Abstract

This article examines the growth of overseas nurse recruitment to the UK and reviews a number of explanations used by migration specialists to explain these developments. It is argued that these approaches provide an incomplete explanation and that an industrial relations perspective enables an integrated understanding of nurse mobility. By highlighting the role of the state in source and destination countries and by placing labour market institutions centre stage, a more adequate account of nurse migration to the UK is developed. Trends in mobility indicate that state policy and employer behaviour have resulted in the internationalization rather than the globalization of the nursing labour market. This facilitates state action to regulate nurse migration, although the results to date using forms of soft regulation have been modest.

1. Introduction

In recent years, health sector employers have assigned a high priority to the recruitment of overseas-trained health professionals, especially nurses, to address recruitment and retention difficulties. Data from the Nursing and Midwifery Council (NMC) indicates that since the 1997 election, almost 80,000 overseas nurses have been admitted to the UK register, comprising approximately 45 per cent of new registrants, compared to 11 per cent in the early 1990s (NMC 2005a). Women migrants are an increasing component of migration flows and there is greater awareness that women are no longer confined to less-skilled sectors of the labour market (see Raghuram and Kofman 2004; Winkelmann-Gleed and Seeley 2005). Nursing is subject to professional regulation and is also one of the most prominent examples of gendered occupational segregation and it is therefore pertinent to assess trends in the employment of migrant nurses in the UK. This article addresses three questions.

First, how has labour mobility among nurses been theorized by migration specialists and can a more integrated account of nurse migration be
developed drawing on industrial relations (IR) scholarship that highlights the role of state regulation and labour market institutions? Second, what are the trends in nurse migration to the UK and how can these patterns of mobility be explained? Third, to what extent have forms of ‘soft regulation’, notably codes of practice on international recruitment, been effective measures in regulating the movement of nurses? It is argued that the distinctive patterns of nurse mobility highlight the limitations of existing equilibrium explanations and the shortcomings of those based on the globalization of labour markets. The role of the state and related labour market institutions have a crucial role in understanding patterns of migration among registered nurses which remain international rather than global.

This article reviews the current state of knowledge about nurse migration drawing on research commissioned by the ILO and the UN University World Institute for Development Economics Research (Bach 2003, 2006). It is based primarily on secondary sources such as registration data from the NMC, which is used to assess trends in nurse migration.

It is also informed by 18 interviews drawn from 12 key stakeholder organizations involved in nurse migration. Those informants were drawn from UK organizations, including the Department of Health (DH), National Health Service (NHS) employers (i.e. acute hospital trusts), trade unions and professional associations (i.e. Royal College of Nursing (RCN) and UNISON), and international organizations (ICN, ILO, IOM, PSI and WHO) with some key informants reinterviewed in 2006. Respondents were key policy makers who had a direct policy or managerial responsibility for international recruitment. In some organizations, discussions were held with more than one respondent; for example, in the DH, civil servants from the workforce and nursing divisions were interviewed. International respondents were interviewed by phone, while those based in the UK were interviewed face-to-face. In most cases, the interviews were recorded and fully transcribed, and typically lasted between 40 and 90 minutes. The semi-structured interview schedule included: (1) the role of the interviewees and their organization in international recruitment; (2) assessment of trends in nurse mobility; (3) explanations for these trends; (4) the effectiveness of codes of practice and bilateral agreements; and (5) the impact of soft regulation on international recruitment and working conditions. Those interviewed made available additional documentation, provided insights into the policy context, suggested practitioner conferences to attend, and assisted in shaping the analytical framework presented below.

2. Theories of international migration

The analysis of international migration is an eclectic field, fragmented by disciplinary boundaries and differing levels of analysis, resulting in little consensus about the causes and consequences of worker mobility (Massey et al. 1998: 17). Three distinct perspectives have been used to analyse the mobility of health professionals.
‘Equilibrium’ Approaches

Neoclassical economic analysis suggests that migration flows stem from the existence of geographical wage differentials which are governed by the law of supply and demand. Individuals seek to maximize their utility and undertake a form of cost–benefit analysis in terms of expected wage returns, taking account of the probability of obtaining a job (Todaro 1969: 139). Workers from labour-surplus, low-wage countries migrate to labour-scarce, high-wage countries to restore equilibrium and, at that point, migration should cease. This model assumes that migrants act rationally according to a logic of individual economic self-interest and that there are no barriers to mobility.

