

The Challenging Integration Paths of Migrant Health Professionals: The Case of Filipino and Indian Nurses in the UK

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Abstract

This article examines the role of institutional factors in shaping the integration paths of migrant health professionals. For this purpose, it draws on two studies focusing on Filipino and Indian nurses working in the UK which rely on quantitative and qualitative methods, including a web survey and semi-structured interviews. The analysis shows that inequalities have arisen from differentiation processes induced by changes in the institutional settings. Furthermore, inequalities are often reflected in poor working conditions. The authors have identified restrictive rules on immigration and access to the profession as a source of uncertainty, and reveal the differentiation of entry paths, with those arriving through an international recruitment agency more frequently disappointed with their working conditions.

Keywords

Globalization, immigration, inequality, institutions, integration, nursing, professions, recruitment.

Introduction

This article carries out a reflection on how globalization impacts professions in contemporary society. It does so in the awareness of globalization's dual character as a

provider of both challenges and opportunities for professional workers. In addition, it focuses on the *outcomes* of change and the *institutional factors* that contribute to explaining them.

Globalization has loosened the boundaries between professional systems. As noticed elsewhere, “it is now common for professionals from different countries and educated within different systems of professions to provide professional services side by side” (Bellini & Maestriperi, 2018, p. 8). This fact has important empirical implications that can be framed in the theoretical discourse on *differentiation* leading to increasing *heterogeneity* within and between professions.

Differentiation and heterogeneity are straightforward terms that imply a growing division of labour among professions and professionals. A new division of labour was already implicit in the post-industrial transition (Bell, 1973; Touraine, 1969). This process can be understood in the Durkheimian terms of the *functional specialization* of occupations and individuals, in the Weberian terms of *hierarchical differentiation* based on the unequal distribution of power between professional groups (Saks, 2015), or in the Marxian terms of *class exploitation*. Since the 1970s, the number of professionals and the occupations subjected to professionalization have increased at a steady pace, but the social meaning of professional work has changed profoundly. Established professions have lost their power to control the labour market (Haug, 1975; McKinlay & Arches, 1985; Oppenheimer, 1972), while new professions have arisen that rely on weak institutions and are exposed to market competition (Hodgson, Paton, & Muzio, 2015; Muzio, Hodgson, Faulconbridge, Beaverstock, & Hall, 2011). In general, professional jobs no longer ensure adequate rewards in terms of revenue and recognition (see, for instance, Alacevich, Bellini, & Tonarelli, 2017; Maestriperi & Cucca, 2018). Moreover, professionals are affected by *marginalization* (Butler, Chillas, & Muhr, 2012) and *precarization* (Murgia, Maestriperi, & Armano, 2016).

Insofar as it creates the conditions for an international division of labour, globalization transfers competition to a global scale. This change has led to the growing importance of peripheral countries in the geography of professions but also implies rising inequalities related to new forms of exploitation.

To give substance to these seemingly abstract speculations, the article draws on a case study, namely that of *foreign-educated nurses* (FENs) and, in particular, the experiences of Filipino and Indian nurses recruited by healthcare organizations in the United Kingdom—the latter defined as *internationally recruited nurses* (IRNs). What makes this case valuable is that the Philippines and India are the two biggest providers of foreign-born health workers for OECD countries, while the UK is their primary destination in Europe. In this context, we focus on two critical processes: first, the *migration flows* of skilled professionals; second, global-scale *recruitment practices*. These processes are intertwined and shape FENs’ employment patterns and working conditions. On the one hand, they create favourable

conditions for migrant workers to enter the UK's nursing profession, resulting in changes in its social structure. On the other hand, they give rise to inequalities and forms of marginalization as the expression of differences in treatment based on multiple factors, ranging from *ethnicity* and *immigration status* to the *recruitment channel*, *type of employer*, and *employment contract*. However, this is a result of policy changes; noticeably, their situation has worsened, especially since the crisis of 2008, as a consequence of government funding cuts to the National Health Service (NHS) and the introduction of stricter rules on immigration and migrant workers' access to the profession.

