# 1 Introduction: The Global Mobility of Healthcare Workers

## 1.1 Introduction

Health professionals are one of the key labour market sectors open to international transfer. The number of immigrant doctors and nurses working in Organisation for Economic Co-operation and Development (OECD) nations has increased 60 per cent between 2005 and 2015, from 1.1 million to 1.8 million (World Health Organization; WHO 2017a). Nursing in particular presents one occupational group where skilled labour exit is evident (Kingma 2006). Indeed, the opportunities for overseas migration are often one of the main reasons candidates enter the nursing profession in the first place (Walton-Roberts et al. 2017a). These workers generally seek a better life for themselves and their families, and in the process of their migration, they contribute to an ongoing differentiation of the healthcare delivery map by concentrating human health resources in core economies. Structural processes determine the variable conditions of work in different places (conditions of work, investments in health systems, the status and rights of health workers), and this frames health workers' migration decisions. This section introduces the issue of health worker migration. Beginning from a historical perspective, we see how the legacy of colonialism is evident in the geographies of migration pathways and the hierarchies embedded within healthcare occupations and systems. We consider new geographies and temporalities of health worker migration that reveal the increasingly complex processes that frame the global distribution and circulation of health workers today. We then consider how health worker migration became a global social policy issue of concern for multilateral institutions such as the International Labour Organization (ILO), the World Health Organization (WHO) and the United Nations (UN). Multilateral interventions have resulted in the landmark 2010 WHO Global Code of Practice on the international recruitment of health personnel.[1] This voluntary code aims to establish and promote principles and practices for the ethical international recruitment of health workers and to facilitate the strengthening of health systems (WHO 2010a). We explore these efforts at governing health worker migration. This section closes by considering some of the wider system issues health worker mobility raises, including how it relates to the promotion of universal health coverage (UHC) and how it is embedded in the sustainable development goals (SDGs), humanities' aspirational goals for a better world in 2030.[2]

[1] www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf.
[2] https://sdgs.un.org/goals.

## 1.2 Origins, Growth and Significance of Global Health Worker Migration

Florence Nightingale is considered the mother of modern nursing. Her life and legacy are instructive for our interests since they represent two enduring features relevant to the global migration of nurses and other healthcare workers, the lasting influence of colonial geographies and hierarchies and the denial and misrepresentation of women's intellectual contributions to healthcare delivery and leadership. Nightingale's career reflects Britain's colonial and military history, and recognition of her prodigious contribution to nursing, and social policy more generally, remains eclipsed by sexist reviews of her work (cf Hogan 2020). As Lynn McDonald (2010), the editor of a sixteen-volume collection[3] of Nightingale's works has argued, Nightingale has earned the fame but not the respect that she deserves. The legacy of Nightingale aligns with the global mobility of nurses; both are features of the modern age. The colonial origins and extensive mobility of Nightingale's nursing career echo today in the reality that gaining a nursing credential is akin to acquiring a "passport" for emigration (Connell 2014). Such mobility and gender representation remain prominent in the contemporary era, in that over 80 per cent of nurses are women and the share of immigrants in the nursing workforce in OECD nations ranges from 5 per cent in France to 25 per cent in New Zealand.[4] Alongside increasing numbers of migrant health workers, the spatial and temporal patterns of health worker mobility have diversified. This mobility, in all its complexity, unsettles notions of *national* health systems, in no small part due to the international composition of the health workforce.

Nightingale's legacy continues to be intensely debated because of her support for British empire and colonialism, and her paternalist and racist views of Indigenous communities. In 2020 an article in *Nursing New Zealand* argued that continuing to venerate Nightingale was "disrespectful and painful" and that "Raising her as the beacon for nursing globally causes trauma and re-ignites the history and pain of colonialism" (Brookes & Nuku 2020, p. 35). Engaging a deeper understanding of colonialism is therefore central to contemporary analysis of this phenomenon. Critical engagement with what can be called the "colonial remnant" (Kwete et al. 2022), contextualizes not just health worker migration, but global health itself: "Decolonization as a process is still an unfinished agenda in today's world and global health is a mere reflection of this fact" (Kwete et al. 2022, p. 2). Kwete et al. (2022) suggest systematic

[3] www.wlupress.wlu.ca/Series/C/Collected-Works-of-Florence-Nightingale.
[4] https://migrationdataportal.org/themes/migration-data-relevant-covid-19-pandemic.

attempts to recognize these colonial remnants in global health need to occur at three levels, that of practices, the institutional/organizational and at the policy level. This section offers a review of some of these colonial remnants.