This neoclassical approach has been developed to consider the economic disparities between source and destination countries, which are often expressed as ‘push’ and ‘pull’ factors. Push factors correspond to influences on labour supply and the forces of expulsion which stimulate migration, while pull factors are equated with the demand for labour and direct attention to the factors that attract migrants to move to other countries. With its intuitive appeal that migration can be explained by the location and intensity of push–pull factors, particularly disparities in wage levels, the model has become the dominant framework for explaining international nurse mobility (e.g. Aiken et al. 2004: 71; Buchan et al. 2003: 9). Vujicic et al. (2004) tested the push–pull model for nurses and doctors. The results indicated very great disparities between wages for nurses and doctors in source and destination countries, but there was little correlation between the supply of healthcare migrants and the amount of the wage differential. Portes and Rumbaut (1990) point out that major labour flows often arise from countries at intermediate levels of development rather than the poorest countries, and migrants are not drawn from the poorest groups in society as is implied by the push–pull framework. This suggests that migrant behaviour is rooted in particular social contexts, but these attributes are suppressed when only economic differences are considered (Piore 1979: 8).

Consequently, the push–pull approach, by focusing on the economic calculations of individuals, renders invisible a number of actors and institutions. In particular, state regulation is integral to an analysis of contemporary migration because ‘the idea of individual migrants who make free choices . . . is so far from historical reality that it has little explanatory value’ (Castles and Miller 2003: 25). Finally, critics note that by viewing migrants as homogeneous, neoclassical analysis is impervious to the influence of gender and ethnicity (Parrenas 2005). It is this concern to expand the unit of analysis from the individual to the household and community that has been termed the ‘new economics of migration’.

The New Economics of Migration: Household and Network Approaches

The starting point of this approach is that migrant behaviour can only be understood in the context of larger units, typically the household, but
sometimes the community. Stark (1984) claims that it is the utility maximization of the household, rather than the individual, which explains migrant behaviour. Household decision making involves the allocation of different roles to individuals in order to diversify and attenuate risk and to ensure capital accumulation.

It is a short step to expand the frame of reference from the household to the network. The network is often characterized loosely as a web of relationships and acquaintances, not confined to immediate kin, which link potential migrants in source countries with existing migrants in destination countries. These networks provide potential migrants with information about employment opportunities, housing and visa requirements. The network is therefore conceived as an important mechanism for reducing the risks of migration and over time, as networks become embedded within destination countries, it enables community formation. Migration becomes self-sustaining as the network continues to replenish its labour supply, irrespective of the conditions that initiated migration (Massey et al. 1987).

The role of households and migration networks has been a less prominent feature of studies of nurse mobility, reflecting formal licensing requirements and opportunities associated with mobility of professional labour compared to the unskilled workers that Massey et al. (1987) studied. Nonetheless, decision making within households that encourages women to become nurses in order to gain employment abroad, spreading risk and bolstering household income, is noted in studies of Filipino nurses (Ball 2004: 125; RCN 2003a: 28).

The idea of the social network is important because it draws attention to migration as a collective social process, drawing in a broader range of actors than equilibrium theories. One concern, however, is that the idea of networks is drawn too narrowly, excluding the role of the state and employers in stimulating recruitment that fosters large-scale migration (Krissman 2005). Bringing in the capacity of the state to regulate the flow of migrants into a country also raises doubts about the assumption that migration becomes self-perpetuating, irrespective of the actions of nation states and employers. A second limitation is the assumption that networks are essentially benign with community links, ensuring that migrants are not exploited. This characterization ignores the increasingly pivotal role of recruitment agencies and brokers as well as the state that is seeking to benefit from migration (Goss and Lindquist 1995: 330). It also underplays divisions within communities and households.

A prominent feature of gendered accounts of migration, however, is the conflicting interests and patriarchal values within many households. Parrenas's (2005) study of migrant Filipino women highlights the hidden causes of migration. These include escaping from abusive relationships, the wish to avoid the demands and responsibilities of their families, but also the resentment of other women in the household left with additional caring, gender-defined, responsibilities (Parrenas 2005: 113–14).
Globalization

The current preoccupation with migration as a defining feature of globalization has its origins in the historical-structural tradition within migration studies. This approach suggests that migration arises from the insertion of countries into an international division of labour in which cheap labour from source countries is mobilized to advance the interests of employers in first world countries (Sassen 1988). For advocates of globalization, the integration of economic activity through markets, which transcends national boundaries, has intensified competition for capital and labour, and has resulted in the ‘age of migration’ (Castles and Miller 2003: 4). There is acknowledgement that globalization is not necessarily benign because it may bring detrimental consequences to labour, especially women, in poor countries. Consequently, ‘Citizens of poor countries . . . have a strong incentive to seek work in more fortunate parts of the world’ (Ehrenreich and Hochschild 2002: 8). This type of emphasis on the inevitability of more countries being drawn into the migration process, as globalization intensifies, is routinely used as an explanation for nurse migration. Van Eyck (2004: 10) surveyed 600 health professionals in 12 countries and argued that nurses are reluctant migrants whose ‘choices are shaped by the ways in which nation-states are integrated into the global economy’. Poor working conditions are exacerbated by privatization and marketization, which ‘facilitates the global integration of health care labour markets’ (emphasis in original).