Here, we provide new evidence of concerns that emerged from previous studies, interpreting their implications from a specific theoretical perspective, and looking at health professions as "global" professions—that is, professions engaged in intense processes of transnational migration, mostly from the Global South to the Global North. In the next section, we present this perspective, problematizing the consequences of professional migration. Furthermore, we draw on neo-institutionalist theory to create an interpretive framework for the outcomes of this process in terms of differential integration paths and rising inequalities. After that, a methodological section describes the research design and methods. The analysis then develops in two stages: based on survey data, it gives evidence of the poor working conditions of nurses coming from abroad; based on semi-structured interviews, it traces the causes of the inequalities by looking at the institutional factors most likely to influence migration flows and assimilation processes. The conclusions focus on professional change in the context of the broader processes of change affecting contemporary society.

The rise of global professionalism in healthcare

Globalization has redrawn professional geography and morphology (see Dent, Bourgeault, Denis, & Kuhlmann, 2016). Nowadays, it is relatively simple for professional workers to travel across country borders to provide professional services. This change has been possible not only because *services* are increasingly provided by global professional firms, namely multinationals that dominate global professional markets (Muzio & Kirkpatrick, 2011), but also because *careers* are becoming "boundaryless" (Cohen & Mallon, 1999). This has multiple implications in terms of how professionalism is interpreted and performed, from the development of transnational careers to the emergence of new "local" ways of practising a profession: the former case presupposes the rise of international jurisdictions, involving the standardization of careers; the latter implies that the same—country-based—regulations can have different—culturally influenced—outcomes.

As Bourgeault, Wrede, Benoit, & Neiterman (2016) notice, the transnational migration of professionals is not a new phenomenon in human history. As the authors point out, human capital flows are linked to the colonial nature of relationships between nations. Colonial powers contributed to shaping the professional systems in the colonies. In this context,

migrations reflect the North-South divide, with high-skilled professionals emigrating from source countries in the Global South to destination countries in the Global North (see also Kapur & McHale, 2005). Of course, this is truer for the UK and Commonwealth countries, which had maintained formal ties, but now form a free association. What is new today is the number of countries involved, the pace of the movements, and the impermanency of the choices (see De Haas, Castles, & Miller, 2020).

Following Bourgeault et al. (2016), we assume that professionals' spatial mobility develops along different paths, depending on the travel capacity of professional expertise. As the authors remark, healthcare still is characterized by a low degree of mobility due to its being tied to country-based institutional settings and professional regulations (see Bourgeault, Neiterman, LeBrun, Viers, & Winkup, 2010; see also Wrede, 2010). However, the demand for healthcare workers in the Global North has grown continuously due to the ageing of the population, the rise in multiple chronic conditions, and the ageing of the local health workforce. Consequently, health professional recruitment has developed as a transnational industry (see Pittman, Folsom, & Bass, 2010).

The attention of sociological literature has been centred on the problem of the *integration* of migrant health professionals in the destination countries, which involves *professional acknowledgement* and *socio-cultural assimilation*. Moreover, most of this literature has focused on experiences of *discrimination and racism* at the workplace (for the nursing profession, see Allan, Larsen, Bryan, & Smith, 2004; Diccico-Bloom, 2004; Hagey, Choudhry, Guruge, Turritin, Collins, & Lee, 2001; Kingma, 2006) and *organizations' internal logics* (Finotelli, 2019). From this point of view, local contexts inevitably influence integration processes.

This article shifts the focus to the *institutional factors* that regulate migration flows and shape the paths of migrant health professionals' socio-professional integration. Neo-institutionalism provided the theoretical basis for the analysis, particularly when looking at the interconnections between labour migration, the labour market, and welfare institutions from a political economy perspective (see Portes, 1995). Indeed, recruitment processes (a mix of *community* and *market regulation*) rank among the most influential institutional arrangements (see Campbell, Hollingsworth, & Lindberg, 1991; Hollingsworth & Boyer, 1997), along with the rules regulating immigration (*state regulation*) and access to the professional labour markets (*associative regulation*).

The international recruitment of nurses has become a "necessary labour market" to manage shortages, while a range of government policies, often unrelated to migration, create a demand for migrant labour (Ruhs & Anderson, 2010). Moreover, healthcare facilities in high-income countries have outsourced international recruitment to specialist agencies. A full-chain industry that arranges nurses' migration and work-related services has flourished. International recruitment agencies have become "gatekeepers," playing a critical role in the

social processes underlying healthcare work's global commodification (see Connell & Stilwell, 2006; Findlay, McCollum, Shubin, Apsite, & Krisjane, 2013).