### 1.2.1 Geographies of Health Worker Migration

The development of healthcare systems was core to the "civilizing" mission of colonial expansion, as well as central to the success of military campaigns (Arnold 1993). War necessitated care for military personnel, and nursing personnel and medical science approaches spread with colonial military and missionary activities. British colonialism saw the spread of allopathic curative health and nursing traditions from the British Isles to colonial outposts such as India, resulting in outcomes marked by medical pluralism representing both colonial authority and Indigenous resistance (Bala 2012), to the benign neglect and reproduction of the poor status of nursing (Healey 2010). In the process, social hierarchies and understandings of healthcare traditions were transplanted into societies with their own specific cultural norms and histories of care. Nursing traditions fanned out from the core of colonial empire in the late 1800s and by the early 1900s, the United Kingdom (UK) and the United States of America (USA) had become active in promoting a certain vision of nursing professionalization that reflected hierarchies of race, nationality, gender and religion. The vision of nursing professionalization promoted in the UK quickly spread to the "colonies" of Canada, Australia, New Zealand, Ireland and then beyond.

The post-World War II (WW II) period saw the flow of nursing labour reverse away from arrival in the colonies to one that drew labour out of the colonies to be stratified into the health systems of high-income states. Starting with the formation of the National Health Service (NHS) in the UK, this public health system relied on the incorporation of medical and nursing professionals trained in South Asia, the Caribbean and African states. Trained through the "benevolence" of the civilizing mission, colonial systems reversed the movement of health workers during the post- WW II period to the enormous benefit of high-income nations. The launch of the NHS resulted in a massive expansion of demand for the inclusion of health workers from the edge of Empire into the British National Health System. This integration, however, remained marked by hierarchies, reflecting a stratified and segmented process organized by those in power in the core. For example, nurses trained in the colonies were positioned as lower ranked than British nurses, and this became concretized through training regulations and hierarchies that articulated with citizenship differences. Rafferty and Solano (2007) detail the creation of the Colonial Nursing Service,

which directed British nurses to various parts of the Empire. They identify how in the post-1945 period the directional flow of this chain reversed as the needs of the UK's NHS exceeded the domestic supply of nurses. Controlled through the UK's 1943 Nurses' Act, the creation of the "nurse assistant" position placed foreign-trained nurses in subservient positions vis-à-vis British trained nurses. Colonialism, therefore, created and reinforced a relationship of inequality both at home and overseas for nurses trained in the colonies, but later drawn into the UK. Immigrant physicians who were trained in South Asia, Africa and the Caribbean and found employment in the NHS were often concentrated in the sectors least favoured by UK citizens. This included general practice, especially beyond the metropolis, and geriatrics, a speciality that did not formally exist in the UK until marginalized immigrant doctors developed it through their ground-breaking work (Raghuram et al. 2011). In Canada, the rise of Medicare in the 1960s depended upon the incorporation of foreign-trained health professionals, and by 1984 one-third of all doctors in Canada were immigrants (Mullally & Wright 2020).

In the 1960s, rapid economic development and expanding opportunities for women meant that the traditional work of nursing was increasingly less attractive. As health systems expanded, demand for nursing personnel exceeded domestic supply and drove countries such as the USA and Germany to seek workers from Asia. Education and training contributions from core nations, initially offered as philanthropy and development assistance, now emerged as a labour market primer that created a surplus to feed into the core nations to service their healthcare needs. The USA called upon neocolonial linkages to draw in nurses whose training they had helped to forge through Rockefeller Foundation investments. Catherine Choy (2003) has documented how the USA's active role in promoting nursing education in the Philippines eventually created a perpetual source of care labour that the USA drew upon for its own demands. During this time international agencies of the UN and ILO became attentive to the growing significance of international medical migration, and how it intersected with the fields of development, education and health (Yeates & Pillinger 2019).