Structural accounts, which highlight the importance of the globalization process, provide an important corrective to the exclusive focus on the individual in the equilibrium approach. Critics of globalization, however, contest the novelty and scale of economic integration (Hirst and Thompson 1996). First, they suggest that the globalizers are ahistorical because they downplay previous periods of migration, which in the case of nurses, resulted in substantial migration to the UK in the 1960s and 1970s (see Mejia et al. 1979). Second, internationalists, such as Hirst and Thompson, regard the nation state as dominant because although economic activity extends across national boundaries, it is governed by relations and interests of nation states. This contrasts with the perspective of globalizers that emphasize interconnectedness and integration in an increasingly borderless world. McGovern (2002) draws on this distinction between internationalization and globalization to examine the recruitment of professional footballers to the UK, employment that shares with nurses the existence of immobile capital and relatively mobile labour. He demonstrates that the recruitment process is increasingly international, but recruitment is marked by a regional rather than a global orientation because employers prefer to rely on known sources of labour to reduce uncertainty and transaction costs. This distinction is valuable in considering the case of nurses and the extent to which there is growing diversity in migrants’ national origins.

To summarize, migration studies provide important insights at different levels of analysis. Migration specialists, however, bemoan the fragmented
nature of these studies leading Goss and Lindquist (1995) to develop a more integrated approach which highlights the role of employers and the state in active recruitment, giving rise to what they term migration institutions. This approach has many similarities with an IR perspective which complements awareness of the role of individuals, households and structural features of the global economy with an understanding of how institutions, especially the state and labour market institutions, regulate migration, providing a fuller explanation of current patterns.

3. The state, labour-market institutions and employment regulation

Edwards (2005: 267) emphasizes that one of the strengths of IR is that it is open to a range of disciplinary approaches because it is not a closed paradigm. He reiterates that at the centre of an IR approach is an emphasis on the rules and expectations that govern the employment relationship in which it is accepted that these rules are contested and influenced by relations of power between actors. As Flanders (1970: 86) points out, rules are a generic description for a variety of instruments that regulate the employment relationship which include legislation and other forms of state intervention (e.g. codes of practice), formal agreements and managerial and trade union decisions. Some rules are established beyond the workplace; for example, protective legislation that limits the discretion of workplace actors. Therefore, IR incorporates different levels of analysis in terms of the nation, sector and workplace.

A curious feature of much migration analysis is that it is relatively disinterested in the policies of the state with a narrow focus on immigration policy. Massey acknowledges this difficulty: ‘The state and its policies are thus central to explaining contemporary migration . . . nothing invalidates traditional approaches to migration more than border controls’ (Massey et al. 1998: 14). In contrast, within IR, the state is viewed as the only actor that has the legitimacy to construct the overall framework of rules that shapes IR behaviour (Howell 2005). In terms of migration, the state plays a key role in terms of policies that encourage, facilitate and control mobility. State policy in both source and destination countries is crucial for understanding migrant flows, hence, in what follows state policy in the Philippines (the largest ‘exporter’ of registered nurses) is considered in conjunction with the policies of the UK state.

In what ways has the state established the rules of migration? First, the mobility of nurses is distinctive because it is influenced strongly by the regulatory frameworks of individual governments that control the training, recruitment and deployment of health professionals. Governments regulate the supply of health professionals (via establishing the number of training places, etc.) and effective demand for health professionals (via public expenditure decisions) influencing the demand for overseas health professionals in source and destination countries. Moreover, especially in highly centralized
health systems like England, employer policy is shaped strongly by the policy guidance and targets that originate in central government (Bach 2004).

Second, governments influence the number and deployment of overseas health professionals. Governments in source countries can actively seek to deploy nurses overseas, while destination countries can encourage overseas nurses to work in their country. The rules governing work permits and occupational licensing standards, as well as broader migration policy, are important state-directed influences that shape patterns of nurse mobility. Consequently, in contrast to equilibrium accounts that focus on individual agency or structural accounts of globalization that emphasize the erosion of state capacities, the continuing importance of state policy in explaining the causes of nurse migration for both destination and source countries is highlighted below. Although state capacity is more influential in a sector like health, and among professions like nursing subject to national occupational licensing requirements, it is notable that recent scholarship has emphasized the degree to which globalization does not erode the capacity of nation states (Weiss 2004).

A second distinctive feature of IR analysis is the importance that it attaches to the role of labour market institutions in governing the employment relationship. This contrasts with mainstream migration literature in which employers are rendered largely invisible: ‘The employer and the complex networks of recruitment agencies are remarkable in their absence in most accounts of international labour migration’ (Goss and Lindquist 1995: 337; see also Krissman 2005: 23). Employers are an integral part to an IR perspective because they not only generate employment opportunities, but also structure jobs in particular ways that may be conducive to employing migrant labour. As Piore (1979) has argued, migration stems from employer demand, with governments organizing recruitment to fulfil employer requirements. Piore suggests that it is the attributes of jobs that are available to migrants, which is crucial in explaining migration rather than the attributes of workers. Employers favour migrant labour when jobs are low-status, rather than necessarily low-paid, which makes it hard to attract employees. Migrants may also be used by employers in higher-status jobs if demand is variable and migrants can be confined to this variable portion of demand. Piore (1979: 40) uses the case of foreign-educated physicians in the USA to illustrate this argument. Explanations of migration, therefore, need to bring centre stage the behaviour of employers.