Scholars have looked at the role played by international recruitment agencies not only in serving as “lubricators” for the migration flows of health professionals (Salt & Findlay, 1989) but also in channelling them beyond patterns rooted in family networks or colonial ties (Ball, 2004; Connell, 2010). In this sense, agencies can be seen as “globalization agents,” which contribute to turning health professions into “global professions” (Bludau, 2010; Findlay et al., 2013).

Research methods

The analysis that follows is based on data from two research initiatives promoted by the International Labour Organization (ILO) within the framework of the Decent Work Across Borders (DWAB) project and conducted by one of the authors, Davide Calenda, between 2013 and 2015. Both studies targeted FENs working in the UK—specifically, Filipino and Indian nurses—focusing on different aspects, namely *working conditions* and *ethical recruitment practices* (Calenda, 2014; 2016). Calenda carried out additional research at the beginning of 2020 to collect up-to-date information.

The two studies relied on both quantitative and qualitative methods of data collection. Data were gathered from first-hand sources in the participating countries: the UK, Philippines, and India.

In the study on *working conditions*, ten semi-structured interviews were carried out with key informants (see Appendix: list of interviews). A reasoned procedure was followed to identify the key informants among representatives of relevant institutions such as regulatory authorities, professional associations, and trade unions. Then they were contacted and interviewed in 2013. Given the explorative nature of the fieldwork, the interviews were adapted to the interviewees' roles and the type of organization worked for. Their aim was to acquire information on past and current trends in international staffing, nurse recruitment practices, the regulatory framework, and policy issues.

In addition, a web survey was addressed to Filipino and Indian nurses working in public and private healthcare facilities in the UK.ⁱ This research tool aimed to gather information on the nurses' backgrounds and working conditions.ⁱⁱ In total, 433 responses were collected from March to June 2013. Almost eight in ten respondents were women, the majority of whom aged between 31 and 40 (for more details, see Calenda, 2014). Most of them were from India.ⁱⁱⁱ

In the study on *ethical recruitment practices*, the fieldwork was carried out through the analysis of documents and semi-structured interviews with key informants. A total of twelve interviews were done with the managers of recruitment agencies and other key informants

in the participating countries, in particular three in the UK, four in the Philippines, and five in India (see, again, Appendix), in 2014. Their aim was to talk about the agencies' choices and approaches and other significant issues.^{iv}

A few remarks are necessary regarding the age of the data and the survey sample quality. As already mentioned, the data were collected between 2013 and 2015, which makes them dated, considering that in the meantime Brexit has occurred, and migration policies have changed. These altered circumstances made additional research necessary. Additional on-desk research and interviews with key informants have been carried out to update the picture. Focused interviews were administered by e-mail or videoconference with ILO officers and social researchers. However, the 2013-2015 data have maintained their explanatory power concerning the impact of globalization on professionals' migration dynamics, the related problems of socio-professional integration, and rising inequalities. Moreover, the use of a non-probability sample prevented statistical inference. In addition, when combined with the data collected through semi-structured interviews, the survey data gave an essential contribution to understanding the phenomena being studied. Indeed, the analysis benefited from a "mixed-methods" research design prioritizing qualitative method (interviews) while using quantitative methods (the survey) in the preliminary phase.

Unequal working conditions

Labour issues arising from the growing presence of FENs in the UK have been addressed by trade unions, which have fostered research since the mid-2000s (see Pike & Ball, 2007; UNISON, 2009). These studies have helped identify a set of problems, such as *job and sector segregation* (the tendency to use FENs in the private sector rather than in the "secure" public sector), *barriers to professional development*, and *discrimination practices* in the workplace. These problems reflect well-known patterns of labour market segmentation. However, a narrowed focus on the UK case allows us to appreciate how their impact has varied over time, depending on changes in the political and economic spheres (see "Immigration rules and professional regulation").