By the 1970s the pattern was generally cast in terms of the migratory routes of healthcare workers. Ex-colonies became the source from which core nations drew in trained health workers. The post-colonial period saw some newly independent nations participate in the provisioning function of this global supply system. Doctors, nurses and other health professionals from these lower-income countries were attracted to higher-income nations, the apex of which include the USA, and the UK in Anglophone circuits, and France and Portugal within the Francophone and Lusophone circuits. Growing settler colonies such

as Canada and Australia were also active participants, together with parts of Europe, including Germany, which recruited Korean nurses as guest workers, while portraying this as development assistance (Jung 2018). By the 1970s this process was increasingly cast as one of resource extraction from underdeveloped nations to high-income nations. Moreover, it was increasingly common for migrant health professionals to be stratified into lower positions in the occupational hierarchy in destination countries. Occupational and geographical stratification was, and remains, a common experience for immigrant healthcare professionals; working in poorer and less serviced communities (Reddy 2015), and in occupational sectors less attractive to domestically trained health workers (Raghuram et al. 2011).

In the Lusophone context, Angolan and Mozambican immigrants moved to Portugal in the late 1970s to escape civil conflict, and this included physicians who tended to be underutilized and employed below their skill level (Eaton 2003). Lusophone Africa (where the Portuguese language is spoken) includes Angola, Cape Verde, Guinea-Bissau, Mozambique, São Tomé, and Príncipe and, Equatorial Guinea. African regional migration agreements (including Portuguese-speaking nations) have increasingly focused on intra-regional mobility accords (including visa-free travel), but these have vacillated in response to economic decline and rising xenophobia (Adepoju 2001). Middle-class Brazilian immigrants to Portugal also benefitted from various twentieth-century reciprocal labour rights accords, yet by the1990s conflict over the recognition of Brazilian dentists' credentials working in Portugal resulted in profound diplomatic tension over non-reciprocity. This was eventually resolved with a specific dispensation requiring supplementary training for Brazilian dentists, a case that marked a "rupture in the paradigm of reciprocal treatment" but was "consistent with colonial disjunctures . . . " (Torresan 2021, p. 181). Francophone migration circuits include one between Quebec and France governed by The Quebec-France Agreement, which allows a person who has training and a permit to practice a regulated profession or trade in one partner territory, to have their skills recognized to be able to work in the other. Mutual recognition includes nurses, midwives, doctors, pharmacists and other allied health occupations.[5]

The 1970s also saw the emergence of Petro-states drawing in internationally trained health workers. After the Organisation of the Petroleum Exporting Countries increased oil prices, oil-producing states in the Middle East embarked on elaborate development agendas that included rapid expansion of their

[5] www.quebec.ca/emploi/reconnaissance-des-etudes-et-de-lexperience/faire-reconnaitre-son-experience/entente-quebec-france.

healthcare systems. Countries such as Saudi Arabia and United Arab Emirates (UAE) became new nodes in healthcare worker migration routes. Asian countries including India, Pakistan and the Philippines provided medical personnel to these expanding health systems, which relied on English as the working language, and thus these nodes became part of a wider Anglophone migration system (Percot 2006).

Considering this expanding circulation of health workers from lower- to higher-income nations, the brain drain argument became more intense into the 1990s, when Nelson Mandela berated the UK government for poaching South African nurses (Martineau et al. 2002).[6] As President of South Africa, he watched as the nation struggled with the AIDS epidemic and health workers fled to work in higher-income nations. The reality of lower-income nations using their resources to train health professionals, and then watching as they exited to plug the holes in high-income nations, was seen as unjust, immoral and a perverse subsidy (Mackintosh et al. 2006). However, the justification for global action on this matter was limited in the closing decades of the twentieth century, considering the prevailing neoliberal tendencies that shaped global relations from 1980s onwards. The power of markets and the hegemony of "free" trade to determine international relations had made the training and migration of healthcare workers just another form of goods and services embedded in the global economic system. In some cases, states engaged in excess training of health-care workers as a form of labour export. This tapped into the tendency for migrants to remit income to their families, thereby improving the balance of payments for low-income labour-sending nations. The epitome of this is the Philippines, as the nation sought to address its fiscal challenges from the1970s onwards through an explicit labour export policy, one where nurses formed a central group of deployed workers (Choy 2003; Rodriguez 2010). It was also understandable why so many health workers from lower-income nations embraced international migration, since relative conditions of work and pay are better in higher-income nations. For example, Indian healthcare workers can earn incomes anywhere between 20 and 90 per cent more than their home earnings, and more depending on their speciality and country of settlement (George & Rhodes 2017). However, this exchange can potentially hollow out public health systems resulting in the continued decline of employment conditions, which acts as a key migration driver in low-income economies. Structural adjustment programs (SAPs) imposed by multilateral institutions such as the World Bank also initiate this public disinvestment (Lewis 2006). Not only were high-income nations

[6] www.theguardian.com/society/2005/may/18/politics.publicservices.

extracting health resources in the form of trained workers but they were also contributing to perpetuating the conditions of exit driving this global migration system.