Analysis of labour market institutions is not confined to the role of employers but can incorporate the role of other labour market institutions; for example, recruitment agencies that are becoming prominent in influencing the flow of migrant labour (Lowell et al. 2004: 15). Trade unions remain integral to an IR approach, especially among highly unionized occupations, which is often the case for nurses. Employers and trade unions are often the authors of rules that are established via collective bargaining, but even if this is not the case, they have the capacity to influence state policy. Employers
lobby the state to take account of their labour requirements and capitalize on state policies promoting mobility. Trade unions shape and interpret state rules to safeguard the interests of their membership. To summarize, an IR approach can build on the insights from existing studies of migration and incorporates a greater sensitivity to the role of the state and other labour-market institutions in explaining the patterns of mobility.

4. Explaining nurse migration to the UK

Trends

Indications of the flows of overseas nurses can be gauged from NMC data that record the numbers of nurses and midwives registered to practise in the UK. There are some data limitations because the NMC register indicates the intent to work rather than actual employment status. Some nurses may join the professional register but not take up employment as a nurse or decide not to work in the UK. The key indicator in terms of tracking the inflow of overseas nurses relates to the number of new entrants on the annual register. During the period April 2004 to March 2005, 11,477 overseas trained nurses joined the register out of a total of 33,257 new admissions (NMC 2005a: 9).

Figure 1 compares the overall trend in UK and non-UK admissions (excluding the European Economic Area (EEA)) over the last decade. It indicates a rapid growth in overseas (non-EEA) registrations, both in terms of overall numbers and as a proportion of all NMC initial registrations. The proportion of overseas nurse registrants peaked in 2001–2002 when, for the first time, more than half of new entrants were overseas trained. This growth in overseas nurses reflects the influence of state policy with a decline in UK-trained nurses in the mid-1990s arising from the decreases in student-training places commissioned by the NHS, in conjunction with staff shortages.

FIGURE 1
Admissions to the UK Nurse Register from the UK and Other (Non-EEA) Countries 1994/95–2004/05

Source: NMC 2005a.

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These trends started to be reversed from the late-1990s with an expansion of nurse-training places reflected in the increase in UK admissions (Figure 1) and the easing of shortages in entry-level nursing posts, which have traditionally been filled by overseas nurses (RCN 2005a). International recruitment of nurses has started to decline despite a significant backlog of approximately 37,000 overseas nurses who are unable to register because of the shortage of clinical placements (RCN 2005a: 19) and buoyant demand from the independent sector.

Table 1 provides a detailed breakdown of non-EEA overseas registrations since the surge in overseas recruitment from the mid- to late-1990s. The largest proportion of overseas nurses trained in the Philippines, with other Commonwealth countries, notably India, heavily represented among source countries. The contribution of the Philippines is especially significant. In 1998/1999 it accounted for only 1.4 per cent (52) of total overseas admissions, compared to 45 per cent (5,593) in 2002–2003, and remained at 20–30 per cent of overseas admissions in subsequent years, indicating the importance of understanding the role of the Philippines in the dynamics of nurse migration to the UK. In contrast, only just over 1,000 of the 33,257 initial entrants were

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*a* Indicates countries from which active recruitment by the NHS is prohibited (see discussion).

*Note:* Listed by most numerous country applicants in 2004–2005.

from the EEA and the proportion has hardly changed in the last decade (NMC 2005a), signalling that the EEA remains a relatively insignificant source of overseas nurses.

Three points can be highlighted from this data. First, there are greater fluctuations in the number of non-UK (non-EEA) registrations than UK registrations which may indicate that numbers of overseas nurses are much more susceptible to changes in employer demand than UK registrations. Second, the consistently low level of EEA registrations raises doubts about the utility of the globalization thesis. Under European Union (EU) regulation on the free movement of labour, nurses and midwives are entitled to automatic recognition by the NMC as long as their qualifications comply with EU training standards. The absence of increased numbers of EEA registrants suggests that linguistic barriers and/or employer preferences limits the degree of globalization of the nursing labour market. Third, Table 1 provides little evidence of increased diversity of national origin among nurse migrants, indicating that the nurse labour market is characterized more by internationalization than globalization. An IR approach indicates that these trends in nurse migration derive from state policy and the role of labour market institutions.