The survey conducted in 2013 drew a similar picture (for an extensive analysis, see Calenda, 2014). Three quarters of those in the sample entered the UK during the period of mass recruitments, between 2000 and 2005. In a favourable economic situation, the National Health System (NHS) pursued workforce expansion across the health professions, including international recruitments from the Philippines and India. Most respondents followed a *typical entry path*: they successfully registered with the UK's Nursing and Midwifery Council (85 per cent); then, they started to work as nurses in the private sector, in residential care or nursing homes (87 per cent); finally, they turned to the NHS (which was the current employer for 70 per cent of the total respondents). Most of them (85 per cent) were employed on an open-ended and full-time contract.

Several studies have suggested that the easiest way for employers to deal with the funding cuts in the public health sector was to reduce personnel and intensify work shifts and workloads (see, for instance, Aiken, Sloane, Bruyneel, van den Heede, & Sermeus, 2013). Changes in immigration rules also influenced the way employers use migrant workers, raising the risks of unfair treatment in the workplace. FENs are vulnerable to such pressures.

The survey revealed that many respondents deemed their *employment situation* to have worsened since they started to work in the UK: half of them, for instance, affirmed that they had experienced a decrease in job security; almost 30 per cent reported a reduction in career development opportunities. A substantial number expressed dissatisfaction with the *quality of work*: more than one third complained that their role, work duties, and responsibilities were not in line with their rank or qualifications; around 30 per cent criticized their managers for not recognizing their efforts, and the lack of autonomy in organizing their work; 60 per cent even reported that they were often forced to work unpaid extra hours.

The pioneering studies promoted by the Royal College of Nursing (RCN) in the early 2000s had already provided evidence of such difficulties. In the same vein, the FENs interviewed by Smith, Allan, Henry, Larsen, & Mackintosh (2006) largely declared that their skills and experiences were not recognized. This scant attention might also stem from the increasing segmentation and hierarchization in the field of nursing (see also Daniel, Chamberlain, & Gordon, 2001; more recently, see Castagnone & Salis, 2015).

The respondents also expressed concerns regarding *equality issues*—specifically, unfair treatment and discrimination in the workplace, driven by ethnic motives and poor diversity management. In fact, six out of ten declared that they had experienced harassment, bullying, or abuse in the previous 12 months, by users, colleagues, or managers. Three quarters of respondents affirmed that ethnic motives were behind these practices.

These findings confirmed what had emerged from prior studies. Allan & Larsen (2003) found that discriminatory practices often originated from managers' poor understanding of integration issues. According to the Royal College of Nursing (2013), one third of the nurses surveyed denounced cases of harassment, bullying, or abuse from teammates or managers. The proportion was higher among ethnic minorities and in the private sector.

The survey data also disclosed that rising inequalities were leading to a higher propensity to *consider re-emigrating*: more than 50 per cent of those who reported experiences of ethnic discrimination in the workplace or worsening working conditions (against 30 per cent of those who did not) were planning to leave the country. When asked about the first reason for leaving, they indicated their disappointment with the working conditions (21 per cent), along with the lack of career opportunities (15 per cent) and, generally, uncertainty about the future (14 per cent). Consistently with previous research (see again Aiken et al., 2013),

the survey results allowed us to hypothesize that discriminatory practices also affect the *quality of care* provided to patients.

Explaining rising inequalities

In the previous section, we showed that the mass admission of FENs to the UK labour market in the early 2000s triggered a process of differentiation within the nursing profession, which brought about rising inequalities in terms of employment situations and quality of work. Against this background, the FENs turned out to be exposed to unfair treatment and discrimination in the workplace, in addition to job insecurity, limited career prospects, and unsatisfactory working conditions. As underlined, the international recruitment of nurses has become a necessary labour market to manage shortages, in the context of a growing demand for migrant labour. Despite their functional indispensability, FENs occupy a low position in the hierarchy of health professionals and often find themselves trapped in exploitative situations. The consequences of these changes go far beyond the professional system, as they are also likely to affect the quality of care. In the following pages, we focus on the institutional factors that explain how we got to this point.

Immigration rules and professional regulation

Institutional factors, such as state rules on immigration and the characteristics of the labour markets in destination countries, play a critical role in shaping the paths of migrant workers' socio-professional integration. In the case of nurses, immigration rules evidently intersect with the rules for accessing the profession imposed by the licensing authorities. Together, immigration rules and professional regulation influence the ways FENs assimilate in the destination countries. Here, problems arise concerning recognition of the skills acquired by FENs in their countries of origin. These problems increase their vulnerability, with the resulting risk of incurring obstacles to professional development or even deskilling.

