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**RECRUITING FOREIGN NURSES FOR THE UK:
THE ROLE OF BILATERAL LABOUR AGREEMENTS**

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PhD in Social Policy

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DECLARATION

I declare that this thesis is of my own composition, based on my work with acknowledgement of other sources, and has not been submitted for any other degree or professional qualification. The thesis includes material published by myself. The relevant reference is given in the bibliography and a copy of this publication is attached in the appendix.

Evgeniya Plotnikova.

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ABSTRACT

This thesis is about policy instruments for the regulation of international labour mobility. It focuses on the use of government-to-government agreements on the cross-border movement of nurses, negotiated between source and destination countries. This research is a qualitative case study of agreements signed in the early 2000s between the UK and Spain, South Africa, the Philippines and India. It aims to understand the role of these agreements in British policy as perceived by actors in the destination country. It addresses three questions: 1) What types of agreements did the British government negotiate? 2) Why did the British government negotiate these agreements? and 3) What functions did these agreements perform?

Employing the notion of ‘policy tools’ as an organising concept, this thesis’s analytical framework draws on political sociology and the conception of policy instruments as being composed and brought into existence by actors and their power relations in multilevel policy contexts. This study is based on documentary analysis and elite interviews with experts in international organisations, officials in the Department of Health (England), recruitment officers in the source countries, and professional nursing organisations and trade unions in the UK.

This thesis argues that government-to-government agreements between the UK and supply countries emerged from a discourse on the ethical recruitment of health workers which was framed in the language of human rights. One of the roles of these agreements was to contain contradictory and conflicting interests between and within institutional actors involved in the international recruitment of nurses on both sides of the migration process. More broadly, the research addresses and advances the discussion of the policy instrumentation approach, and contributes to the understanding of the choice of policy tools and their performance in an ambivalent policy context.

LIST OF ABBREVIATIONS

APEC	Asia-Pacific Economic Cooperation
CARICOM	Caribbean Community
CASME	Caribbean Community Single Market and Economy
CAZ	Covenant on Migrant Health Workers
CEEC	Central and Eastern European countries
CS	Commonwealth Secretariat
CSME	Caribbean Community Single Market and Economy
CSME	Commonwealth Countries
DENOSA	Democratic Nursing Organisation of South Africa
DFID	Department for International Development
DH	Department of Health
EC	European Commission
EU	European Union
FO	Foreign Office
GATS	General Agreement on Trade in Services
HSWP	Highly Skilled Workers Programme
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICN	International Council of Nurses
IELTS	International English Language Testing System
IFP	International Fellowship Programme
ILO	International Labour Organization
IMF	International Monetary Fund
ISCO	International Standard Classification of Occupations
IT	Information Technology
MDGs	Millennium Development Goals
MFN	Most Favoured Nations
MoU	Memoranda of Understanding
NAFTA	North American Free Trade Agreement
NHS	National Health Service
NMC	Nursing Midwifery Council
OECD	Organisation for Economic Co-operation and Development
OME	Office of Manpower Economics
OWWA	Overseas Workers Welfare Administration
POEA	Philippine Overseas Employment Administration
RCN	Royal College of Nursing
SADNU	South African Democratic Nursing Union
SATSE	Spanish Nursing Trade Union
SAWS	Seasonal Agricultural Workers Scheme

SBS	Sector Based Scheme
SGCN	Spanish General Council of Nursing
UN	United Nations
US	United States
WHO	World Health Organization
WHS	Working Holidaymakers Scheme
WPS	Work Permit System
WTO	World Trade Organization

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1. Introduction

1.1 SETTING A BACKGROUND

The latest medicine and the newest technologies may have little impact on human health if there are not systems with skilled personnel in place to deliver health care services (World Health Organization, 2006a). The size, distribution and composition of the health workforce have a crucial impact on the quality of health service delivery. Today, one of the key problems shared by many health systems in both developed and developing countries, is a shortage of health workers¹. As reported by the World Health Organization (WHO), there is an estimated global shortage of 4.3 million health workers, including doctors, nurses, midwives, community workers and pharmacists. This trend is expected to increase by 20% within the next two decades (World Health Organization, 2006b). It is estimated that by 2020, the United States (US), one of the major receiving countries, will face the need for an additional one million health workers. The same number is required in African regions in order to meet the Millennium Development Goals (MDGs) by 2015. Furthermore, it is predicted that European Union (EU) countries will face a shortage of 1 million health workers by 2020 (Wismar et al., 2011).

What are the reasons for this increasing scarcity in health personnel around the world? The answer might be obvious for developing countries with chronic underinvestment in health systems, low salaries and poor working conditions for health workers. However, developed countries also experience shortages in health

¹ It should be noted that the policy and research literature often uses the terms 'health professionals', 'health care professionals' and 'health workers' interchangeably. For clarity of terminology, this study uses the term 'health worker' except for cases where the term 'health professional' or 'health care professional' is used in primary sources. This choice is informed by the position of the WHO, and the International Standard Classification of Occupations (ISCO) established by the International Labour Organization (ILO) (WHO, 2006a; ILO, 2004a). Based on these sources, the study defines health workers as all health service providers, including physicians, dentists, nurses, pharmacists, public health specialists, laboratory technicians or other health service providers who deliver personal and non-personal health services. This term does not include health system workers, that is, managerial and support staff, such as health economists, managers and planners, who are not engaged in the direct provision of health services but ensure that the health systems function to attain their goals. It is also important to mention that based on the ISCO definition, health professionals does not include nurses, as nurses are placed into the separate category of nursing professionals.

personnel; to an extent that is perhaps less alarming than in developing countries, but still visible in health service delivery.

A complex interplay of factors explains the global nature of this phenomenon. Demographic and epidemiological changes, political priorities, economic conditions, technological innovations and consumer expectations increase the demand for health workers globally (Kline, 2003). These growing pressures, placed on the health sector and individual providers of health services, produce various forms of labour mobility. These include intra-sector transitions from public to private health care institutions; inter-sector mobility when professionals leave health care related jobs and move to other occupations; and, finally, geographical migration to foreign countries which provide better employment conditions for health workers. The last of these forms of labour mobility has significantly accelerated over the past three decades. As reported by the European Health Observatory on Health Systems and Policies, foreign health workers made up over 10% of doctors in Belgium, Portugal, Spain, Austria, Norway, Sweden, Switzerland, Slovenia, Ireland and the United Kingdom in 2008 (Wismar et al., 2011). In the OECD countries, around 20% of doctors come from abroad. In 2008 foreign-trained nurses made up a significant share of all nurses in countries such as Ireland (47.1%), New Zealand (22.1%), Australia (16.4%) and the UK (8%) (Organisation for Economic Co-operation and Development, 2010). The inflow of foreign nurses in the same year was particularly high in Italy and the UK with 28% and 14.7% of all newly registered nurses respectively (Wismar et al., 2011).

In some Gulf States, such as Kuwait and the United Arab Emirates, more than 50% of all health workforce are migrants (World Health Organization, 2010). Although the financial crisis of 2008 has stabilised and even slowed down the pace of labour mobility in a number of countries, the overall number of health workers moving across borders continues to rise (Organisation for Economic Co-operation and Development, 2010).

The growth of cross-border mobility of health workers since the 2000s has led to the re-establishment of a long-standing debate, which began in the early 1970s, around the problem of 'brain drain'. Many questions which were posed four decades ago remain unresolved and thus require further attention today. These include:

- How many health workers move across borders each year?
- How can the consistency of qualifications and the quality of health services delivered by foreign health workers be ensured?
- How can the rights of migrant health workers facing the risk of exploitation and of racial and gender discrimination in receiving countries be protected?
- What are the appropriate policies to manage health worker migration?

Among these questions the present work takes a closer look at the governance of health personnel in international migration. It discusses the role of bilateral labour agreements in the regulation of the cross-border mobility of nurses.

1.1.1 THE RISE OF CROSS-BORDER NURSE MOBILITY

In the late 1990s and the early 2000s, the cross-border mobility of health workers increased significantly and reached a critical point. The number of work permits granted in the UK to overseas nurses and doctors during the period 2001 to 2006 was 147,640 and 17,779 respectively (Buchan et al., 2008). This can be compared to the estimates of overall health worker migration produced by Mejia in 1978, of 14,000 nurses moving across national borders and 140,000 physicians practicing outside their own countries (Mejia, 1978). This data indicates a significant intensification of migration flows of international health workers today, not only to the UK but also possibly across the world. Moreover, this data points to a shift in occupational and gender mobility, with nurses becoming more active labour migrants (Martineau et al., 2004; Stewart et al., 2007).

One of the key experts in the field of global nursing, Professor Buchan, lists a group of determinants of expanding overseas employment opportunities for both medical professionals and nurses (Buchan et al., 2006). These include improved transportation links and relatively reduced travel costs; an increasing number of recruitment agencies mediating cross-border mobility; the proliferation of access to

the internet as a source of knowledge about jobs and employers; mutual recognition of qualifications; and negotiation of government-to-government agreements facilitating migration flows. A number of scholars recognise similar factors driving the internationalisation of the nursing profession in particular. Among these are globalisation of the market and the development of free trade agreements; intensified information flows; moving towards international nursing standards. Nursing does not have a long history of recognising professional qualifications across country borders, therefore a number of recent initiatives taken at the international level became an important step to ease international nurse mobility. For instance, New Zealand and Australia concluded Trans-Tasman Agreement in 1998 which mutually recognises qualifications of health workers, including nurses, between the two countries; the European Federation of Nurses Associations is currently discussing a system of comparable degrees for nurses from European Union countries; finally, professional organisations such as the International Council of Nurses [ICN] and Public Services International [PSI]) also advocate for unified professional standards and protection of labour rights of health workers across the world (Martineau et al., 2004).

The general trend of nurse migration, gradually increasing since the 1970s, rocketed in the late 1990s. In an effort to address the temporary shortages in health personnel, many developed countries were actively recruiting from developing countries. As policy analysts have argued, this recruitment drive deepened the chronic crisis in human resources in health across the globe, particularly in poor regions such as Sub-Saharan Africa (Kline, 2003; Bourgain et al., 2008). A cycle was thus created whereby the shortage of nurses in developed countries stimulated outflow of health workers from the developing world and, as a consequence, contributed to the critical situation in their health systems. This cycle occupies the present policy discourse and research agenda. Two related questions are commonly posed: how to address the problem of the global nurse shortage and how to effectively regulate the international migration of nurses.

Scholars in labour studies and industrial relations distinguish a group of reasons for the shortage of nurses in both developed and developing countries (Clark et al., 2006). The nursing shortage in the majority of developed countries is seen as a periodically emerging gap between labour supply and demand. This gap is a result of

an imperfect health labour market model, in which the relevant adjustments take a longer amount of time than in competitive labour markets (Zurn et al., 2002). In these conditions, the imbalance between supply and demand is likely to become static in the long-term. As with most other markets, the labour market for nurses is characterised by market failures, but what is unique is the extent of these market failures. The nurse labour market is particularly vulnerable for a number of reasons. First, both labour supply and labour demand rely on the socio-demographic structure of the population in general and the nursing workforce in particular. For instance, in developed countries, demand for long-term nursing care increases with growth in the older population. At the same time, ageing of the nursing workforce leads to high retirement rates and decreased labour supply (Baumann et al., 2004). Second, reproduction of human resources for health is a time-consuming and costly process. Labour supply is affected by a substantial time lag between education and practice. For instance, on average at least 3 years are required to train a nurse. Therefore, it takes years to see the results of an increase in training places. Moreover, the introduction of more training places as an individual measure would not necessarily solve the problem of labour shortage. The stability of the workforce also depends upon whether the health profession attracts young talent and whether experienced staff are motivated to stay in practice despite professional hazards associated with health care, such as heavy workloads, night shifts and psychological pressures. Third, nursing is predominantly a female profession. The availability of flexible working hours and part-time options is essential to attract and retain female workers. Finally, econometric evidence suggests that the labour supply of nurses is unresponsive to wage increase. This indicates the prevalence of incentives other than wage, such as job satisfaction, training opportunities and relations with colleagues (Barigozzi and Turati, 2009).