State Policy

The Labour government, elected in 1997, used a sustained period of economic growth to address long-standing under-investment in public services. In 2000, the NHS Plan for England set a target of increasing the number of nurses by 20,000 by 2004. This target was achieved by 2002, largely because of the contribution of overseas nurses. The government established a revised target that is to recruit an additional 35,000 nurses, midwives and health visitors by 2008, compared to the position at September 2001 (DH 2002a: 15).

The extent to which the Labour government facilitated nurse migration was influenced by its overall approach to skilled migration, its ability to recognize the scale of nurse shortages, and its capacity to develop rules and infrastructure that led to a large increase in overseas nurses coming to the UK. First, the migration regime has a crucial bearing on employment because overseas non-EEA nationals are not able to work without a work permit, which has to be obtained by an employer and linked to a specific job. For work permits, the UK designates certain professions as shortage occupations, and registered nurses and midwives have been included in this category. This designation enables employers to seek a work permit for an internationally recruited nurse without having to first advertise vacancies in their local labour market. It also signalled to overseas nurses that the UK state was actively seeking nurses to work in the UK, reflecting the overall emphasis in government policy of encouraging skilled worker migration (Home Office 2006).

Second, the Labour government placed a higher priority on HR issues than its Conservative predecessors, reflected in the publication of the first
national HR strategy for the NHS and the establishment of the ‘recruitment and retention unit’ in the DH. The complex funding and commissioning system of nurse education, in conjunction with the three-year training requirement to become a registered nurse, indicated that nurse shortages could not be addressed in the short term by increased training places. Although some NHS trusts had experimented with overseas recruitment, it was not until the DH undertook targeted international recruitment efforts that the number of overseas nurses employed in the UK started to increase rapidly. This growth was not confined to the NHS, and the independent sector emulated the example of NHS employers. According to Buchan (2004: 15) ‘active recruitment . . . has been the dominant dynamic in recent years. Without it the number of nurses coming to the UK from other countries would have been much smaller’.

Third, the DH established an institutional infrastructure. In 2001, a director of International Recruitment was appointed supported by International Recruitment Co-ordinators, with the number of staff recruited internationally comprising a key component of each Workforce Development Consortium’s performance framework. These co-ordinators aided NHS trusts in their recruitment efforts, working with approved recruitment agencies, organizing recruitment events in the UK and overseas, and disseminated a newsletter to NHS trusts. Financial support was also made available to trusts for international recruitment initiatives and this enabled managers to travel to the Philippines and recruit batches of 50–100 nurses at a time. The DH also actively marketed the NHS through its website, providing information about the cost of living and providing pen portraits of nurses, who extolled the virtues of nursing in the UK (DH 2002b).

Finally, the state strongly influences occupational licensing requirements, with authority delegated to the NMC. A nurse cannot practise in the UK without being registered by the NMC. In 2004–2005, the NMC considered 37,063 cases, more than three times the number of new overseas registrations, and allocated decisions to 15 categories of which the most frequent was that the ‘applicant must undertake a 3–6 month clinical placement’ (NMC 2005a: 12). NMC decisions therefore influence the number of overseas nurses available to work. Severe backlogs in registration are likely to discourage nurses from seeking employment in the UK.

From September 2005, the NMC fundamentally altered its education requirements, introducing the Overseas Nursing Programme (ONP), which requires all overseas nurses to undertake 20 days of NHS induction via programmes delivered by a higher education institute. It is estimated, however, that only 1,500 ONP-accredited places are available each year. The trade association of the private sector recruitment industry criticized this decision and suggested it would ‘have an enormous impact on nurse recruitment from overseas’ (Recruitment and Employment Confederation 2005). This prediction appeared prescient because 46,000 overseas nurses who applied to the NMC for registration since September 2005 are awaiting ONP places, but only 8,000 places are available per year (Strachan-Bennett and
Doherty 2006). These trends demonstrate the capacity of state policy to shape flows of migrant nurses to the UK.

**The Philippines**

State policy cannot be considered exclusively in terms of the destination country because this does not explain why particular countries are so integral to the flow of nurses to the UK. The prominence of the Philippines as a source country for nurses arises from active state promotion of migration, which is termed state-managed migration.

The Philippines is the largest source of registered nurses working overseas with strong demand for Filipino nurses in the USA and latterly in the UK. This stems from US colonial links, ensuring proficiency in English and a college-based nurse education that dovetails with the requirements of destination countries (Choy 2003). In 1970, there were 63 nursing schools, but this has increased rapidly to 198 in 1998 and 370 by 2005, reflecting the profitability of the nursing ‘business’ (Kingma 2006: 22). Although nursing schools are privately owned, it is the Philippine government that has sponsored their growth by easing the regulations on the establishment of nursing schools (Choy 2003: 111).

The Philippines, therefore, provides an important illustration of the role of state-directed policy, in which the demand for Filipino nurses remains buoyant. This has encouraged an increasing number of Filipino doctors, approximately 4,000 in 2004, to retrain as nurses. Moreover, the Philippine model is being emulated by India, among others (Kingma 2006: 21–23).