While state policy in the UK has proven to be effective in shaping the processes of recruiting FENs since the creation of the Colonial Nursing Service in 1940 (Solano & Rafferty, 2006), it has also influenced their positioning in the labour market (Bach, 2010). According to Young (2011), three policy phases can be identified over the last two decades. The first period followed Tony Blair's rise in 1997 and extended until 2006. In 1998, his government launched a policy of expanding the NHS workforce, which paved the way to intense international recruitment, especially from the Philippines and India. The two periods that followed—from 2006 to 2008 and from 2009 onwards—were characterized by gradual restrictions on migration flows.^v This change reflected a policy shift that aimed to bring in migrant workers on temporary work permits. A points-based system regulating entry routes and permissions was adopted. Furthermore, stricter licensing requirements were established by the Nursing and Midwifery Council (NMC), making it difficult for overseas nurses to gain registration (Buchan, 2007; Bach, 2010).

Several scholars have contended that such restrictions generate a climate of uncertainty among FENs (see Jayaweera, 2015). Moreover, they sustain that these changes have impacted the FENs' working conditions significantly, influencing their choice of whether to stay or leave the country (Buchan, 2007; Bach, 2010; see also Meardi, Lozano, & Martín Artiles, 2011). Others argue that reductions in the annual admissions of overseas nurses hides downgrading, with FENs being recruited to work as healthcare assistants (Nichols & Campbell, 2010). Following this line of interpretation, some authors have claimed that downgrading increases demotivation and worsens the problematic relationships between nurses and healthcare assistants (Smith et al., 2006; Aboderin, 2007).

There is evidence that moving nursing staff to lower pay bands^{vi} was a way to cut costs and that this kind of practice was primarily directed towards those who had not yet secured their legal status in the UK (see Snow, 2009; see also Cangiano, Shutes, Spencer, & Leeson, 2009; Royal College of Nursing, 2013). A key informant from a British trade union reported the case of a Filipino nurse who arrived in the UK in the 1970s and still works despite having reached retirement age:

She told us that nurses in her trust had been demoted from Band 6 to Band 5.^{vii} She said she didn't mind for herself but for younger migrants who risk not being able to match the requirements for applying for permanent settlement. (Trade unionist, UNISON, UK, 2013)

The uncertainty of their legal status exposes FENs to pressures from their employers. Given the centrality of financial eligibility for obtaining settled status, some of them have a higher propensity to accept longer work shifts and heavier workloads.

They need to keep their job and earnings in order to secure their legal status in the UK. (Trade unionist, UNISON, UK, 2013)

In 2006, the third Blair government removed general nurses from the shortage occupation list, but nurses from the Philippines and India continued to arrive in the UK as students. Student visas became the predominant mode of entry. Key informants confirmed that many migrant nurses arrived as students hoping to work as nurses:

Students, together with senior care workers, represent the last generation of nurses. Only a few Filipinos have succeeded in coming to the UK as registered nurses in recent years. Many others—we don't exactly know how many—came to the UK via student visas. Senior care workers were hoping to become nurses, but this has not happened due to legal constraints and a lack of job opportunities. (Officer, Filipino Embassy, UK, 2013)

Another key informant from UNISON described what he called the “immigration trap”:

They came as students, but they were nurses in the Philippines and are now working part-time as caregivers. When, in 2008-2009, the government stopped recruiting general nurses, recruitment agencies in the Philippines told them to come as students. Despite being trained and working as nurses, many hoped to find a sponsor to move role and an employer who would hire them. Many came, they found poor-quality courses, and no one told them that they couldn't work. In the meantime, the work permit mechanism was replaced by the points-based system. Many of them became undocumented. The exact number is unknown, but we know that there were a lot of them: an assisted voluntary return programme, mostly targeted to refugees, was offered by a charity in collaboration with the IOM [International Organization for Migration]. The Home Office told the charity that Filipinos in such a situation could also be assisted. In the end, they were in the top ten countries list assisted by the programme. (Trade unionist, UNISON, UK, 2013)

Another key informant explained how the changes described above produced their effects in recent years, from 2016 onwards, with the first cycle of “revalidation”—that is, the three-yearly process requiring registered nurses to demonstrate that they are fit to practice.