In the late 1990s there were evident shortages of health workers in developed countries. Such shortages were caused by characteristics of the nursing labour market as an imperfect model and a number of conditions, including the growth of the elderly population and greying of the nursing workforce, declining prestige of the nursing profession among young females as more attractive career opportunities became available, low job satisfaction and a high rate of professionals leaving

nursing jobs (Simoens et al., 2005). The shortage of nurses in developed countries in the late 1990s was also, importantly, a result of political decisions inspired by the cost containment policy in the health service. For instance, in the early 1990s the Conservative Government in the UK considerably reduced the number of training places for nurses (Aiken et al., 2004).

While in developed countries the shortage of nurses is a periodic short-term phenomenon typical for health labour markets in general, the shortage in the medical and nursing workforce in developing countries has reached a chronic and critical phase. The WHO estimates that 57 countries experience a critical shortage in the health workforce, having less than 23 health workers per 10,000 of the population (World Health Organization, 2006b). All of these countries are in the regions of African and Asia. The reasons for this shortage are well recognised. They include such countries taking a high share of global disease burden, underinvestment in nursing education, and massive outflow of health workers who are attracted by higher salaries, better living conditions and promising career opportunities abroad (Kline, 2003). The latter, as already mentioned above, has become one of the top issues on the policy agenda (Stilwell et al, 2004).

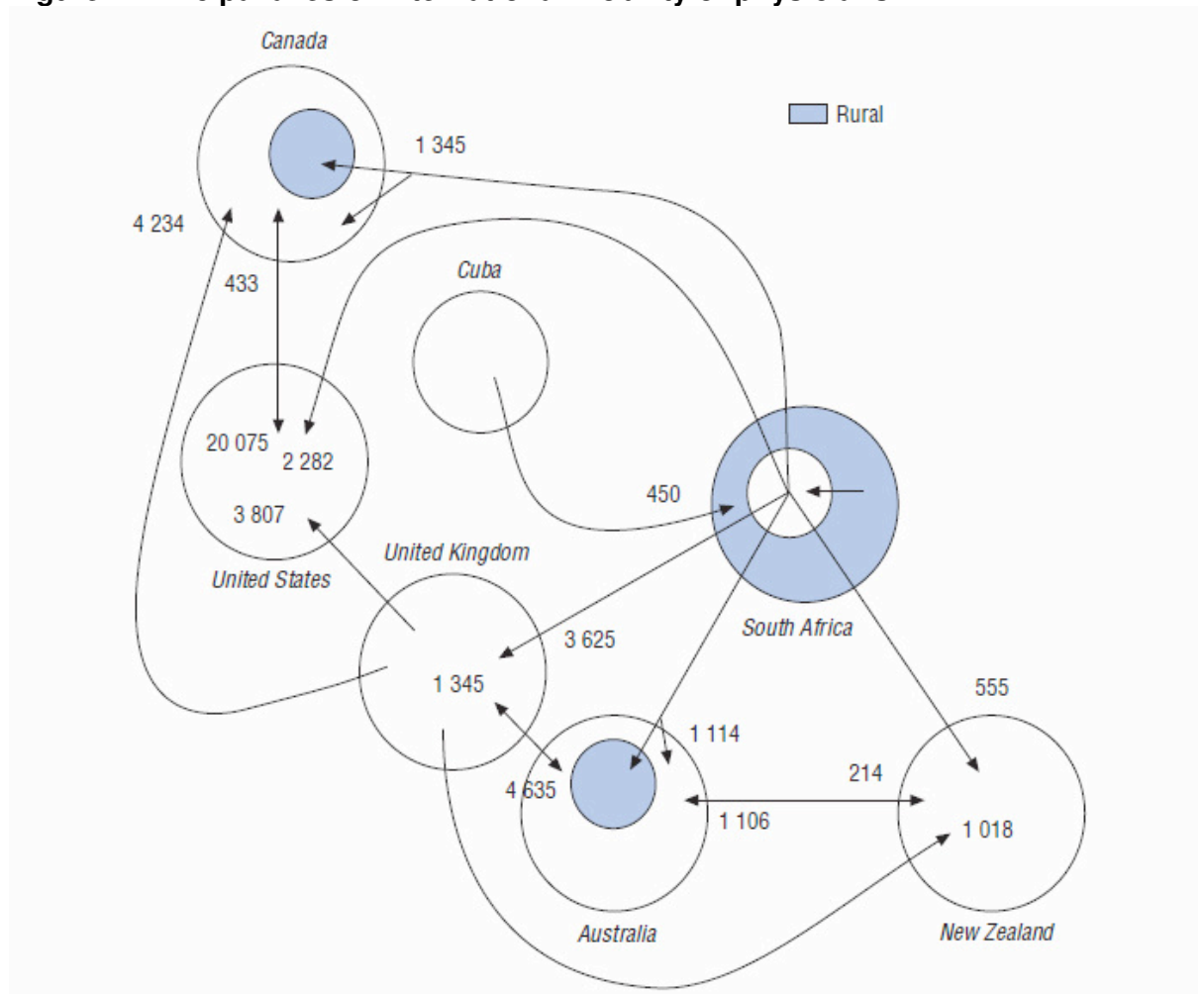
Discussion of the effective regulation of the cross-border mobility of health workers has been present in the policy discourse since the ‘brain drain’ problem was originally exposed in the early 1970s (Martineau et al., 2004). At that time it was mainly portrayed as a national regulatory problem of controlling the number of labour migrants by using restriction, retention and information as the key tools (see Chapter 2). This debate continues four decades later, however, the regulatory problem has now reached a new, global level, which requires a joint response from the governments of developed and developing countries.

1.1.2 INTERNATIONAL NURSE MIGRATION AS A REGULATORY PROBLEM

The contemporary dynamics of international mobility of health workers, for both doctors and nurses, are often referred to as a ‘carousel movement’ and ‘brain circulation’ (Blitz, 2005; Ncayiyana, 2009). This type of migration is described in an OECD report that illustrates mobility patterns of South African physicians based on

the medical registry data for 1998 (Organisation for Economic Co-operation and Development, 2004a) [See Figure 1].

Figure 1 Principal axes of international mobility of physicians



Source: OECD, 2004a.

The Figure 1 illustrates a complex and multilayer picture of migratory routes when Canadian doctors move to work to the US, and are then replaced by South African doctors from urban areas. Meanwhile, the South African government covers the shortage of physicians in rural areas with Cuban doctors. Likewise, the United Kingdom, which loses health workers to North America, recruits from other European countries such as Germany, Poland and Spain. At the same time, Germany receives doctors from Central and Eastern European countries, such as the Czech Republic (Organisation for Economic Co-operation and Development, 2004a). A

similar picture could be drawn illustrating migration flows of nurse professionals. While British nurses choose to work in Australia, the US and New Zealand, back home they are being replaced with recruits from the Philippines who receive nurse training in their home country due to strong migratory aspirations. They start their migration journey by first arriving in the Middle East countries such as Saudi Arabia or United Arab Emirates to improve professional skills and save money for further move in their migratory journey to the UK, where after practicing for couple of years, they move again to the US – the final desired destination for many Filipino nurses (Kingma, 2006).

These two examples illustrate not only contemporary migratory routes of South African doctors and Filipino nurses but also provide a snapshot of a more general trend in health personnel migration around the globe. The latter includes many stops in the migratory route between and within developed and developing countries where one country often becomes a stepping-stone for a move to another state. The complex and multilevel character of contemporary migration is only one of the challenges in regulation of health worker mobility. A number of other factors contribute to the problem of effective governance in cross-border movement of health personnel. These factors include: flows of labour migration increase dramatically; the networks of private recruitment agencies proliferate across geographical borders; and regulatory tools in labour migration evoke questions of mutual coherence.

To demonstrate why and how the regulation of international nurse migration becomes a problem, it is necessary to examine the tensions in the governance framework and from where these tensions originate. In other words, one must explore what types of regulation exist, who the political actors producing these regulatory frameworks are, and how their positions on international labour migration co-exist.

To begin with, the contemporary regulatory framework in the migration of nurses comprises many layers of regulation introduced at the national, bilateral, regional and international levels (see Chapter 4, Figure 4). With more regulatory tools being introduced at the international level, a global governance framework has emerged, with international agencies becoming more visible and, some might argue,

more influential in migration governance. International organisations such as the WHO, the ICN and the World Trade Organization (WTO), have introduced a number of instruments in relation to health labour migration: the *WHO Code of Practice* (WHO, 2009), the *ICN Position Statement on Ethical Recruitment* (International Council of Nurses, 2001a) and the *Mode 4 on Movement of natural persons* in the *General Agreement on Trade in Services* [GATS] (World Trade Organization, 1995a). Global regions, such as the North American Free Trade Agreement (NAFTA), the Caribbean Community (CARICOM), Commonwealth countries, the Asia-Pacific Economic Cooperation (APEC) and the EU, have also become active agents producing mechanisms to manage the migration of health workers.

Although the number of cross-border policy tools is growing, some scholars have questioned the implementation capacity of international instruments as many (with the exception of the directives of the European Commission [EC]) principally have recommendatory intentions (MedAct, 2003; Martineau et al., 2004; Stewart et al., 2007). As some scholars argue, the nation-state, using ‘hard’ law mechanisms, still remains the key regulator of the global health labour market despite the proliferation of mainly soft governance tools produced by the international agencies (Bach, 2007). Among these ‘hard’ law tools, immigration rules are the most obvious instruments used to regulate cross-border migration. In fact, the type of immigration system a country operates reveals much about the national economic and political climate. Immigration rules tend to open the gates in times of economic prosperity and political loyalty to foreign labour migrants, while economic downturn and political leadership in favour of anti-immigration policies tends to lead to restrictive measures and immigration caps. For instance, the UK is an example of a country with a periodically changing immigration system.

However, it is not only immigration rules that control access to the national labour market. The dominant position of the nation state has been maintained by using an array of policy tools. Professional organisations and registry bodies are the gatekeepers responsible for ensuring coherence between the qualifications and language skills of foreign health workers, and the national standards. For instance, the overseas nurse can operate in the UK only if his/her qualification is approved by the Nursing Midwifery Council (NMC) and his/her language proficiency, evaluated

using the International English Language Testing System (IELTS), is not lower than 7.0 (Nursing and Midwifery Council, 2008).

In addition to immigration rules and professional regulation, there are specific policies that national governments apply to either attract or restrict the access of foreign migrants to the labour market. Such policies include labour market tests, guidance for employers specifying the countries eligible for recruitment and bilateral labour agreements.

The governance framework outlined above is incomplete without consideration of business interests and their impact on the pace of labour migration. As described by Kingma, international recruitment of nurses has become a highly profitable business managed by networks of private agencies. Flexible, fast and adaptive recruitment agencies play a significant role in facilitating the migration process. Often driven by a desire to attain maximum profits, they bypass normative regulations such as immigration rules and the voluntary ethical guidelines of international organisations (Kingma, 2006).

The multilevel structure in the regulation of health labour migration, as described above, raises the question of how coherent one regulatory tool is with another and how different levels of governance co-exist with one another. This aspect of the regulatory problem in the cross-border mobility of health workers was well illustrated in the early 2000s when the recruitment of foreign nurses in the UK reached its peak. At this time, the voices of many political actors, including government authorities, trade unions, professional organisations in both the UK and source countries, and international organisations, became abundant. The claims of these political actors revealed multiple conflicts which problematised the regulation of health worker migration (see Chapter 6).

The first dimension of this regulatory problem, perhaps typical for many sectors and not merely the health service, pertains to public attitudes to migrant workers and specifically the perception that they are taking jobs from natives as a result of their willingness to work longer hours for less money. For policy-makers, this widespread perception often becomes a point of reference when restricting labour market access for foreign-born workers. At the same time, labour immigration is considered to be an important factor supporting economic growth in many

developed countries where the native population has been increasingly ageing. This poses a regulatory problem: how to balance the inflow of the right number of foreign migrants to keep the economy growing and public discontent about high migration rates, issues of migrant integration and dependency of immigrants on the national social security system.

The second dimension of the regulatory problem pertains to the question of how to ensure the professional qualifications and language proficiency of foreign health workers. Although there are professional organisations monitoring the skills of international health workers, the coherence of education systems and professional standards across the world remains a problem. For instance, the *EU Directive on the Recognition of Professional Qualifications* (Council Directive 2005/36/EC) which allows professionals, including health workers, educated in the EU region to bypass the national supervisory bodies caused concerns of national professional organisations and health care practitioners about standards and patient safety (Royal College of Nursing, 2011). These concerns led to a review of the implementation of this Directive which is due for completion at the end of 2011.