Patterns of health worker migration are evident in terms of the Global South to Global North flows. Traditional colonial relations frame some of these migration corridors, such as the movement of nurses from the Philippines to the USA, doctors from India, Pakistan and parts of Africa to the UK, nurses from the Caribbean to both the UK and USA, and dentists from Brazil to Portugal. Pacific Islanders are also plugged into networks with Australia and New Zealand. This traditional pattern of movement from the Global South to North has been in place for most of the latter part of the twentieth century, but more recently, the geography of healthcare worker migration is becoming more complex.

### *1.2.2 Changing Dynamics of Health Worker Mobility to the Middle East from Asia, and from Eastern and Central Europe to Western Europe*

The rise of the Petro-states in the post-1970s period created new lines of health worker mobility, including Global South to Western Asia networks, some of which reflect long-established trading networks. Emerging and lower-income nations have also entered the global trade in healthcare services by, among other things, seeking international standards accreditation to provide specialized quality health care at competitive prices relative to more developed and well-established markets (MacReady 2007). A lack of domestically trained professionals in emerging Gulf States necessitated the massive importation of international workers to staff health systems as domestic systems of training were being developed (Ennis & Walton-Roberts 2018). In Asia and the Middle East, this investment and the development of health systems "is, in effect, globalizing health care" (Crone 2008, p. 117). Such development has drawn heavily on India as a source for nurses (George 2005), as well as other South Asian countries such as Nepal (Adhikari 2019). Increased south–south migration across Africa is also evident (Crush et al. 2015). Consider that over one-fifth of medical graduates newly licensed to practice in Nigeria are internationally trained (half from Asia and half from Africa). Currently, the top sources for immigrant doctors in South Africa include Nigeria, the UK, Cuba and the Democratic Republic of the Congo. Also, in Trinidad and Tobago half of the doctors are foreign born and foreign trained (coming from India, Jamaica and Nigeria) (WHO 2017a). Within Europe the ascension of new Eastern European member states has seen an increase in the east-to-west movement, for example, nurses from Poland working in the UK. Internal north-to-north migration is also evident, in part as a response to ethical recruitment demands, but also reflecting

specific circuits of mobility, such as English language migration circuits including the UK, Ireland, Canada, New Zealand, Australia and the USA, and Francophone recruitment by Quebec in France and Belgium.[7]

Increasingly complex patterns of mobility are emerging not just in terms of geography, but also in terms of temporality and directionality. The range of intermediaries involved in the global mobility of health workers contributes to novel forms of temporary worker placements, for example as locums or highly specialized surgical teams contract hired to complete specific surgeries (Crush 2022). In the UK's NHS, the increase of agency work includes foreign-born workers, with 34 per cent of NHS agency staff being foreign-born compared to 17 per cent of non-agency staff (Hudson-Sharp et al. 2017). Of all South African doctors registered in Ireland, only 20 per cent report that they work *only* in Ireland, suggesting they work across multiple jurisdictions (WHO 2017a). We should also add to this complexity growing internationalized and privatized medical education. For example, Indian medical students train in China and Russia (Yang 2018), and Canadians and Americans train in the Caribbean (Morgan et al. 2017). Assessing the basic outlines of health worker mobility under these changing conditions disrupts the traditional assumptions of national state (public) funding of national health education systems and highlights the challenges emerging to the traditional Anglophone educational hierarchy. Such changes are connecting diverse regions of the world through increasingly globally orientated models of health training, skills development and professional mobility (Kingma 2006; Percot 2006; Walton-Roberts 2014, 2015c).

Health worker migration is propelled by the globalization and marketization of health care, which is itself a form of mobility in terms of ideas, ideologies and discourses (Levitt & Rajaram 2013). As corporate healthcare delivery systems expand geographically to lower-cost locations, we appear to be moving towards "flat medicine" for certain socio-economic classes who select their treatment options from a global landscape of health service integration (Crone 2008). Healthcare workers become one more factor that is sourced and "plugged in" to these emerging health service nodes. Health workers, whose international migration is spurred on by differences in opportunity between national systems, are now also increasingly distributed between public and private systems within national contexts. Internationally oriented health systems seek health professionals with international training, and the circulation of medical professionals between Global North and South health systems transmits both skills

[7] https://ici.radio-canada.ca/nouvelle/1771017/recrutement-infirmieres-preposes-etranger-sante-quebec.