What is noted less frequently is that very low levels of health service funding contribute to the estimated 30,000 unfilled nursing positions in rural areas (OECD 2003: 75), but at the same time, many newly qualified nurses find it difficult to gain employment. Consequently, another effect of state policy is that in order to gain employment overseas, nurses work for low wages or as volunteers to obtain the necessary experience. This situation reinforces a feedback loop, which depresses domestic nurse wages and encourages exit overseas (Ball 2004: 125).

**Labour Market Institutions: The Role of Employers and Trade Unions**

Although the nation state has a dominant role in regulating migration, employers and trade unions interpret state policy and seek to shape it in a way that promotes their interests. Since the mid-1990s, NHS trusts have become increasingly reliant on overseas nurses to fill vacancies, particularly for entry-level nursing posts. Employers in 10 NHS and non-NHS hospitals rated international recruitment as the most straightforward method to address recruitment and retention difficulties, with many managers noting the commitment of their overseas recruits (RCN 2003b). Other advantages for employers include the ability to employ registered nurses and pay them lower salaries during their period of adaptation. In addition, the presence of
overseas nurses has promoted the ethnic diversity of the workforce and made NHS trusts more responsive to the health needs of local communities (Gerrish and Griffith 2004: 583). The Philippines was the most common country from which all these trusts had actively recruited because of information that there was a plentiful supply of nurses available, Filipino nurses were college educated in English, and the Philippines was excluded from the DH’s list of countries that should not be targeted for recruitment (RCN 2003b).

Recruitment agencies have become an integral institution facilitating nurse migration (Ball 2004: 123) and also often shape the experience of employment. Recruitment agencies are the ‘preferred recruitment route’ according to NHS managers because they can screen applicants and deal with the NMC paperwork (Hardill and MacDonald 2000: 687). Agencies assist nurses to gain a work permit and find a placement to undertake their period of supervised practice, prior to registration, but charge nurses substantial fees of up to £5,000 (e.g. Grzincic 2004). It is not only unlawful for UK-based agencies to charge applicants a fee for recruitment, but it also places many nurses in a highly dependent position; this vulnerability is reinforced when the employer provides accommodation. Recruitment agencies also differ in the degree to which they fulfil their contractual obligations. In some cases, nurses anticipate that they will be working in acute hospitals and are actually destined for employment as poorly paid care assistants in nursing homes (RCN 2003a).

In terms of trade unions, the RCN and UNISON have been active in trying to alter the regulation of migration adopted by the UK state and highlighting the consequences of migration for the workforce. Both the RCN and UNISON acknowledge the right of individuals to migrate, value the role of overseas health workers in augmenting the workforce, and seek to increase their membership by recruiting overseas health workers, often using low subscription rates to entice overseas nurses into membership. They have also provided support to internationally recruited nurses working to contracts offering poor pay and discriminatory conditions. They remain critical of the inadequate working conditions that has led to poor retention of UK health professionals and are wary of supporting targeted large-scale overseas recruitment (RCN 2005b; UNISON 2004).

The RCN and UNISON have put pressure on the DH to strengthen its ethical recruitment guidelines to include private sector recruitment agencies and independent healthcare sector providers. Revised government guidelines were published in 2001 and 2004, which highlights the capacity of trade unions to modify state policy. Both organizations have been active in highlighting the plight of internationally recruited nurses and lobbied the government to establish a confidential national overseas nurses’ advice line to combat exploitation.

The RCN, and to some extent UNISON, have commissioned and publicized research that has put the government on the defensive in terms of the degree to which it is ethical to undertake large-scale overseas recruitment and
used research to inform its guidance to employers. The RCN has called for internationally recruited nurses to be paid on the same terms and conditions as their UK counterparts and lobbied for nurses undertaking adaptation, prior to inclusion on the NMC register, to be paid as registered nurses rather than on lower grades (RCN 2005b: 8). During 2003, the RCN published research that highlighted the prevalence of discrimination and low pay among overseas nurses, especially in the independent sector, and revealed the lack of recognition of their skills and previous experience (RCN 2003a). In response to these grievances, UNISON has established an Overseas Nurses Network in Scotland and its 2005 health conference carried a motion proposing that similar groups be established in England (UNISON 2005).

5. Regulating nurse mobility: the growth of ‘soft regulation’

The UK government aims to regulate the flows of nurses to the UK to benefit source and destination countries but has been more reluctant to deal with the abuses that overseas nurses face, especially outside the NHS. International recruitment has been integral to the Labour government’s NHS HR policies. It adopted an international recruitment code of practice to emphasize that recruitment must be carried out in an ethical manner and to deflect potential criticism of its approach. Soft regulation, particularly codes of practice, are becoming increasingly important in the regulation of IR practices, reflecting a shift from ‘hard’ to ‘soft’ regulation. Soft regulation has been characterized as dealing with general principles rather than specific rights and often provides for further negotiation among the actors rather than producing final outcomes, indicating that soft regulation is permissive rather than compulsory (Marginson and Sisson 2004: 54–59).