Third, the regulation problem has been discussed in relation to the labour rights of foreign health workers in the country of destination, such as to protection from occupational and racial discrimination, social benefits coverage, and representation in professional associations and trade unions (Kingma, 2006; Smith et al., 2006).

Finally, the regulation of foreign health worker migration reveals a long-standing opposition between the state and the health profession (Johnson, 1995). On the one hand, national policies, such as bonding (an obligation to practice after graduation in public institutions), are adopted by the governments of source countries to protect the sustainability of national health systems and to ensure that an appropriate number of health workers is retained in the country. On the other hand, these policies affect the rights and freedoms of health workers. Migration of health personnel not only produces contradictory relations between state and profession; it also exposes a conflict between governmental obligations to protect public health and international treaties designed to secure individual freedoms (World Health Organization, 2002).

In sum, the effective regulation of health worker mobility has been challenged by a number of tensions, including an increasing number of health worker migrants, a lack of data documenting migratory paths, the proliferation of private recruitment agencies and the expansion of regulatory frameworks to the global level.

As revealed above, the regulatory problem poses a number of questions, such as how to balance economic needs and negative public discourse around migration; and how to ensure coherence of professional qualifications of foreign health workers with national standards, particularly when automatic recognition of qualifications is promoted at the international level. Finally, since migration of health workers involves and affects many stakeholders with different interests, the core of the regulatory problem is how to manage migration without compromising the rights of individuals, patients, and health workers, and the needs of the national health systems in both source and destination countries².

A number of regulatory measures have been proposed in response to this problem. First, there are restrictive measures, including immigration rules, bonding schemes, and training programmes tailored to the local needs of source countries. Most of these policy measures were criticised in the 1970s for limiting the international labour mobility of health workers and postponing their departure only in the short-term (see Chapter 2).

The second type of proposed regulation includes retention tools which encourage health workers to stay in their home countries and tools facilitating return migration. The former relates to a broader discussion in the current policy debate about promoting the effective implementation of human resource strategies in destination countries. These measures include improved recruitment, retention and training of home-grown nurses. It is argued that such policies will decrease reliance on foreign health workers in destination countries and therefore slow down the ‘brain drain’ from poor global regions. The other group of tools in this type of regulation is measures facilitating return migration. These require collaborative action between governments and international and professional organisations in source and destination countries, to improve working conditions, salaries and the provision of benefits for health workers, primarily in low income countries. One example of such

² In this work the terms destination and recipient countries are applied interchangeably; likewise for source and supply countries.

measures is the Caribbean Managed Migration Programme. However, such individual cases are exceptions rather than practice (Stewart et al., 2007).

Third, an important tool in the regulation of migration is information, notably monitoring of the current stock of health workers in a country as well as migration trends of inflow and outflow. Collection of consistent information still remains a problem in many source countries (Pittman et al., 2007).

Fourth, many source countries strongly advocate the introduction of compensatory polices. These are monetary contributions in the form of tax, tariff or direct transaction from destination to source country for the loss of health workers. This type of measure was widely discussed in the 1970s, but no evidence exists on its practical implementation since that time (Gish and Godfrey, 1979; Clark et al., 2006).

Finally, a group of measures recently proposed in policy debates and academic discussions includes ethical tools in international recruitment. Reference to ethical tools in the recruitment of health workers initially appeared in the late 1990s when the first guidelines for the recruitment of nurses were introduced by the English Department of Health (DH). This initiative has since been taken further by other countries, such as Ireland, the US and Canada, and international organisations, such as the Commonwealth Secretariat (CS) and the WHO.

Apart from Codes of Practice, another tool in ethical recruitment is bilateral labour agreements. A number of bilateral agreements were negotiated in the early 2000s on the cross-border mobility of nurses (Clark et al., 2006; Aspen Institute, 2011). The UK was among a few destination countries which concluded them. However, there is a lack of in-depth case studies on the effects produced by these regulatory instruments. It is for this reason that the present research pays attention to these policy tools in the British context of the international recruitment of nurses.

1.1.3 BRITISH CONTEXT

In the late 1990s, the British health sector was characterised by a severe labour shortage of both doctors and nurses³. As the DH reported in 2001, ‘the biggest constraint on the National Health Service (NHS) capacity was the need to increase the number of staff’ (Department of Health, 2001). In a workforce survey conducted by the Office of Manpower Economics (OME) in 2001, more than two-thirds of NHS employers acknowledged recruitment problems and about half experienced difficulties with staff retention (Buchan, 2002). In the same year, the NHS reported a shortage of 57,000 nurses (Stewart et al., 2007). This staffing crisis affected London and South East England in particular, where the vacancy rate grew at twice the national average due to increasing living costs and housing prices (Malhorta, 2006).

The reasons for this national shortage were several: ageing of the population, greying of the nursing workforce, the declining prestige of nursing as a profession, a reduction in training places for nurses in the early 1990s, and the fast growing demand for nurses in the late 1990s as a result of the expansion of the health service. The first three factors are typical for many other developed countries. The growing number of elderly citizens increases demand for long-term nursing care, while the supply of nurses reduces with the ageing profile of the nursing workforce and fewer young people choosing this profession as a life-long career. In Britain in particular, nursing became a rather unpopular profession due to insufficient retention strategies, poor working conditions and low pay when compared to rather attractive options available in other English-speaking countries such as the US, Australia and Canada (Deeming and Harison, 2002). Moreover, the NHS experienced a growing vacancy rate as more nurses looking for flexible working patterns chose register with agencies rather than work directly on NHS contracts (Deeming, 2002).

As mentioned above, these factors are typical for many countries, yet it is the country-specific political context that often becomes a catalyst of such general trends. The nurse shortage in the British labour market in the late 1990s is an

³ This research focuses on the UK shortage of registered nurses (RN): graduate nurses who completed pre-registration nursing programme are legally authorised (registered) to practice by the Nursing and Midwifery Council (NMC, 2008).

excellent example of the way in which the change of political leadership and political choices in planning for national health care, affect both supply and demand in the nursing workforce.

When the New Labour Government came to power in 1997, it announced its modernisation plan for the NHS (Ham, 2004). One of the Labour Party's electoral promises was a commitment to expanding the NHS, reducing waiting lists and improving the quality of the health service. A considerable financial investment in the NHS led to a rapid increase in the demand for health personnel (Department of Health, 2000a). The Government committed to fund over 100 new hospitals and 500 new one-stop primary care centres by 2010. The expected growth in staff numbers was as follows: 7,500 more consultants, 2,000 more GPs, 20,000 extra nurses and 6,500 extra therapists. These plans in health service expansion produced contradictory outcomes. The domestic labour market could not at that point provide the extra numbers of nurses to satisfy the growing national demand due to an insufficient number of nursing schools resulting from significant cuts in the early 1990s under the rule of the Conservative Government (Buchan, 1999; Buchan and Edwards, 2000).

As mentioned above, in 2000 the New Labour Government announced a target of 20,000 extra nurses to be recruited by 2004, in order to meet demand and supply (Department of Health, 2000a). Several mechanisms were suggested to achieve this target. These included more funding for nurse education; an increase in student intake in nursing programmes; and improvement of recruitment, retention and return mechanisms. Of these, international recruitment to fill vacancies with the foreign health workers became the short-term strategy commissioned by the Department of Health (Adhikari, 2010). The results of the training and return policies were expected to be a long-term solution. By 2002, the recruitment target of 20,000 nurses was successfully reached with a significant contribution from international recruitment, primarily from developing countries. From April 1998 to March 2005, more than 70,000 international nurses registered in the UK (Nursing and Midwifery Council, 2005). However, the active recruitment drive raised criticisms that UK employers were 'poaching' health workers from poor regions of the world. In response to these concerns, the Department of Health introduced an ethical recruitment policy,

represented by the Code of Practice and government-to-government agreements⁴ with a number of developing countries, including India, the Philippines, China, Indonesia, South Africa and others. Negotiations also took place with European suppliers of the labour force, including Spain, Germany, France, Italy and Poland. The performance of the Code of Practice was debated in public. Numerous critics argued that the Code failed as a tool to stem the outflow of health workers from source countries (Buchan, 2002; Mesquita and Gordon, 2005; Mensah et al., 2005; Clark et al., 2006; Martineau and Willets, 2006). Less attention, however, was paid to the role of bilateral labour agreements negotiated at that time. Data on bilateral labour agreements is limited and fragmented, mainly presented in descriptive accounts within the policy statements of international organisations and some academic articles (Buchan and Dovlo, 2004; Clark et al., 2006; Connell, 2007; Pagett and Padarath, 2007; Aspen Institute, 2011). This gap inspired the present study to focus on the in-depth analysis of types of agreements, reasons for their negotiation and their functions in the British policy for the recruitment of foreign nurses.

1.2 THE AIM AND RESEARCH QUESTIONS

The aim of this thesis is to understand the role of bilateral labour agreements in the British policy for the recruitment of foreign nurses. This study poses three questions:

- 1) What types of agreements did the British government negotiate?;
- 2) How did these agreements originate?;
- 3) What functions did these agreements perform?

A number of objectives are pursued to answer these questions. First, this study identifies bilateral initiatives between the UK and source countries in the cross-border movement of nurses that appeared in the early 2000s; second, it describes organisational arrangements and the content of these agreements; third, it explores the policy context of their negotiation; and finally, it reveals and interprets the functions of identified bilateral arrangements.

⁴ In this thesis, I apply the following terms interchangeably: bilateral labour agreements, government-to-government agreements and bilateral agreements.

The interest in these policy tools arises for two reasons. First, there is lack of research on government-to-government agreements negotiated by Britain in the early 2000s as part of the ethical recruitment policy (see Chapter 2). Scholars predominantly pay attention to unilateral initiatives introduced by the British Government in ethical recruitment such as the Code of Practice (Department of Health, 2004a). As noted above, agreements negotiated by the UK are mentioned in a number of studies and policy reports. However, these are mainly descriptive accounts. No in-depth case study on the selection and consequences of these instruments has been conducted. Second, the interest in bilateral labour agreements emerges as they are not common instruments in the British labour migration policy (Rollason, 2004). The latter mainly operates generic schemes, such as the work permit system in the late 1990s and early 2000s, and the points-based system introduced in 2008. Like many other receiving countries, and despite active campaigns initiated largely by labour exporting countries (such as the Philippines), Britain has for a long time ignored requests to negotiate bilateral labour agreements with source countries. It is for this reason that the negotiation of bilateral labour agreements in the early 2000s attracted my attention and encouraged analysis of their role in the British recruitment policy.

The choice of qualitative methodology in this study is determined by the aim to develop an interpretative understanding of the role that agreements played in the British policy on the recruitment of foreign nurses. As discussed in Chapter 3, this research applies the case study as a principal strategy to explore the origins and consequences of agreements between the UK and four source countries. Elite interviews and policy documents, the key sources of empirical data, are analysed using the techniques of qualitative data analysis.

1.3 THESIS OUTLINE

This thesis consists of eight chapters, including the introduction and conclusion. The aim of Chapter 2 is threefold. The first section gives an overview of empirical studies on the international migration of health workers from the 1970s to the present. This section identifies gaps in past and contemporary research on the cross-border mobility of nurses and its regulatory tools. Based on this review, the second part of

this chapter presents the sources for the formulation of research questions. The final section of this chapter introduces the policy tools approach, which provides a conceptual framework for this study of bilateral labour agreements. This section describes how the original ideas of two political scientists, Linder and Peters, about cognitive and contextual factors in the selection of policy tools were adjusted for the purpose of this research. Finally, this chapter concludes by explaining how the concepts of contexts, actors' perceptions and functions are integrated in this study to address the question of the origin and consequences of bilateral labour agreements.

Chapter 3 discusses the research design of this study. It outlines the philosophical grounds of research methodology applied in this study. This chapter continues by justifying why the British practice in the negotiation of agreements is selected as a case; why agreements with four source countries, namely India, the Philippines, South Africa and Spain, are chosen as units of analysis in this case; and why the study focuses on the recruitment of nurses in the early 2000s. The chapter then proceeds with a description of methods employed for data collection and data analysis. Chapter 3 also considers the practicalities of conducting elite interviews, such as selection of and gaining access to interviewees, and ensuring confidentiality and trustworthiness of obtained materials.