The years from 2016 to 2019 are important, as July 2016 is when English language tests became applicable to EU nurses. Those years were the first cycle of revalidation for nurses. So, nurses could no longer passively pay their fees and remain registered: they had to submit evidence of practice, signed by another registered nurse. I expected a lot of nurses to drop off in that period. From the Philippines data, you can see that only 85 nurses left between 2002 and 2016, while more than 200 left in 2018-2019 alone. Nevertheless, the NMC's revalidation evaluation found that the difference in those leaving the register has been negligible. (Researcher, Anglia Ruskin University, UK, 2020)

After that, Brexit brought further restrictions that are having paradoxical effects. The Brexit-focused agenda of the government led by Boris Johnson gave high priority to facilitating the recruitment of foreign-educated doctors and nurses to respond to the growing need for health personnel (90,000 vacancies in NHS trusts in 2019; see British Medical Association, 2020). The Immigration and Social Security Co-ordination (EU Withdrawal) Bill (2020) imposed stricter controls on immigration, defined and implemented through the Immigration Rules. The latter included a fast-track NHS visa for doctors and nurses, on condition of holding a job offer, speaking English, and being trained to a recognized standard; at the same time, however, they raised the requirements and costs of the immigration application.^{viii} The British Medical Association (2020) expressed concern about the disincentivizing effect of such provisions for migrant health professionals working in the

NHS, putting the professional system under stress and affecting “the efficient and safe running of the health service.”

Recruitment practices

Other institutions that play a critical role in regulating health professionals’ migration flows are market actors, namely international recruitment agencies. The research activities carried out between 2013 and 2015 aimed to fill a knowledge gap, as recruitment practices were poorly explored (see Young, 2013). For this reason, the survey questionnaire included a subset of conditional questions for those respondents who declared that they were recruited before moving to the UK. These questions aimed to check for differences between recruitment channels—whether managed directly by the employer or intermediated by an agency—and to assess their impact on professional trajectories. They were also directed at understanding whether the respondents had experienced problems with the recruitment process. The most frequent problems reported in the literature are: first, insufficient, inaccurate, or misleading information received about the type of employer, the terms of employment, and work tasks; second, the excessive fees charged to migrants by recruitment agencies. The UK Department of Health’s (2004) Code of practice for the international recruitment of healthcare professionals^{ix} and the World Health Organization’s (2010) Global code of practice on the international recruitment of health personnel deemed these practices unethical.

The analysis of the survey data revealed that 60 per cent of respondents were recruited before moving to the UK. Half of them were recruited directly by the employer; the other half were recruited through a recruitment agency. Among the others, almost 25 per cent were recruited by the employer after they arrived in the country: most of them had entered with a student visa; then, they found a job as a nurse and changed their legal status. Focusing on IRNs, six out of ten respondents reported problems with insufficient, inaccurate, or misleading information. A similar picture emerged concerning excessive recruitment fees. Indeed, less than 30 per cent of those recruited through an agency would recommend it to others. The share of respondents who expressed disappointment with the recruitment process was higher among those hired through an agency (see also Pittman, Herrera, Spetz, & Davis, 2012).

The data also suggested that the recruitment process experience went on to correlate with working conditions. For example, the respondents recruited directly by the NHS declared that they were satisfied with their working conditions more often than the others. Those who were disappointed with the recruitment process more frequently reported having experienced harassment, bullying, or abuse from teammates or managers.

Analysis of the interviews brought additional elements to complete the picture. A first point is about the codes of practice. These codes rely on voluntary adherence, and there is no

statutory mechanism to ensure compliance. As such, they are difficult to implement. As a key informant explained:

The problem is that these codes are ineffective, especially because IRNs often have no options other than accepting what agencies offer them. Improvements in the recruitment process hardly come from the nurses' side, and this is a limit. [...] We talked to several Filipinos working as nurses in the UK, who mortgaged their houses and incurred debts to pay the agency. (Trade unionist, UNISON, UK, 2013)

That said, one interviewee claimed that the situation had improved following the creation of a list of agencies that adhere to the UK's Code of practice and a support service to help NHS organizations follow its principles. The same person explained how the process works:

We have an application process: we ask key questions; then, we check. We make spot checks on the agencies' website. [...] If we find or hear about a breach of the code, we undertake an investigation process and, in the end, remove the agency from the list. (Officer, NHS Employers, UK, 2013)

Nevertheless, the most effective monitoring tools are "informal networks," through which information and reputation circulate:

We have a network of employers that we use to communicate. We also have personal networks from which we get feedback. (Officer, NHS Employers, UK, 2013)

A second point has to do with the extension of unethical recruitment practices to persons other than overseas nurses, in which employers play a direct role:

Unethical recruitment is now affecting senior care workers, either recruited by international agencies or UK businesspeople. [...] We organized briefings with [the senior care workers] to understand how they were recruited. We discovered that they were charged high fees. [...] We found that they had to pay at least 6,000 pounds to come and be hired here. Agencies go to rural areas, where they know people have lands and properties to loan in order to pay for being recruited. (Officer, Kanlungan Filipino Consortium, UK, 2013)

Two remarks must be made here. First, the channels through which FENs are recruited seem to have a predictive effect on their exposure to exploitation from employers in the UK. IRNs in particular already experience abuse before being recruited. Second, attempts at "soft" regulation, through non-mandatory codes of practice, have proven to be of little effect in preventing unethical practices.

That said, the International Labour Organization (2019) published a guide in the same vein—that is, drawing non-binding principles and guidelines—entitled General principles and

operational guidelines for fair recruitment and definition of recruitment fees and related costs. This document has the merit of defining what is meant by recruitment fees: “any fees or costs incurred in the recruitment process in order for workers to secure employment or placement, regardless of the manner, timing or location of their imposition or collection” (p. 12).

Discussion and conclusions

The analysis conducted in the previous pages brought evidence of considerable heterogeneity in the field of health professions in the UK. The focus on the nursing profession allowed us to show that migrant workers have contributed to increasing heterogeneity. The article has also revealed that this heterogeneity involves differential paths of socio-professional integration and rising inequalities among nurses from abroad as observed among nurses recruited from the Philippines and India. It has also shown that inequalities are reflected in poor working conditions, which, in turn, may affect the quality of care. Although they are considered “essential workers” and give a precious contribution to their host society, these professionals are often overqualified for their jobs and find themselves trapped in precarious employment situations, mostly because of their immigration status.

Restrictive rules on immigration and access to the profession has paved the way to processes of precarization, downgrading, and segregation, putting FENs in a vulnerable position, exposed to exploitative situations. In fact, they are admitted more and more often on a temporary work permit, employed as healthcare assistants, and treated as “foreigners,” regardless of the time spent in the host country and the contribution given to society. In addition, a differentiation of entry paths emerged, with those arriving through an international recruitment agency frequently being disappointed with their working conditions and experiencing cases of harassment, bullying, or abuse. In light of that, the recruitment channel turned out to be a critical variable. The research findings suggested that such abuse is part and parcel of a lucrative recruitment industry, centered on the critical role of private agencies that operate as facilitators of migration flows on a global scale. All in all, Brexit, on the other hand, is an intervening variable that has not altered the picture. What it has done, however, is increase levels of uncertainty, which act as a disincentive for migrant health professionals to come to or remain in the UK.

These findings have remarkable theoretical implications for the study of professions. In general, they allow us to understand how global-scale change processes induce processes of differentiation within and between professions at different levels: macro-systemic (the professional system); meso (professional groups); and micro (professionals). The outcome of this interplay of processes is heterogeneity, above all in terms of inequality.

Drawing on Bellini & Maestripieri (2018), we defined the “within” dimension as referring to the position that each practitioner can access in a given professional labour market,

influenced by individuals' either ascribed (age, gender, ethnicity, and social origins) or acquisitive (education, professional qualification, as well as legal status and language skills in the case of a migrant worker) characteristics. As the authors notice, "differentiation 'within' can [...] occur over time, when regulation intervenes to loosen the boundaries of a professional activity or to modify the terms by which social closure is put into practice" (p. 7). "In this sense," they continue, "institutional change can be seen as a form of change which shapes professionalism from within" (p. 7). This is the case of the nursing profession in the UK, where institutional changes (in immigration rules, professional regulation, and recruitment practices) have induced differentiation processes based on acquisitive characteristics (the legal status of migrant worker), inevitably related to ascribed characteristics (ethnicity). These have caused rising inequalities among professionals (at the micro level) and put the professional system under stress (at the macro-systemic level).