Codes of Practice

International recruitment has generated controversy, notably in 1997 when Nelson Mandela criticized the UK for recruiting nurses from South Africa. This led the DH to issue guidelines requiring the NHS not to recruit actively from South Africa and the Caribbean (DH 1999). A more detailed Code of Practice was issued in 2001 which included guidance on working with recruitment agencies and reiterated that NHS trusts should not target recruitment at developing countries unless the DH had a formal agreement with a particular country (DH 2001). It was not until 2003, however, that the DH published a list of less-developed countries to end the uncertainty among NHS trusts about which countries they were prevented from targeting. During 2004, the DH further strengthened the Code of Practice (DH 2004). The UK government is proud of its record suggesting that: ‘We were the first nation to produce international recruitment guidance based on ethical principles and the first nation to develop a robust code of practice’ (DH 2004: 3). This is the case, but the effectiveness of this form of soft regulation has been questioned (e.g. Kingma 2006: 127–32).
First, there is the narrow content of the Code which focuses on general principles of ethical recruitment and induction, but does not attempt to regulate or even identify best practice in terms of pay and working conditions. This can be contrasted with the guidance from the RCN (2005b) and UNISON (2004) which advises on unlawful and exploitative contracts, pay and grading, working hours, tackling racism and support from trade unions.

The second limitation relates to the coverage of the Code and the exclusion of the independent sector. This enables the independent sector, often using private sector recruitment agencies that recruit from ‘prohibited’ countries, to act as a staging post for employment in the health service. Many nurses and midwives recruited to the independent sector later move to the NHS for better pay and working conditions, a situation that allows NHS employers to argue that they are in compliance with government guidelines, because they are not actively recruiting from prohibited countries. The Labour government has resisted pressure to make the Code mandatory for the independent sector, in part because it is sensitive to criticism that it is interventionist and over-regulates the private sector. The 2001 Code, however, invited private sector recruitment agencies to sign up to its provisions.

In light of the continuing criticism by the RCN and UNISON, the DH issued a strengthened Code (DH 2004). This went further than the 2001 guidance because it required NHS trusts to use only recruitment agencies that complied with the Code but it still excluded the bulk of the independent sector care which constitutes long-term nursing and social care. Recent figures indicate that the number of agencies signed up to the Code declined by 21 per cent, down from 178 in 2004 to 140 in 2005, out of an estimated 800 agencies. Moreover, only 32 out of the 140 agencies have gained two references from NHS trusts, verifying that they are complying with the Code (Parish 2006). The RCN has suggested that many agencies, especially if they only recruit for the independent health sector, appear to see little merit in restricting their choice of source countries by adhering to the Code. This interpretation has been rejected by the DH, which argues that the decline in the number of agencies signed up to the Code stems from the reduction in international recruitment activity. This shift in demand has created financial difficulties and stimulated merger activity among agencies, reducing the number signed up to the Code.

Third, the impact of the Code can be gauged indirectly by examining the consequences of the Code on the numbers of nurses coming from overseas. Table 1 indicates that even a conservative estimate (because this estimate excludes ‘others’ which may include prohibited country recruits) suggests that during 2004–2005, 3,247 nurses were registered from prohibited countries, including substantial numbers from some of the poorest countries in the world — Malawi, Nepal and Swaziland — with very small nursing workforces. This does not, in itself, indicate that the Code is being broken because the Code only applies to active recruitment by NHS trusts and does not cover individual health professionals who ‘may be considered for employment’ (DH 2004: 7). It has been suggested, however, that ‘agencies evade the ban by
instructing individuals to say they were applying of their own volition' (UNISON 2006: 6). The continuing flow of internationally recruited nurses reinforces criticisms that its scope is too narrow.

It has also been argued that the Code is inherently discriminatory because it restricts the freedom of movement of health professionals from certain countries while allowing it to continue from others (Rowson 2004: 22). A more frequent concern, however, is that a voluntary code is a relatively weak regulatory mechanism because it has no legal basis. Despite the generally negative appraisal of the Code, it needs to be remembered that other countries active in international recruitment, such as Canada and the USA, have not developed codes of practice to influence the behaviour of their healthcare employers. Despite its voluntary nature, the Code has been important in changing the behaviour of NHS employers and more recently, recruitment agencies, as the Code has been strengthened. The recruitment industry and independent sector providers, aware that the Labour government is expanding the role of the independent sector in the NHS, recognize the long-term financial incentives to work with the NHS and comply with the Code. The development of the Code, therefore, serves an important function in publicizing good practice for employers on issues such as induction and training, influencing the climate in which international recruitment occurs, and signals that the UK recognizes that its recruitment activities impact on source countries.