Chapter 4 gives an overview of the tools used in the regulation of cross-border labour mobility with a particular focus on the subject of this study: bilateral labour agreements. It traces the evolution of these policy tools since the 1960s, when agreements were mainly used as recruitment schemes to bring foreign labour to Europe, to their present multifaceted role as tools of regional integration, co-operation, protection of migrant workers' rights and mechanisms to cope with migrant labour overstays. The chapter introduces the types of bilateral labour agreements negotiated worldwide. It then proceeds with an examination of those bilateral labour agreements that were negotiated on health-related matters. The chapter finalises the account of these policy tools by stressing the status of bilateral labour agreements in the British immigration policy. It concludes with an outline of

bilateral agreements that were negotiated between the UK and several source countries on the cross-border mobility of nurses.

The aim of Chapter 5 is to produce a descriptive account of bilateral labour agreements negotiated on the cross-border movement of nurses between the UK and the four source countries selected for analysis in this research, namely Spain, India, the Philippines and South Africa. The first section in this chapter describes the status of the source countries in the global nurse market. The following section focuses on the content and types of agreements negotiated with each particular country, as well as the activities of the English Department of Health as the primary government agency in the UK responsible for these agreements. The final section summarises these descriptions by identifying types of country-suppliers, types of agreements and types of responsibilities fulfilled by the Department of Health in each bilateral agreement.

Chapter 6 explores the policy context within which agreements were negotiated and perceptions of the institutional actors in relation to the policy problem of nurse migration. The analysis presented in this chapter identifies political actors and their claims in relation to the recruitment of foreign nurses in the UK. The chapter then discusses two strands of the policy context in the negotiation of agreements. The first is the international debate around nurse migration and how the human rights language was exploited by political actors to express their opinions about the international recruitment of nurses in the early 2000s. The second is the British national context of the ethical foreign policy promoted since the New Labour Government came into power in 1997 and how this discourse shaped the British policy on the international recruitment of nurses. This chapter concludes with a presentation of how the recruitment of foreign nurses was problematised in the early 2000s, and how conflicting interests of political actors influenced the selection of bilateral labour agreements. Chapter 6 draws conclusions from the analysis of policy documents, media reports and elite interviews with policy-makers who were involved in the negotiation of agreements and a broader group of political actors who

became active participants in the debate around the international recruitment of health workers in the UK in the early 2000s.

Chapter 7 analyses the consequences of bilateral labour agreements. To reveal what these agreements mean for a destination country, this analysis draws on examination of the perspectives of political actors in Britain: policy-makers, international recruitment co-ordinators, professional organisations and trade unions. To systematise and present these interpretations, this analysis employs Merton's conception of manifest and latent functions and dysfunctional consequences.

The final chapter of this thesis summarises the key findings of this study. It then discusses the relevance of this research to the current policy discourse, and the theoretical and methodological contributions of this work to the policy tools approach. This chapter concludes by exploring prospects for future research on policy tools and the regulation of health worker migration.

2. LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

INTRODUCTION

This chapter, together with two following chapters, continues to set up a background for this research by looking at the policy discourse and research agenda in the field of health worker migration and discussing the conceptual framework of this study.

This chapter consists of three sections. The first explores the policy discourse and research agenda around the regulation of international migration of health workers over the past 40 years. The aim of this historic account is to reveal the key themes, and more importantly, the principal shifts and gaps in the research on health worker migration since the 1960s. This review creates a background for explaining why, among many topical issues discussed in the literature, this study focuses on particular types of policy tools in the regulation of cross-border migration of nurses.

The second section of this chapter identifies the themes in policy debates and gaps in existing literature that inform my research and explains how the research questions were formulated.

The third and final section of this chapter introduces the basic concepts in the analytical framework of the thesis. It integrates the concepts of context, perceptions and functions discussed in the policy tools literature⁵. This section starts with an introduction of the policy instruments approach, reviewing how policy instruments studies progressed from primarily descriptive accounts of policy tool types to explanatory accounts of their selection and consequences. It then identifies the theoretical grounds of the studies of policy tools, tracing a shift from the rational-choice theory dominant in the 1970s to the currently prevailing political sociology perspective. This review concludes by providing a rationale for the application of the political sociology perspective in this study. Specifically, it explains how two concepts, perceptions of actors and contexts, were integrated with functional analysis of policy tools with the aim of developing an understanding of the meaning that bilateral agreements had in the British policy for the recruitment of foreign nurses.

⁵ In this text, the terms 'policy tools' and 'policy instruments' are used interchangeably.

2.1 POLICY DISCOURSE AND RESEARCH AGENDA

The policy discourse and the research agenda of the nurse migration is, to a large extent, a product of a broader debate around cross-border mobility of health workers. Therefore, this section reviews how this broader discourse developed, since it first appeared over the four decades ago, and how the interest to migrant nurses in particular was formed.

Over the past 40 years the topic of international migration of health workers was 'on' and 'off' the policy discourse and research agenda. The first noticeable appearance of this topic on the international policy agenda was during the 1960s. It was reinforced with growth in health workforce mobility worldwide, which reached its peak in the late 1960s and early 1970s. The rise of international health labour mobility became a part of the overall growth in international labour migration, stimulated by growing labour demand to meet the needs of the post-war reconstruction. In the health sector in particular, increasing demand for health personnel was caused by the development of advanced technologies in disease treatment and the expansion of health care services in Western, industrialised and predominantly English-speaking, countries (Wright et al., 2008).

The growth in the cross-border mobility of health workers, recorded throughout the mid-1960s and mid-1970s, attracted the attention of the international community. Concerns were first expressed in 1963 at a United Nations Conference. Policy-makers recognised that developing countries, which experienced the skilled labour out-migration, were 'unable to keep up with the rapid pace of scientific and technological development, being witnessed in Western Europe and North America' (Wright et al., 2008).

In response to these concerns, a number of research projects were launched to shed light on the problem. Their common aim was to identify major receiving and donor countries; to explore the scope, routes and motivation for health workers to leave their countries of origin; and, finally, to discuss the consequences of, and potential solutions to, the problem of 'brain drain' (Ash and Mitchell, 1968; Committee on the International Migration of Talent, 1970; van Hoek, 1970; Gish,

1971; Mejia, 1978; Fraser, 1977). Studies conducted in the 1970s shared a number of common features. First, they primarily focused on the cross-border mobility of doctors (Abel-Smith and Galaes, 1969; Margulies and Bloch, 1969; British Medical Journal, 1977; Gish and Godfrey, 1979) with only rare exceptions offering fragmented data on nurses. The dominant focus on doctors largely reflected the general trend of a higher number of doctors than nurses migrating abroad (Mejia, 1978).

Second, research conducted in the 1960s-1970s discussed health worker migration as a 'brain drain' problem. The latter was seen as an indicator of the failure of health care systems in donor countries to supply a sufficient number of health workers for their internal needs. Research reports provided a number of policy recommendations to prevent the causes and address the consequences of the 'brain drain' problem. Recipient countries were advised to increase the training of the domestic health workforce; provide technical assistance to developing countries in health workforce related issues; and adopt flexible (but not stringent) immigration rules to allow a limited number of migrant workers to temporarily cover occasional shortages in personnel. For the less developed countries, scholars suggested improvement in the education system; the introduction of incentives for highly skilled health workers; and the provision of rewards for professionals returning from abroad (Committee on the International Migration of Talent, 1970; Gish and Godfrey, 1979). A range of regulatory measures was discussed. At that time, scholars already criticised restrictive tools such as bonding schemes, in which graduates were obliged to work for a number of years in home countries before they were allowed to practice abroad. Such tools were seen to postpone but not prevent the departure of skilled labour. Among other solutions, scholars proposed changes in health worker education systems in developing countries, including adapting the curriculum to the local needs of developing countries rather than to the standards of developed countries. It was thought that this would lead to the withdrawal of medical students who had graduated in developing countries from the international labour market, and in doing so, decrease their mobility (Gish and Godfrey, 1979).

Finally, research in the 1960s framed the problem of health worker migration in terms of 'outflow' and 'out-migration' (Gish, 1971). In this discourse, the position of

developed countries was described as that of receiving labour, which was overproduced in other countries. The depiction of developed countries was thus rather neutral at the time, particularly in comparison to later portrayals in the 1990s of developed countries actively recruiting and ‘stealing’ health workers from poor regions (see further in this Section).

One of the major contributions in this field was a series of studies commissioned by the WHO in the mid-1970s and supervised by Mejia (Mejia, 1978). Mejia’s work was widely recognised in the scholarly community as the stepping-stone to understanding international migration routes and the reasons for health worker migration. It was acknowledged as the pivotal study in revealing the flow and stock of physician and nurse workforces in more than 40 countries (Bach, 2007). The research suggested solutions for the ‘brain drain’ problem and attempted to predict future migration trends (Mejia, 1978).

Since the 1980s, the policy discourse around the international migration of health workers has changed. During the economic downturn which proceeded the oil crisis in 1973, many developed countries introduced restrictive immigration measures (Rystad, 1992). As a consequence, a sharp decline was observed in cross-border labour migration, including that of health workers. Moreover, by the 1970s an increase in the domestic supply of medical professionals in recipient countries slowed down the demand for foreign graduates (Mejia, 1978; Wright et al., 2008). International migration of health personnel continued throughout the 1980s and 1990s but at a significantly lower level. The policy discourse and research agenda on the migration of health workers took a much slower pace. Research was mainly pre-occupied with questions about the declined availability of posts for foreign doctors (Richards, 1994); the need for sufficient systems in national workforce planning; the implications of immigration restrictions for overseas medical professionals; and the problems overseas medical professionals faced in coming to the UK and other developed countries (Smith, 1981; Lowry and Cope, 1994).

In the late 1990s and early 2000s, a new recruitment drive in the health sector caused a re-emergence of the ‘brain drain’ debate. Studies conducted in the late 1990s and the early 2000s share two common features with those of the 1960s. First, they focused on similar dimensions of international migration, including the

identification of destination and recipient countries; and the exploration of migration routes, motivations of health workers moving abroad, the consequences of migration patterns and policy solutions. Second, scholars writing in the late 1990s and 2000s continued to indicate the lack of data on migrant health workers and to raise the problem of effective mechanisms in the regulation of health labour migration (Wismar et al., 2011). Although these two themes echoed the research agenda of the 1960s, contemporary studies were characterised by a number of substantial changes in the framing and scope of these problems.

First, in the early 2000s, the discussion on skilled labour migration became more profound as a result of intensified labour mobility in general, and in the health sector in particular (Bach, 2004a).

Second, the shift in occupational and gender mobility, with nurses becoming more active labour migrants in the 2000s than they were in the 1970s, sharpened the interest of contemporary researchers in nurse migration (Martineau et al., 2004; Stewart et al., 2007; Kingma, 2008). Recent studies pay more attention to the individual experiences of migrant nurses, investigating their motives, expectations, recruitment and employment experiences abroad, as well as future aspirations and plans (Buchan, 2006; Likupe, 2006).

Third, policy-makers and researchers became more concerned with active recruitment strategies that developed countries apply to attract skilled labour. In the 1970s, the problem was mainly discussed in the context of the individual choice of professionals seeking better career prospects, higher wages and better working conditions. The problem addressed in policy debates at that time was how to devise appropriate regulation for the 'natural' migration of health workers (Gish and Godfrey, 1979). In the contemporary era, accusatory discourse in policy and research became more profound. It underlines the decisive roles of the government in destination countries and private recruitment agencies working across borders, in driving an intensive outflow of the health workforce from poor nations (Kingma, 2006). In this context, the perception of wealthy regions has changed from that of being 'receiving' countries to that of being 'aggressively recruiting' countries. In the 1970s, their position was predominantly described as accepting the outflow of foreign skilled labour, while in recent times, destination countries are more often

accused of actively recruiting skilled labour. The incorporation of active recruitment mechanisms in national workforce policies is criticised as a strategic choice of developed countries which delivers a cheaper and quicker method to address shortages in the national labour markets (Martineau and Willets, 2006).

The other distinctive feature of the contemporary research agenda is the framing of the ‘brain drain’ problem in the discourse of global ethics and human rights (Wright et al., 2008). Policy debates on the cross-border movement of health workers in the health sector intensively relate to the human rights framework, which reveals the contradictions between individual and institutional actors involved in the international migration of health workers (see Chapter 6). Since the early 2000s, a wider range of international organisations (including the International Council of Nurses, Realizing Rights: the Ethical Globalization Initiative and the International Labour Organization) have joined the debates around the active recruitment of health workers from developing countries. These organisations have launched a number of research projects, campaigns and policy initiatives addressing the negative consequences of active international recruitment (see Table 1).

