics about the register are available to the public; the most recent report is for March 2008, we obtained the newer data from the NMC by filing a Freedom of Information request. The data by country of origin are only available at the national level.
3. As of 2012, the EEA consists of the EU and its 27 member states, the three EFTA states (Iceland, Liechtenstein and Norway) and Switzerland. Citizens of these countries have the right to work in the UK without first getting permission from the UK Border Agency.

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Abstract translations

Le travail de soins, la migration, et la citoyenneté: Infirmier/ères internationaux/ales dans le RU

Des débats récents portant sur le déficit d'infirmier/-ères qualifié(e)s dans le nord planétaire font partie d'une crise plus large des effectifs de la profession d'infirmier/ère. Des gouvernements occidentaux ont augmenté leurs recrutements des infirmier/ères internationaux/ales pour pouvoir ces pénuries, mais cela fait accélérer la migration globale des infirmier/ères. Le Royaume-Uni est un nœud-clé dans la migration globale des infirmier/ères. L'augmentation du niveau de la migration internationale des infirmier/ères a à la fois de graves conséquences pour les pays envoyeurs et les pays récipients, ainsi que des implications pour le système de santé et, bien sûr, pour les infirmier/ères individuel(le)s. Dans cet article nous examinons des tendances récentes dans la dépendance du RU des infirmier/ères formé(e)s à l'étranger. Nous utilisons des données provenant du registre national des infirmier/ères de 1994 à 2012 pour suivre l'admission des infirmier/ères internationaux/ales au registre et leurs pays de provenance. Aux années 2000s il y avait une légère hausse en provenance du sud planétaire (surtout des pays subsahariens, de l'Inde, et plus récemment des Philippines) et une basse relative en provenance des pays qui servent traditionnellement de sources d'infirmier/ères comme l'Australie et la Nouvelle-Zélande. Nous faisons usage de l'éthique de care féministe pour souligner les façons dans lesquelles les infirmier/ères formé(e)s à l'étranger qui travaillent au RU se trouvent dévalué(e)s en dépit de la dépendance du RU de leur travail et nous suggérons donc une reconsidération de la citoyenneté en termes qui inclurent de façon explicite le care.

Mots-clefs: infirmier/èrestravail du soinsmigrationéthique de carecitoyennetémondialisation.

Trabajo de Cuidado, Migración y Ciudadanía: Enfermeros Internacionales en el Reino Unido

Lo debates recientes acerca de la escasez de enfermeros en el Norte Global se enmarcan dentro de una crisis en la fuerza de trabajo en el sector de la

enfermería a nivel global. En respuesta a la escasez, los gobiernos de occidente han incrementado el reclutamiento de enfermeros extranjeros, acelerando su migración global. El Reino Unido es un nodo central en dicha migración. El incremento de la misma tiene profundas consecuencias tanto para los países emisores como para los receptores, así como también para los sistemas de salud, y por supuesto, para los propias enfermeros. En este artículo nos proponemos explorar las tendencias recientes en lo que respecta a la dependencia que el Reino Unido tiene de las enfermeros formados en el extranjero. Usamos los datos del registro nacional de enfermeros correspondiente a los años 1994-2012 a fin de rastrear la admisión de los enfermeros internacionales al registro, así como sus países de procedencia. Desde los inicios del 2000, ha habido un aumento en el número de enfermeros del Sur Global (en especial de aquellos procedentes de los países subsaharianos, de India y más recientemente, de Filipinas) mientras que el número proveniente de Australia y Nueva Zelanda, países tradicionalmente proveedores, ha relativamente declinado. Nos basamos en un enfoque feminista de la ética del cuidado para resaltar las formas en los que las migrantes enfermeros entrenados fuera del Reino Unido, pero que trabajan en ese país, son desvalorizados a pesar de la dependencia que el país tiene de su trabajo. Asimismo, proponemos repensar la ciudadanía de forma que sea más inclusiva del trabajo de cuidado.

Palabras claves: enfermeras/ostrabajo de cuidadomigraciónética del cuidadociudadaníaglobalización.