6. Conclusion

The UK health sector has become increasingly reliant on the recruitment of overseas nurses to fulfil its staffing requirements, but there has been insufficient attention directed to explaining these trends. This article reviewed equilibrium, network and structural accounts of migration, which differ in terms of the level of analysis and the balance between structure and agency. It suggested that these perspectives in isolation are insufficient to explain contemporary patterns of nurse migration. They share a focus on the behaviour of migrants whether at micro level in response to income differentials or at macro level in response to the impersonal dynamics of the global economy. These accounts share a neglect of the behaviour of employers and the state which are crucial to understanding contemporary patterns of migration.

To build on the insights from migration specialists, an IR approach has been used, which is open to a range of disciplinary perspectives, to develop an integrated understanding of nurse migration. By placing the role of the state and labour market institutions to the fore, a more comprehensive framework for explaining trends in nurse migration has been developed. Nurse migration to the UK indicates that the policies of the UK state to recruit actively from overseas, in response to labour shortages, dovetailed with the state-sponsored migration of nurses, notably from the Philippines. Employers utilize these sources of labour not only to address labour shortages, but also
because the Philippines provides a reliable, college-educated, English-speaking source of overseas nurses. These practices which are embedded in particular social contexts, rather than a response to impersonal market forces, explain the internationalization rather than the globalization of the nursing labour market.

Patterns of nurse mobility, therefore, do not indicate the emergence of a global labour market for nurses, with little support for increased diversity of ethnic origins in international recruitment. Employers draw on countries that make labour available, and which educate nurses to standards that adhere to employers’ conceptions of good nursing care. The globalization thesis also assumes that the intensity of labour mobility inevitably increases over time irrespective of the actions of nation states. At present, the reverse is occurring in the UK with a decline in international recruitment of nurses. This arises from the Labour government’s sensitivity to accusations of poaching in conjunction with an easing of nurse shortages in the NHS. The Labour government is therefore no longer promoting international recruitment of nurses as employer demand declines.

There are a number of implications for future research and policy. The important role played by employers, recruitment agencies and trade unions in regulating migration has been noted, but our knowledge of many of these issues remains sketchy. This is partly because of data limitations in which researchers are reliant on NMC registration data. NHS and independent sector employers do not keep data on the numbers of overseas nurses they employ or on their pay and working conditions. There is also the need for more research on the crucial role of a number of labour-market institutions including occupational licensing authorities and recruitment agencies which have an important role not only in shaping migrant flows but also in influencing the experience of employment in destination countries.

By emphasizing state capacity, this article has highlighted the opportunities within a highly regulated sector like health to manage actively patterns of mobility. In particular, a relatively small number of nation states have a disproportionate impact on the movement of nurses. The Labour government has sought to protect overseas nurses coming to the UK because it is anxious to portray the NHS as an ethical employer, but has been reactive in monitoring the effectiveness of the Code. The NHS has a strong ‘target culture’ and the Healthcare Commission, the organization that audits the performance of NHS trusts, could be required to monitor NHS recruitment and employment practices and ensure that NHS trusts and independent sector providers that have contracts with the NHS adhere to ethical employment practices. With the increased interest in corporate social responsibility and government emphasis on the NHS as an employer of choice, the NHS needs to ensure that large-scale overseas recruitment does not tarnish its employer brand.

Similarly, the NMC could be more proactive in publicizing and influencing employment conditions of overseas nurses. In 2004, it teamed up with the Philippine Embassy in London to warn nurses that some unscrupulous
recruitment agencies were arranging clinical placements that would not enable them to gain admission to the UK nursing register (NMC 2004: 17). In 2005, the NMC condemned employers and recruitment agencies that charged overseas applicants for supervised practice placements (NMC 2005b). A more systematic approach by the NMC could be developed to ensure that overseas nurses are aware of their employment rights prior to departure from the source country.

Nurse migration has become a prominent feature of the health sector context in recent years. Policy responses are shifting from a reactive agenda that focuses on stemming migration, towards a more ambitious and active agenda of managed migration that seeks to bring benefits to source and destination countries. A central component of any such agenda is an enhanced recognition of the importance of improved working conditions and more effective employment practice to encourage retention of health workers in both source and destination countries. This policy agenda, however, can only be advanced on the basis of a secure understanding of the dynamics of nurse migration in which the role of the state and labour market institutions needs to be placed at the centre of the analysis.

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Notes

1. In July 2006, the Department of Health announced that general nurses were to be removed from the shortage occupation list. The Health Minister Lord Warner explained that the NHS workforce had moved from a period of growth to ‘steady-state’. These measures do not ban international recruitment, but require employers to demonstrate that they cannot fill a post with a UK or EEA applicant before they may apply to the Home Office for a work permit for an internationally recruited nurse.

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