Table 1 Health worker migration: International action

2001	International Council of Nurses (ICN) issued a position statement on ‘Nurse Retention, Recruitment and Transfer’
2002	Realizing Rights: the Ethical Globalization Initiative was founded to promote the right to health
2003	Commonwealth Secretariat introduced the Code of Practice for the International Recruitment of health workers
2004	World Health Assembly Resolution (WHA57.19) requested for the Code of Practice on the recruitment of health personnel
2004/2006	International Organization for Migration (IOM) organised seminars on ‘Migration and Human Resources for Health: From Awareness to Action’
2005	International Council of Nurses (ICN) and Commission on Graduates of Foreign Nursing Schools (CGFNS) founded the International Centre on Nurse Migration (ICNM)
2005	World Health Assembly (WHA) discussed the effects of migration and promotion of fairer recruitment tactics
2005	International Labour Organization (ILO) launched an action programme: ‘The International Migration of Health Service Workers: The Supply Side’
2006	Establishment of the Global Health Workforce Alliance (GHWA)

2007	Realizing Rights: the Ethical Globalization Initiative and GHWA organised The Health Worker Migration Policy Initiative
2008	Global Forum on Human Resources for Health (Kampala), discussions held on the draft of the WHO Global Code
2010	Adoption of the WHO Global Code on the recruitment of health personnel

Over the past 10 years these ongoing discussions – of health worker migration in general and cross-border nurse mobility in particular – resulted in several attempts to implement an ethical recruitment approach. A number of mechanisms were suggested under the ethical recruitment initiative, such as guidelines and codes of practice for employers and independent recruitment agencies, and bilateral agreements between governments on the cross-border migration of health workers (Buchan and Dovlo, 2004). The latter became the focus of this research.

2.2 ORIGIN OF THE RESEARCH QUESTIONS

An initial interest in bilateral labour agreements as government tools evolved in the current research from analysis of policy debates and a review of studies carried out in the past decade on health worker migration. These revealed active discussions concerning ethical principles in the recruitment of foreign health workers and tools which might be used to implement these principles.

As already stressed, the main focus of previous studies and policy debates was unilateral and multilateral ethical codes of practice in the recruitment of health workers from overseas. At the time of writing, around 15 Codes of Practices pertaining to ethical recruitment were identified worldwide. These were introduced by governmental agencies, professional associations and trade unions, at both national and international levels (see Appendix 1). A number of research initiatives explored these instruments of ethical recruitment, their content and effects (MedAct, 2003; Martineau et al., 2004; Connell, 2007). Scholars acknowledged that such codes of practice establish common principles in the recruitment of foreign health workers. However, codes of practice were criticised for having a declarative character rather than any real impact on the recruitment strategies of private agencies and the migration experiences of individuals. It was argued that these tools lacked

enforcement power and had underdeveloped monitoring mechanisms. Moreover, some scholars suggested that codes of practice had discriminatory effects as they worsened employment prospects for foreign health workers applying individually from countries on restricted lists for recruitment (Mesquita and Gordon, 2005; Mensah et al., 2005). Although a number of studies were launched to investigate the impact of ethical recruitment codes of practice, no fundamental research was undertaken into the role of government-to-government agreements negotiated in line with ethical recruitment policy. Some research does provide information on agreements but this is fragmented (Buchan and Rafferty, 2004; Buchan and Secomme, 2006; Clark, 2006 et al.). It is estimated that since the mid-1990s, around 15 ethical agreements have been negotiated between national governments on the cross-border mobility of health workers (see Appendix 2). However, no substantial study had been carried out to explore the consequences of these policy tools and their role in the regulation of cross-border migration of health workers. This gap is addressed in this research.

The interest in studying policy tools pertaining to health labour migration was also reinforced by topical policy discussion about the role of the state in the regulation of international labour mobility (Clark et al., 2006). On the one hand, following the ‘globalist’ argument, the sovereign capacity of the state to control international migration was seen to deteriorate as the role of international and private institutions in such affairs increases (Cornelius et al., 1994). On the other hand, it has been argued that the state remains an important player in the regulation of international migration in general and in labour migration in particular. The government continues to smartly exercise its power using an array of ‘hard’ and ‘soft’ instruments to control the international migration of labour. These instruments include immigration rules, language tests, professional accreditation and non-binding mechanisms such as codes of practice. Selection among these tools depends on the country-specific context and factors such as economic demands, political preferences and socio-cultural determinants (Guiraudon and Lahav, 2000). Internationalisation is therefore a more adequate term than globalisation to capture the contemporary development of the labour market beyond the boundaries of the nation-state yet still under its prevailing control (Buchan and McCaffery, 2007). This consideration of the

role of the government led to a specific focus in the current research on governmental policy tools, such as bilateral ethical recruitment agreements.

The interest in bilateral labour agreements was strengthened further upon reviewing policy reports prepared by international organisations, including the IOM and the OECD (Organisation for Economic Co-operation and Development, 2004b; International Organization for Migration, 2005a). These reports examine bilateral labour agreements in different sectors in terms of the history of their development, the types that exist, the purposes to which they have been put and their current status in the regulation of international labour migration (for a detailed description, see Chapter 4). Briefly, these reports discuss two trends. First, over the past fifty years, bilateral labour agreements have gone through a noticeable transformation. They have shifted from fulfilling the primarily economic function of meeting labour shortages in national labour markets by recruiting foreign labour, to meeting a diverse range of political, cultural and welfare protection objectives. Second, it has been suggested that there has been a weakening in the role of government-to-government labour agreements in facilitating mechanisms of labour migration, since the number of labour migrants moving across borders outside agreements significantly exceeds the capacity of these policy tools (Bobeva and Garson, 2004). The diversification of functions on the one hand, and the declining role of bilateral labour agreements on the other, stimulated the present research interest in the reasons why some countries still negotiate these agreements today; particularly those destination countries such as Britain which have not implemented them in the past.

2.3 CONCEPTUAL FRAMEWORK

The preceding discussion has highlighted a number of gaps in existing empirical studies regarding health worker migration. In order to respond to these gaps and to the questions posed in the policy discourse, this thesis examines bilateral labour agreements through the prism of the policy tools approach. Chapter 1 set out the research questions and explained why this research is framed as a study of policy tools. These questions echo the classical themes explored in the policy tools literature about types of policy tools, their selection and their consequences (Hood, 1983;

Linder and Peters, 1989; Weiss, 2000; Salamon, 2002; Peters, 2002). Moreover, the rationale to develop a conceptual framework based on policy tool studies also lies in the contribution that research on ethical recruitment agreements brings to the subject area of policy tools. The explanatory schemes, previously developed within the policy instruments approach⁶, mainly focus on policy tools which the government applies within national borders, such as tax policies, grants, loans and insurances; and tools of governance introduced by third parties such as non-government bodies and private institutions (Salamon, 2002). It is only recently that scholars in policy tool studies have paid attention to the instruments of cross-border regulation developed by international organisations and intergovernmental institutions, for instance directives of the European Commission (Kassim and Le Gales, 2010). However, as scholars have re-focused their attention on the international arena, very little discussion exists about the policy tools introduced by national governments that have an international scope of regulation. Furthermore, as the following section reveals, the policy tools approach does not pay sufficient attention to why governments tend to select tools that have not previously been used extensively in certain policy domains. For instance, the UK labour immigration policy primarily employs generic schemes, such as a point-based system, rather than bilateral labour recruitment tools which give privileged access to workers of certain nationalities (see Chapter 4). This makes bilateral labour agreements negotiated by the British Government in the early 2000s an excellent case to explore.

This brief introduction to the reasons why policy tool studies became a source for building the conceptual framework of this study is further developed in the next section, which describes in more detail the development and theoretical grounds of policy tool studies.

2.3.1 POLICY TOOLS APPROACH

Academic debate around policy tools has been developing as a branch of public policy analysis. What types of policy tools exist? Why do policy-makers apply certain tools and ignore others? What are the outcomes of these policy tools? These

⁶ The terms ‘policy tools’ and ‘policy instruments’ are used interchangeably in this text.

practical questions became the foundation of the principal stands of analysis in classical policy tool inquiry: types of policy tools, policy tool selection and the consequences of policy tools.

The first examples of policy tool studies originated in the analysis of government action and date back to the 16th-17th centuries. However, it was not until the 20th century that these studies became systematic and were recognised as a substantial subject area. An historical account of policy tool studies produced by Hood distinguished the two principal foci of scholars in the 20th century: analysis of government instruments in specific policy domains such as crime and public health, and analysis of generic tools (Hood, 2007). Empirical data accumulated in these studies stimulated speculations around typologies of policy tools, which then became the dominant research theme in the second half of the 20th century.

The first typologies were based on classification of economic policy tools (Kirschen, 1964). The economic emphasis was explained largely by an interest in the monetary means of government policy and their economic effects. In the 1980s and the 1990s, the classificatory analysis of policy tools continued, with more sophisticated analysis of political and behavioural dimensions of policy tools. These typologies considered such criteria as coercion and control mechanisms used by the government (Lowi, 1972); degree of intrusiveness (Phidd and Doern, 1978); and behavioural impacts of policy tools (Schneider and Ingram, 1990).

One of the most cited typologies of government tools was introduced by Hood in his work *Tools of Government* (Hood, 1983). He distinguished between three basic components of a control system: policy tools for gathering information, tools for standard-setting and tools for modifying behaviour. This typology originated from a distinction between types of regulatory resources used by government: nodality (information), authority (legal power), treasure (money) and organisation (organisational capacity). Two decades later, this classification was revised by Le Gales and Lascoumes, who added two new dimensions to Hood's original typology: type of political relation and type of legitimacy. Based on these criteria, French scholars distinguished a variety of types of policy tools: legislative and regulatory, economic and fiscal, agreement-based and incentive-based, information-based and

communication-based, and de jure and de facto standards (Lascoumes and Le Gales, 2007).

Since the early 1990s, studies of policy tool typologies have paid attention to the new types of policy tools: tools of 'new' governance, technology-based tools, instruments of cross-border regulation and 'soft' mechanisms. Research interest in the 'new' governance tools represented a shift in policy practice from direct government tools to the tools of non-federal, third-party government, from command and control instruments to bargaining and persuasion tools (Salamon, 1989). This shift was stimulated by the privatisation of public sector services and the development of information technologies. The common feature of the 'new' governance instruments was their indirect form, that is, their reliance on 'third parties' such as banks, private hospitals, universities, industrial corporations, and so on. The second new type of policy tools, technology-based tools, were brought about by technological innovations such as Closed Circuit Television (CCTV) systems and electronic identity cards. This encouraged a new stream in policy tool studies, namely analysis of e-tools in governance and technology as a policy instrument (Lessig, 1999; Bennett and Raab, 2006). In the early 2000s, the scholarly community recognised the lack of research on cross-border (intergovernmental) tools introduced at interregional and global levels. This discovery stimulated closer academic attention to policy tools applied across national borders. An example of this is research on the Open Method of Coordination (OMC) and other instruments applied across EU countries (Mörth, 2004; Bache, 2010; Kassim and Le Gales, 2010). Finally, the interest in soft mechanisms was stimulated by the proliferation of voluntary non-binding tools applied by both governments and international bodies (Mörth, 2004; Schafer, 2006; Guzman and Meyer, 2010).

Two other principal areas of analysis in policy tool studies are preoccupied with questions of how policy tools are selected and what their consequences are. The first dates back to the 1970s and used predominantly rational choice logic. The rational choice explanation suggested that policy tools are a set of well-defined technical devices available for choice which can be arrayed on a continuum according to their attributes, such as level of coercion and visibility (Doern and Wilson, 1974; Phidd and Doern, 1978). The rational choice approach argued that

policy tool selection is based on the empirical records of the successes and failures of a given instrument across problem situations and, additionally, the policy-maker's calculation of the benefits and costs of their choice (Trebilcock and Hartle, 1982). In the 1990s, the rational choice conception of policy tools received widespread criticism and there followed a shift to political sociology explanations. The latter portrays policy tools as a product of social relations where the balance of power between actors impacts their selection and performance (Lascoumes and Le Gales, 2007). Following this conception of policy tools, scholarly discussion has turned from the evaluation of tool effectiveness to the exploration of the political dimensions of their choice (Schneider and Ingram, 1990; Lascoumes and Le Gales, 2007) and the analysis of the informal functions of policy tools (Weiss, 2000).