(Hagander et al. 2013) and ideas about the role of markets in the health system (Levitt & Rajaram 2013).

### 1.2.3 Global Social Policy Governance on International Health Worker Recruitment and Migration

Throughout the 1960s UN agencies focused on the significance of training and education systems in the production of skilled workers vital for development, particularly health workers. While initially focused on supply at the national level, the issue of international "brain drain" became apparent when assessments of the supply of skilled heath workers had to address the reality of worker outflows due to international migration. By the 1960s, United Nations Educational, Scientific and Cultural Organisation (UNESCO) and the ILO were addressing the issue of "brain drain," and in 1966 UNESCO proposed a model of compensation between sending and receiving nations as one approach. This principle of compensation has remained, "influential, if contested, over the longer term" (Yeates & Pillinger 2019, p. 35). The growing international demands for healthcare workers resulted in lower-income states' health educational investments funding a global labour supply mechanism. By the early 1970s the term "brain drain" was commonly used to identify the extraction of highly trained professionals such as doctors and engineers. The inclusion of nursing into this debate through key reports by Mejia et al. (1979) feminized this social policy field and provided an important meeting ground for the ILO and WHO to monitor this practice (Yeates & Pillinger 2019, p. 62).

By the 1990s the acute global maldistribution of health workers was evident, together with the realization that more effective health system development was unattainable without addressing the right balance and distribution of health workers. For example, sub-Saharan Africa continued to export nurses overseas even as the region faced a shortfall of 60,000 nurses (Packer et al. 2009). As the 1990s progressed there was greater acknowledgment of, and demand for, policies that addressed the global imbalance of health workers. As global interest and acknowledgment of the gravity of this issue emerged, the WHO became actively involved in the creation of the second multilateral instrument focused specifically on health workers (after the ILO's 1977 nursing personnel convention), the WHO Global Code of Practice on the International Recruitment of Health Personnel (Yeates & Pillinger 2019).

Due to the uneven geographical distribution of health workers and the necessity of adequate numbers of health workers for sustainable health systems, signatories to the WHO Code agree to engage in ethical international recruitment of health personnel as part of strengthening health systems. Subsequently,

global health diplomacy was effective in the creation of a series of voluntary codes of conduct to discourage health worker migrant recruitment from countries experiencing crisis-level shortfalls in medical staffing (see Section 4 for more on codes). The WHO Global Code of Practice on the International Recruitment of Health Professionals (adopted in May 2010) is considered a landmark agreement that "suggests evolution in the capacity of the WHO Secretariat, Member States, and civil society to engage in global health 'law-making'" (Taylor & Dhillon 2011, p. 22).

One of the main motivations for voluntary codes is a desire for transnational social justice because the "brain drain" of health workers represents an inequitable distribution of training investments between sending and receiving regions. However, even in this area, the justice dimension of ethical codes is limited by the fact that in some cases out-migration is promoted by the sending state as a form of labour export policy (Rodriguez 2010). It is also difficult to characterize international migration as a problem when fiscally constrained health systems generate unemployed and underemployed health professionals in the source country (Lorenzo et al. 2007). Migration is also driven by families, and migrant social networks, and is often supported by the state for purposes of remittance generation, leading to the creation of a "migration culture" (Connell 2014). In such contexts, it may be difficult and impractical to curtail migration using voluntary codes.

Other types of mutual agreements accompany the globalization of health care, which is recursively spurred on by trade in health-related services under the World Trade Organization's General Agreement on Trade in Services (Smith et al. 2009). Regional economic and educational convergence processes (including bilateral agreements and Memoranda of Understanding (MOUs)) offer various approaches to expanding credential recognition regimes and promoting health worker mobility. We discuss regional bilateral agreements in more detail in Section 4.

## 1.3 System Issues

### *1.3.1 How Global Health Worker Migration Relates to the Goals of Universal Health Coverage*

Universal Health Coverage (UHC) aims to create a system of coverage so that, "all people have access to the health services they need, when and where they need them, without financial hardship."[8] UHC is a major undertaking considering the inverse care law, in that the availability of healthcare services varies

[8] www.who.int/health-topics/universal-health-coverage#tab=tab_1.