Then, we defined the "between" dimension as referring to the interactions between occupational jurisdictions (Abbott, 1988), based on dynamics of professional power (Johnson, 1972) and social closure mechanisms (Parkin, 1979). Although it was not a focal dimension of our analysis, evidence emerged concerning interprofessional (between nurses and healthcare assistants) and intercultural (between foreign and native nurses) conflicts that would require closer inspection. However, a shift in focus to cultural hybridization—defined as a process related to globalization through which "external flows interact with internal flows producing a unique cultural hybrid that combines their elements" (Ritzer, 2010, p. 255)—ought to be considered in order to cast light on an unexplored issue. Indeed, the effects of different professional cultures coming into contact due to migration flows would be worth an in-depth investigation.

An almost neglected perspective is the "beyond" dimension, referring to the bidirectional relationship between professions and society. In this regard, the case of FENs is highly significant. Their professional contribution helps overcome the chronic shortage of nurses in the UK (Buchan, 2007), and therefore mitigate staffing pressures (Health Education England, 2019). Moreover, it ensures the British people a qualified service, which—to put it in terms of "social exchange"—is not adequately recognized or rewarded.

This is truer at the time of writing, as the Covid-19 pandemic is showing. To put it with Buchan & Catton (2020, p. 5), "nurses are at the frontline of the response to the virus, are central to successful progress in suppressing it, and will be the mainstay of post Covid-19 health systems. This has been widely acknowledged but has not come without cost. Nurses have fallen ill or died, [...] and many others are experiencing work related stress and burnout." Assessing the impact of Covid-19 and its long-term effects on the supply of nurses will be a major line of research in the next years. Political choices and institutional action will be critical factors to observe. In the UK, it will be interesting to understand how the combined effects of the pandemic and Brexit will affect what, in the event pre-Covid-19 shortages persist, remains a necessary labour market.

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- i. A random sample could not be created since it was not possible to access the personal data or contact details of potential respondents. Distributing a web-based questionnaire—directly through the associations and indirectly through the British Malayali portal—was seen as an acceptable solution. The selection criteria included the type of employer, the public or private nature of the healthcare facilities, and the recruitment channel.
 - ii. Most of the questions were borrowed from a questionnaire used in a survey carried out by the Royal College of Nursing, with its consent, to guarantee the data comparability.
 - iii. This result is explained by the fact that British Malayali is popular among Indians living in the UK. The Filipino community was the target of the outreach strategy, which was nevertheless not as successful as for the Indian community.
 - iv. In both studies, the interviews had a variable duration from 45 to 90 minutes. A consent form, prepared by the ILO following strict internal ethical standards, was viewed and signed by each interviewee. The interviews were recorded and transcribed, handled confidentially by Calenda and delivered to the ILO (for more details, see Calenda, 2014; 2016).
 - v. In 2006, the UK government raised the requirement for applying for permanent settlement from four to five years. A year later, it set new criteria for the renewal of work permits and visas for senior care workers, requiring them to have Level 3 National Vocational Qualification (NVQ) skills and qualifications, along with a higher minimum salary. Then, in 2012 the UK Border Agency (UKBA) introduced changes to employment-related settlement, among which a new pay threshold applying to anyone entering or switching into Tier 2 of the points-based system who would have been eligible to make a settlement application from 2016.
 - vi. The NHS pay system, covering all directly employed staff, including nurses and healthcare assistants, is based on nine pay bands. Each of them has several pay points. Every year, staff progress to the next pay point.
 - vii. Band 6 ranges from 31,365 to 37,890 pounds per year, while Band 5 ranges from 24,907 to 30,615 pounds per year, depending on the worker's experience, from less than one year to eight or more years.
 - viii. The Immigration Rules, published in February 2020, included the following provisions: visa fees of 1,220 pounds per person (900 pounds for those on the shortage occupation list); an increase of the Immigration Health Surcharge (IHS) to 624 pounds (470 pounds for students).
 - ix. This document has been recently revised and published with a new title, Code of practice for the international recruitment of health and social care personnel (UK Department of Health, 2021).