The origin of the political sociology conception of policy tools can be traced back to the work of Peter and Linder, American political scientists who were the first to introduce a systematic and comprehensive model of policy tool selection. They explained the choice of policy tools through the interaction of policy-makers' perceptions in policy contexts. The legacy of this model is evident in the works of many contemporary scholars (Weiss, 2000; Peters, 2002; Kassim and Le Gales, 2010). My analysis of bilateral labour agreements also derives from their original model for a number of reasons, which are outlined below.

Although Peters and Linder were the founders of the political sociology conception of policy tools, their ideas were developed and extended by Lascoumes and Le Gales. The latter summarised the distinctions between the political sociology conception of policy tools and the previously dominant rational choice theory. Their interpretation implies that policy tools are not politically neutral; on the contrary, they contain values and meanings that affect the policy process. Lascoumes and Le Gales (2007, p.4) argued that:

In the political sociology approach, an instrument is defined as a device that is both technical and social, that organizes specific social relations between the state and those it is addressed to, according to the representations and meanings it carries. It is a particular type of institution, a technical device with generic purpose of carrying a concrete concept of the politics/society relationship and sustained by a concept of regulation.

Lascoumes and Le Gales contributed to the field of policy tool studies by introducing the concept of policy instrumentation. This term refers to ‘a set of problems posed by the choice and use of instruments’ (Lascoumes and Le Gales, 2007, p.4). Policy instrumentation underlines the existing relation between the reasons for introducing policy tools and the effects they produce. Most importantly, the relation between the aims and the outcomes of policy tools are not always straightforward and the election of policy tools can produce unexpected effects (Lascoumes and Le Gales, 2007). Unfortunately, these scholars did not provide a clear methodology of how these unexpected effects could be revealed. To address this gap in the policy tools literature, this thesis applies a revised version of Merton’s analysis of manifest and latent functions.

2.3.2 CONTEXTS, PERCEPTIONS AND FUNCTIONS

To address the question of why the British Government negotiated bilateral labour agreements and what their consequences were, this work integrates the explanatory model of perceptions and contexts developed by Linder and Peters (Linder and Peters, 1989) and the revised version of Merton’s functional analysis (Merton, 1949). This section explains why and how Linder and Peters’ model was integrated into the analysis of bilateral labour agreements and how Merton’s functional analysis was adapted to the purposes of this research.

This study draws on the analytical model proffered by Linder and Peters for a number of reasons. First, this choice was driven by empirical data. Analysis of documents and interviews with policy-makers raised the issue of how perceptions of political actors involved in the debate on migration of health workers are interrelated with the policy context of ethical recruitment. Second, as is acknowledged today, Linder and Peters’ model, became one of the first attempts to apply the political sociology perspective, bringing together both cognitive and contextual factors in its explanation of policy tool selection (Kassim and Le Gales, 2010). It is for this reason that the present study uses the original model rather than later interpretations. Finally, Linder and Peters operationalised, in the most systematic manner, ideas

about the interrelation of structure and agency in the context of policy tool studies (Linder and Peters, 1989).

The model developed by Linder and Peters originates from the interpretative theoretical tradition. They place at the centre of inquiry cognitive factors, namely decision-makers' perceptions of the policy problem and policy tools. They argue that policy problems and policy tools are constructed and interpreted within the policy context and shaped by the perceptions of actors and their interactions in the institutional setting (Linder and Peters, 1989). These ideas draw on the earlier work of Edelman who emphasises the role of symbolism in politics, and the importance of the interplay among actors and settings in the study of political consequences (Edelman, 1964). Following Edelman's ideas, Linder and Peters integrate two main components in their analytical framework: perceptions of political actors and policy contexts. They argue that the choice of policy instruments is conditioned by decision-makers' perceptions of policy tools operating in the complex ecology of contexts (Linder and Peters, 1989, pp. 35-36). This ecology of contexts encompasses decision-makers' organisational circumstances; characteristics of the national political system; the problem situation; and a unique constellation of events and circumstances. The authors define the first two components, organisational circumstances and national policy style, as the institutional setting. The second element of the policy context they call a problem situation. In their understanding, the problem situation is yet another dimension of the policy context which entails behavioural assumptions about how policy problems are addressed and formulated. Policy problem formulation in fact plays a definitive role in instrument choice because instruments are designed to meet the requirements of the particular policy problem, or more precisely, they are intended to respond to its formulation⁷. The variation of policy problem formulations depends on who the actors constructing these formulations are, what their interests are, and how such interests are framed in the policy context. For instance, the international recruitment of nurses as a policy problem could be formulated in different ways depending on whether it is the perspective of individual migrants, a source country, or a receiving state, that is taken

⁷ Linder and Peters apply the two notions of problem situation and problem formulation interchangeably. For terminological clarity and coherence, this work uses problem formulation as a point of reference.

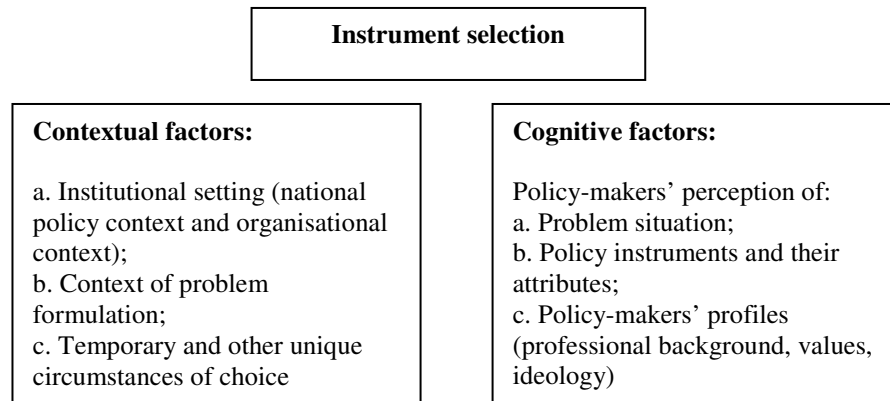
into account. Specifically, from the perspective of individual nurses, the policy problem could be interpreted as a problem of the violation of labour rights; from the position of a donor country it could be portrayed as a 'brain drain' problem; and from a receiving country's stance it could be a problem of integration of migrant health workers at the national labour market. These examples reflect the idea that there are multiple formulations of one policy problem, which creates potential for the application of different policy tools.

Finally, in their explanatory model, Linder and Peters point out a third component of the policy context: the unique circumstances and events which affect policy tool selection. However, the authors pay little attention to this dimension. As these scholars state, inclusion of this component in the analytical model is not absolutely essential but could justify attention to details of the policy context. Detailed accounts of unique events are difficult to generalise and they have restricted explanatory power compared to, for instance, systemic characteristics of the policy context such as national policy style or organisational culture (Linder and Peters, 1989).

In relation to cognitive factors in the choice of policy instruments, Linder and Peters distinguish between three elements: decision-makers' perception of the policy problem; perceptions of the policy tools, their attributes and performance; and, finally, characteristics of decision-makers themselves, such as their personal background, professional profile, values and beliefs.

In sum, Linder and Peters explain the process of policy tool selection using both contextual and cognitive dimensions. They argue that the choice of policy instruments is a product of decision-makers' perceptions, which are shaped in the institutional setting of national and organisational characteristics; the context of problem formulation; and unique circumstances in the policy tool selection (see Figure 2).

Figure 2 Policy tool selection: Linder and Peters' model



Source: adapted from Linder and Peters (1989).

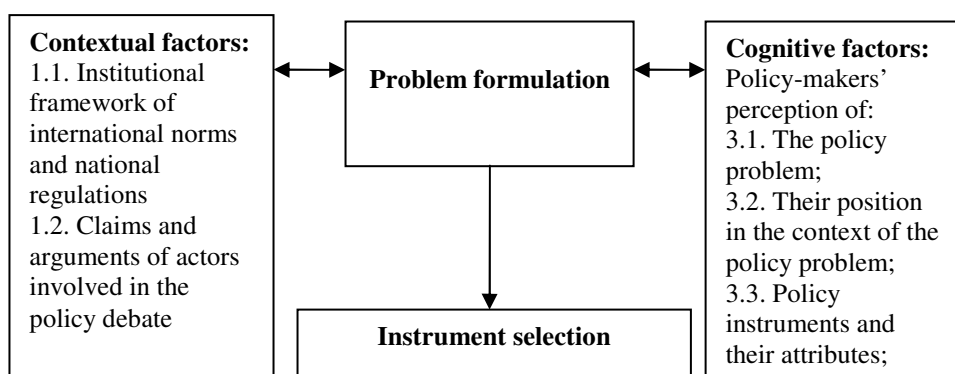
This framework of contexts and perceptions is applied in this study, but with certain adjustments that were driven primarily by the empirical data collected. Following Linder and Peters' definition of cognitive factors, this study considers two components: policy-makers' perceptions of the policy problem and their perceptions of the 'proper tool to do the job'. Instead of particular attention to the individual attributes of policy-makers, the empirical data collected in this research highlighted the importance of decision-makers' self-perceptions in the context of the policy problem (see Chapter 6).

Slight changes to the framework of contexts and perceptions also concern the category of the policy context. In addition to contemplation of the perspectives of decision-makers', as suggested by Linder and Peters, this study covered the perceptions of other political actors; those who were not directly involved in the design and negotiation of agreements but were engaged in practice and debate around the international recruitment of nurses in Britain. Such actors include trade unions, professional organisations, recruitment officers and international organisations. Furthermore, this study does not account for the organisational circumstances of decision-makers. What is considered to be more relevant is an exploration of the international dimension of the policy context. This includes

institutional rules, norms and regulations relevant to health worker migration adopted at the international level, such as the Millennium Development Goals, human rights instruments, and the General Agreement on Trade in Services. In following Linder and Peters' model, where the policy context is not only the institutional setting but also synonymous with the context of policy problem formulation, this study explores how the policy problem of international nurse recruitment was constructed by political actors. However, the status of the problem formulation is, in my analysis, slightly different to what Linder and Peters suggest in their analytical model. While Linder and Peters see the problem formulation as part of the policy context, in my study it becomes an intervening category between contextual and cognitive dimensions of the policy tool selection (see Figure 3). On the one hand, the problem formulation has a cognitive foundation as it originates in actors' interpretations. On the other hand, it becomes a part of the policy context, which shapes the decision-makers' choice of policy tools. The analytical framework, in its adjusted form in the present study, highlights the importance of policy problem formulation as a factor in the selection of policy instruments.

The formulation of the policy problem is produced by actors operating within the institutional setting of rules, norms and values. Concurrently, the context of problem formulation affects policy-makers' perceptions of the policy problem, their self-positions in relation to the policy problem and their perceptions of instruments. As a result, the selection of policy tools becomes an interdependent process between contextual and cognitive factors. The policy-makers decide on the 'best tool to do the job' based on their perceptions of the policy problem, self-perceptions in the problem context and perceptions of tools' attributes. Their decision is conditioned by both the institutional setting and the formulation of the policy problem (see Figure 3).

Figure 3 Policy tool selection: Adapted model



Source: adapted from Linder and Peters (1989).

The model presented above is applied in this thesis to understand how agreements originated. To address the final research question concerning the consequences of these agreements, this study incorporates in the analytical framework the concept of functions. The final part of this section explains how functional analysis fits into this model of policy-makers' perceptions and policy contexts.

The decision to apply functional analysis in the present study was driven by gaps in the policy tools literature. Specifically, existing literature does not provide sufficient explanation of how to reveal the outcomes of policy tools. Occasionally, references are made to the concept of functions as outcomes and consequences, as well as effects of policy tools in terms of their efficiency (McDonnell and Elmore, 1987; Howlett, 2004; Lascoumes and Le Gales, 2007; Kassim and Le Gales, 2010). Moreover, scholars use a plethora of terms to describe the 'hidden' nature of outcomes produced by policy tools. Some of these include: informal and unofficial aims (Cotgrove, 1967); unexpected, unintended and unrecognized consequences (Campbell, 1982); symbolic and mythical politics (Edelman, 1964); hidden dimensions (Kassim and Le Gales, 2010); and underlying assumptions (Schneider and Ingram, 1990). However, no systematised methodology for revealing the hidden effects of policy tools has been proffered. Therefore, this study attempts to address this absence in policy tool studies by referring to Merton's distinction between manifest and latent functions as a methodological device rather

than an explanatory tool. To clarify the distinction between the two, this section explains first, the origin of the concept of function in this research, and second, is the ways in which it differs from functionalism as a theoretical perspective.

Two observations were considered when proposing functional analysis in this study. First, the idea to frame understanding of bilateral labour agreements in Merton's terminology of manifest and latent functions (Merton, 1949) emerged when analysing the claims of policy actors in relation to the ethical principles in the recruitment of foreign health workers, introduced by the British Government in the 2000s. Political actors in source countries and in Britain expressed criticisms of the ethical recruitment policy and primarily the Code of Practice, calling it a 'fig leaf' rather than a real mechanism (Mesquita and Gordon, 2005). This criticism provoked questions about the role of agreements as one of the tools in the implementation of this policy.

Second, the review of the policy tools literature detected that scholars employed various terminologies in examining the complex relations between the official and 'hidden' objectives and consequences in the selection and performance of policy tools. Most of the above-mentioned distinctions emerged from either recognition or criticisms of Merton's identification of manifest and latent functions. The present study explores how revising Merton's original concepts could contribute to understanding the multifaceted role of government-to-government agreements in the British policy for the ethical recruitment of foreign nurses.

Finally, this section outlines the distinction between the functional analysis employed in this research and functionalism as a theoretical tradition. The roots of functionalism as theoretical tradition are located in Spenser's biological analogies of the functions of social institutions and the functions of organs maintaining the life processes in the body (Turner et al., 2002). In the 1930s, functionalism was actively used by social anthropologists. For instance, Radcliffe-Brown developed a functional explanation of social institutions as existing in order to fulfil a set of stable needs (Radcliffe-Brown, 1935). Malinowski argued that: 'to explain any item of culture, material or moral, means to indicate its functional place within the institution' (Malinowsky, 1926 cited in Hempel, 1994, p. 357). Malinowski was one of the representatives of the strong programme of functional analysis which argued that 'all

social phenomena have beneficial consequences that explain them' (Elster, 1994, p.404). A significant contribution to the development of functionalism as a total account of society was made by Parsons. His theory of action posited functional analysis as a universal theoretical framework in the explanation of society where every social system has essential basic needs and exists to promote those needs (Parsons, 1951). One of the attempts to modernise Parsons' ideas and the strong variant of functionalism was undertaken by Merton, American sociologist. He developed so called 'weak' programme of functional analysis arguing that functional needs should be taken as permissive, rather than determinant of social phenomena (Merton, 1949). Moreover, contrary to his colleagues who primarily considered positive or beneficiary consequences, Merton focused on dysfunctional consequences, latent function and functional alternatives of social structures which allowed speculation about dynamics of social change. This 'moderate' variant of functional analysis with a particular focus on diverse consequences of social systems has influenced the analysis of government-to-government agreements used in the present study (see Chapter 3).

CONCLUSION

The literature review presented in this chapter has revealed gaps in the empirical studies on the migration of health workers. As with research conducted during the 1960s and 1970s, contemporary studies seek to identify effective policy tools in the regulation of health worker migration. However, there are certain differences in the way these questions are posed and addressed today, as compared to 40 years ago. First, research now pays more attention to the regulation of nurse migration, and to experiences and problems nurses face in destination countries as well as after their return back home. Second, contemporary studies reveal a number of regulatory problems associated with the impaired power of states and the proliferation of other institutions and agencies governing the migration process. Third, the regulation of skilled migration is today discussed in the framework of global ethics and human rights. This policy discourse stimulated the introduction of policy tools in ethical recruitment, such as ethical guidelines and government-to-government agreements.

The scholarly debate has paid more attention to exploring the efficiency of codes of practice and ethical guidelines, with fewer studies on the impact of the government-to-government agreements. This lack of empirical research provided the impetus for my inquiry into these agreements. The present interest in policy tools was further deepened by contemporary policy discussion about the future of bilateral labour agreements. Finally, lack of conceptualisation of bilateral labour agreements at the theoretical level led this study to approach the policy tools literature, which provided fruitful grounds for speculation about ethical agreements at a higher level of abstraction. Framing my research as a study of policy tools has helped to clarify my original research questions and present them in the trio of classical themes of types, selection and consequences of policy tools, developed in the policy tools literature. The research design and type of methodology applied to investigate these research questions are outlined in the following chapter.

3. RESEARCH DESIGN

INTRODUCTION

This chapter introduces the reader to the research design of this study. The first section outlines the philosophical grounds underlying the methodology of this research. It then explains why this research is a case study, defines the case selected and describes how the units of analysis⁸, time boundaries and locale were chosen. The second part of the chapter describes the methods of data collection used, namely elite interviews and document analysis. It discusses the criteria applied in the selection of documents and identification of informants. It then reveals the problems of access and confidentiality encountered when conducting interviews with elites, and the ways in which these were addressed. The final section concludes by presenting the methods of data analysis employed.

3.1 THE INTERPRETIVIST TRADITION

The methodology of this research originates in the interpretivist tradition, which defines social reality as the product of processes in which social actors negotiate the meanings of actions and situations (Blaikie, 1991). In other words, the social world is constructed through people's lived experiences, interactions and understandings. In terms of the epistemological grounds of interpretivism, knowledge is not an absolute value discovered by the researcher but rather, its construction is derived from everyday meanings and interpretations.

The decision to conduct this study of policy tools in the interpretivist tradition was informed by the nature of the subject of this research - bilateral labour agreements and the research aim of understanding the role of these agreements from the perspective of the destination country.

To begin with, agreements are country-specific and depend on the national context of the negotiating parties. Agreements are accordingly often negotiated in

⁸ The terms 'units of analysis', 'sub-cases' and 'nested cases' are used interchangeably throughout the remainder of this text.

different formats. For instance, as this study demonstrates, there are different types of agreements, which vary from binding arrangements to verbal commitments. Second, some of these agreements set particularly generic objectives using such broad categories as ‘develop co-operation’, ‘promote employment opportunities’ and ‘consolidate and strengthen the friendly ties’. This makes it difficult to measure the effects of bilateral agreements using a quantitative approach in policy evaluation (Rossi and Freeman, 1993). Third, quantitative evaluation techniques might not be sensitive to the latent outcomes of policy tools, as ‘what is to be measured is determined at the start of evaluation’ (Clark, 1999, p.51). Finally, there are multiple interpretations of the effectiveness agreements, expressed by various stakeholders including governments, migrant workers, professional organisations, employers and trade unions, in source and destination countries. A set of standardised criteria might not capture these diverse perspectives.

The research questions posed in this thesis (see Chapter 1) presuppose an in-depth study of actors’ interpretations of policy tools in the context-specific setting. The thesis focuses on the motives and decisions of policy-makers involved in the negotiation of agreements, and the perceptions a wider group of institutional actors have of these agreements, in the policy debate on the recruitment of foreign nurses. It examines such agreements through actors’ interpretations and analysis of the policy contexts within which they operate. To address these aims, the research refers to the logic of hermeneutic explanation which uncovers meaning and achieves understanding, rather than inferring causal explanation of social phenomena (von Wright, 1971). This tradition has a rich background originating in the works of the German philosophers Dilthey and Richert (Ormiston and Schrift, 1990). Ideas of many prominent scholars representing diverse schools of thought have influenced the contemporary interpretative approach: Weber and his method of *verstehen*; Schutz’s phenomenology; Garfinkel’s works on ethnomethodology and philosophy of Wittgenstein (Martin and McIntyre, 1994). This list can be continued, however, what is important to state at this point is the basic claims that unite various approaches in interpretative tradition: first, social practices are meaningful and these meanings are constituted by social actors; second, social phenomenon could be only understood by

discovering the meanings that constitute them and third, the concepts and findings developed by social scientists originate and connect to those concepts employed by individual actors in construction of their day-to-day world (Martin and McIntyre, 1994). The latter claim summarises the methodology of interpretative analysis which was referred to by Schutz as development of 'second-order constructs' (Schutz, 1966), and Giddens as 'double hermeneutics' (Giddens, 1976), whereas Winch references 'logical ties between the concepts employed by lay agents ... in organizing their day-to-day conduct and the concepts of observing social scientists' (Winch, 1958 cited in Giddens, 1987, p.197). This connection of between the worlds of actors and social scientists was well summarised by Giddens (1976, p.162):

Sociology, however, deals with a universe which is already constituted within frames of meaning by social actors themselves, and reinterprets these within its own theoretical schemes, mediating ordinary and technical language.

According to this logic of interpretative analysis, knowledge of social reality originates at two levels: first, as description of every day meanings and interpretations, and second, as reconstruction of these meanings in metalanguages of social science. In this thesis, the analysis of bilateral labour agreements draws on this logic. It first describes actors' interpretations of how and why agreements were negotiated and what their role was in British policy. Based on these interpretations, it then produces sociological accounts of the consequences of these agreements, framing explanations in the language of functional analysis (see Section 3.4). Analysis of empirical data according to an interpretative logic contributed to the identification of a diversity of types of agreements; a multiplicity of actors' perceptions; and an array of functions of agreements at different levels of latency. To retrieve actors' interpretations of agreements in the multilevel policy context of foreign nurse migration, this study employs a case study method.

3.2 THE USE OF A CASE STUDY METHOD

Case study, as a method in social science, is defined as 'empirical inquiry that investigates a contemporary phenomenon in depth and within its real life context

especially when the boundaries between phenomenon and the context are not clearly evident' (Yin, 2009, p. 18). This type of inquiry employs the triangulation of multiple sources of evidence to produce a valid account of a phenomenon. A case study method may be used for explorative, descriptive and explanatory purposes. As recognised by Yin , there is no formula prescribing a researcher's choice in favour of this method, but there are certain conditions which support this choice (Yin, 2009).

Case study becomes a relevant method to use when 'how' and 'why' questions are central to investigation and when the context is essential for an in-depth and holistic understanding of the social phenomenon (Yin, 2009, p.4). Both of these conditions are relevant to this study. This research questions how and why agreements were negotiated and what their meaning was in the policy context of international nurse recruitment to Britain in the early 2000s. This study has explorative, descriptive and explanatory purposes. It maps how many ethical recruitment agreements the UK Government negotiated in the 2000s. It describes organisational arrangements and the perceptions of institutional actors about four of the most visible agreements in policy discourse and practice. Finally, it explains the meaning of these agreements through actors' interpretations framed in the context of the British policy for recruiting foreign nurses.

The crucial step in designing this research was the formulation a particular case study, based on the gaps discovered and the questions emerged from the literature review (see Chapter 2). A single case study of the destination country's perspective in the negotiation of bilateral labour agreements is presented. The case is British practice in the negotiation of bilateral labour agreements in the early 2000s on the cross-border mobility of nurses with India, Spain, South Africa and the Philippines. Identification of this case poses a number of questions:

- Why does it focus on the British perspective and not that of source countries? Why has the UK been selected and not other destination countries?
- Why are agreements with India, South Africa, the Philippines and Spain selected as units of analysis?
- Why is the time frame from 1997 to 2007?

- Why is the recruitment of nurses the focus of the research?

To justify my choices I will address these questions sequentially. First, the interest in the policy-makers' rationale evolves from the evidence that in some destination countries such as the UK, the negotiation of bilateral labour agreements is not a common practice (Rollason, 2004). The question therefore arises as to why such countries eventually decide to accept the efforts of source countries to negotiate bilateral labour agreements; what conditions and reasoning lie behind this decision. Britain is a good example to address these questions as it did not previously use bilateral labour agreements in the health sector (Loizillon, 2004). Foreign labour was normally recruited in the UK, mainly through generic schemes such as the work permit scheme which was applied until 2007, and the points based system, which was introduced in 2008. These schemes opened the labour emigration gates for non-EU citizens based on generic principles such as professional qualifications, English language proficiency, and previous salary rate. These schemes do not prioritise overseas workers based on their nationality. By contrast, bilateral labour agreements narrow labour recruitment to citizens of the source country, which co-signs the labour agreement.

This practice of negotiating bilateral labour agreements, unusual for Britain, provides only a partial explanation of my interest in Britain as a country of destination for many migrant workers. Other important parameters also supported this choice.

In the early 2000s, the recruitment of health workers from overseas was taking place on a global scale and practiced by a number of developed countries such as the USA, Canada, Australia and Ireland. Among these, Britain became the point of reference in the international discourse on the active recruitment of health workers. This international attention evolved for a number of reasons. First, in the year 2000, the UK Government announced that it would use the international recruitment of health workers as a tool to bridge the gap in the national health workforce. International recruitment to Britain became a government-led campaign which organised employers' practices for recruitment from abroad (Department of Health, 2000a). The Government claimed that foreign labour recruitment would be applied

as a short-term measure while the results of the national training and retention programmes were expected. The NHS international recruitment in the late 1990s was recognised as the most systematic and co-ordinated recruitment programme of any country in the world (Buchan and Dovlo, 2004). It was set up to identify and bring to Britain foreign health workers interested in emigrating. As a part of its recruitment process, the DH provided information about job locations, living arrangements and immigration procedures (Department of Health, 2003a). This centralised co-ordination was feasible in the British national health system, where the NHS is the largest employer and subordinated to the Department of Health. This type of government co-ordination was less practiced, if at all, in other recipient countries where independent private employers play a dominant role in the health sector, such as the US, and in countries where regulation of the nursing profession is decentralised to the territorial level, such as Canada (Buchan et al., 2009).

Second, the UK practice of recruiting foreign health workers became the object of international attention in the early 2000s because numerous criticisms were directed to the British Government for actively recruiting in developing countries. In the policy and media discourse, the UK was portrayed as a rich country ‘poaching’ health workers from poor states (Browne, 2001; Boseley, 2005).

Third, in response to these criticisms, the UK Government introduced an ethical policy in the international recruitment of health workers. The ethical principles included guidelines, the Code of Practice and bilateral agreements with source countries (Clark et al. 2006). The UK ethical recruitment policy became a pioneering example, leading the way for later ethical initiatives proposed by some destination countries such as Ireland (Department of Health and Children, 2001) and Canada (Canadian Nurses Association, 2005), and by international organisations in the case of the Commonwealth Code of Practice and the WHO Global code (Commonwealth Secretariat, 2003; World Health Organisation, 2009).

Having determined that my research would be a single case study, the next step was deciding on the units of analysis (embedded sub-cases) in my case. Four sub-cases were selected: agreements with Spain, India, the Philippines and South Africa. The choice of these was completed in a three-stage process. I first identified how many bilateral labour agreements in the health sector were negotiated by the UK in

the early 2000s. I then prepared brief descriptive profiles of these agreements based on analysis of policy documents and interviews with policy-makers and academic experts on the topic. These profiles included factual information such as the date of conclusion of the agreement, the content of the agreement, the category of health workers covered in the agreement, and the estimated number of recruited personnel, if applicable, as not all agreements were about recruitment (see Appendix 3).

These descriptions informed the selection of sub-cases for further in-depth analysis. The exploratory examinations conducted revealed that first, the UK negotiated agreements with countries in the European Union and outside of Europe; second, these agreements were negotiated in different formats and documented in the written form and verbally; and third, agreements between the UK and source countries were referred to in the policy documents as recruitment agreements and Memoranda of Understanding (MoU) (Buchan, 2006a). At this stage an assumption was made that selection of source countries from within and outside the EU, where the UK negotiated agreements in different formats, would allow me to capture the multiple dimensions of the role of agreements in the UK labour recruitment policy. This assumption stimulated investigation of the reasons, functions and performance of agreements in connection with characteristics of the four different source countries that co-signed the agreements: South Africa, Spain, India and the Philippines. Spain is an EU member, advanced economy, whereas South Africa, India and the Philippines are classified by the International Monetary Fund as emerging and developing economies (International Monetary Fund, 2010). Moreover, the agreement with Spain was referred to in the policy documents as a recruitment project (contract); the agreement with South Africa as a MoU on the reciprocal exchange; the agreement with India was not formalised on paper at all; and the agreement with the Philippines involved both a recruitment agreement and a MoU.

Beyond the research driven criteria, the selection of four of these countries was informed by such practical considerations as the availability of information and the visibility of agreements in policy discourse and implementation practice. For instance, the British government negotiated pilot agreements with Indonesia and China, but they were soon after interrupted (see Chapter 5).

When the units of analysis (nested cases) were defined, in-depth accounts of selected agreements were created (see Chapter 5). These included characteristics of the co-signing source countries such as historical links with the UK; characteristics of the nurse supply; and position of the government and other political actors in relation to the out-migration of nurses. These criteria had been identified at the stage of the literature review, when analysing previous studies on health worker migration (see Chapter 2) and further clarified in the analysis of policy documents and elite interviews (see Chapter 5).

Apart from the selection of sub-cases for analysis, there were other dimensions to consider in this research design; namely the choice of time frame and the category of health personnel. All agreements covered in this research were negotiated during the period 2000 to 2003. However, this research focuses on the broader period of 1997 to 2007. This decision was made to allow an exploration of how the negotiation of ethical recruitment agreements was related to the broader policy context of the active recruitment of nurses by the British Government during this 10-year period. Selection of these extended time boundaries allowed first, a historical sketch of how active recruitment started in the late 1990s then developed in the 2000s and came to an end in 2007; and second but more importantly, the contextualisation of agreements in the period of active nurse recruitment.

Lastly, this research focuses on the recruitment of foreign nurses⁹. This category of health personnel was selected primarily due to an interest in bilateral agreements as their content generally refers to the recruitment of nurses. This observation reflects the marked difference in the recruitment patterns of nurses and doctors. Typically, doctors were recruited to Britain individually, often to senior positions. Recruitment conditions normally included substantial financial compensation for relocation. For instance, in the UK, the International Fellowship Programme (IFP), set up to recruit medical professionals in 2001, fully covered relocation expenses (Department of Health, 2003a). Contrary to that of doctors, the

⁹ It is acknowledged that there is no clear definition of who the foreign nurse is (Wismar et al., 2011). National bodies in different countries as well as international organisations use various terms. These include foreign born, foreign trained and nurses of foreign nationality. For the purpose of this study, I apply the definition proposed by the NMC (UK) which defines an international nurse as nurse who received her training outside the European Economic Area (NMC, 2008).

recruitment of nurses involved a less individualised approach. Nurses were typically recruited using so-called batch recruitment, where an agency facilitates the in-country screening and recruitment of several dozens of nurses, working on behalf of one or more UK employers (Buchan, 2002). One more important clarification has to be made. In the late 1990s and early 2000s the major drive in the international nurse recruitment took place in England. Likewise implementation of agreements, for instance, recruitment of Spanish nurses and personnel exchange programmes with institutions in South Africa, was practiced predominantly by NHS employers in England. However, negotiated agreements had a UK-wide application and in fact facilitated a number of recruitment drives in Scotland and Wales. Although, agreements were negotiated by the English Department of Health, which is responsible for the population of England, in the in international affairs, its staff represents the whole of the UK (Department of Health, 2009).

3.3 METHODS OF DATA COLLECTION

One of the major strengths of the case study research design is the triangulation of multiple sources of evidence (Yin, 2009). Different interpretations and types of triangulation are recognised in the literature (Blaikie, 1991; Moran-Ellis et al., 2006). Originally, triangulation was applied in the social sciences to control the accuracy of measurement and validity of findings (Webb et al., 1966). This study refers to a broader understanding of triangulation as a tool which allows the researcher to capture complexity and multiple contexts of phenomena, and to generate a coherent account of reality based on multiple sources of evidence (Fielding and Fielding, 1986). Triangulation may be applied to data sources, investigators, theories and methodologies (Denzin, 1970). In this study it is applied to methods for data collection and data sources.

Data in this research was collected using two methods. The first includes analysis of policy documents, media reports, working papers, research reports and academic articles. The second is the method of elite interviews conducted with British Government officials in the Department of Health (England) who took part in the conclusion of agreements; and officers working in the international organisations

such as the WHO, the Commonwealth Secretariat, the ILO and the PSI, British trade unions and professional organisations involved in debates on the international recruitment of nurses. Triangulation of these two methods contributed to the development of a comprehensive description of agreements, revealing both official positions and the perspectives of different institutional actors about the reasons for negotiations and their consequences beyond those stated in official documents.

Analysis of documents provided an important source of information about the policy context and official positions articulated by institutional actors. In addition to their informative value, documents helped to direct the initial stages of the data collection process. Documentary analysis provided pilot information about agreements which was then used to select units for in-depth analysis and to later identify informants for elite interviews. Analysis of documents also provided background information, which was useful in composing the structure and content of the schedules of questions used when interviewing experts.

In turn, elite interviews corroborated what was established in document analysis, but also helped to reconstruct the undocumented events in foreign nurse recruitment in Britain in the early 2000s. What is more important, elite interviews generated original data on the policy-makers' interpretations of their rationale in concluding the agreements, as well as the perspectives of other political actors such as international organisations, professional nursing organisations and trade unions. It is important to note that the relationship between these two sources of evidence, documents and interviews, is complementary rather than hierarchical. Both provided valuable data and enriched the research findings. As previously noted, the initial review of relevant documents constituted a preparatory stage in the interviewing process. Interviews with experts in turn helped to identify new documents and to gain access to previously unavailable material, for instance texts of agreements with South Africa and documents related to an Anglo-Spanish recruitment project.

This study analyses three types of documents: policy documents, mass media reports and research papers produced by individual academics and research institutions involved in research on the international migration of health workers.

Policy documents were divided into three sub-groups. The first contained the texts of bilateral labour agreements¹⁰.

The second consisted of policy documents relating to agreements, such as policy statements, press releases, minutes, information letters and policy reports produced by the Department of Health. The third group included policy documents produced by the British professional and trade union organisations such as the Royal College of Nursing (RCN) and Unison; and documents on the international migration of health workers generated by international organisations such as the World Health Organization, the International Organization for Migration, the Organisation for Economic Co-Operation and Development, the Commonwealth Secretariat, and the International Council of Nurses. The latter were included in this study to enable reflection on the broader context of international health worker migration in the late 1990s and early 2000s.

As mentioned above, documentary analysis was also conducted on media reports and academic studies on the international migration of health workers. In particular, these materials helped to reconstruct the media coverage of public debates; to ascertain the research agenda on the international recruitment of nurses in the UK in the early 2000s; and to identify the origins of the ethical recruitment policy. Mass media reports published in the UK by the Guardian, the Independent and the BBC, news sources in supply countries such as *'Cape Times'*, *'India Today'* and *'The Manila Times'* as well as professional journals such as *Lancet*, *'International Nursing Review'*, *'Nursing Standard'* and *Nursing Times*, actively discussed international recruitment in the UK and reflected the positions of political actors in Britain, source countries and international organisations. Academic literature analysed included articles and research reports on the international migration of health workers. Two criteria were applied when selecting these: inclusion in the defined research time frame of 1997-2007 and relevance to the issues of migration, international recruitment and workforce shortage in the nursing sector.

¹⁰ The texts were obtained from the Department of Health (England). They include two texts on agreements with South Africa, negotiated in 2003 and updated in 2008; two texts relating to an agreement with the Philippines, one a recruitment agreement dating back to 2001 and the other a Memorandum of Understanding from 2003. An agreement with India was not documented as it was negotiated in an informal manner. Only background documents, such as information letters, agreement updates and minutes, were received from the Department of Health on the agreement with Spain.

As in the case of the documents, there were different types of experts identified for interviews. These included policy-makers involved in the design and negotiations of agreements; practitioners employed by the Department of Health in the implementation of agreements; political actors engaged in policy debates around international recruitment in Britain, such as professional organisations, trade unions and international organisations; and finally, scholars involved in research on the international recruitment of nurses in the 2000s (see Appendix 4).

Interviews were carried out at both the international and national levels. At the international level, interviews were conducted with consultants and officials in the World Health Organization, the International Labour Organization, the International Organization for Migration, the Organisation for Economic Co-Operation and Development, and the Commonwealth Secretariat. At the national level, I interviewed officers in the Department of Health (England), the Department for International Development, the Royal College of Nurses and UNISON; as well as NHS international recruitment co-ordinators; and scholars at the King's College and the King's Fund involved in research on the international recruitment of nurses. In total, 24 interviews were conducted between November 2007 and May 2009. Interviews were audio recorded and transcribed.

The selection of interviewees was determined by the research aim of revealing the perspectives of institutional actors involved in the negotiation of agreements. Those actors who participated in the policy debate and practice of international nurse recruitment in Britain in the early 2000s were also included in the selection. As this research focuses on the role of bilateral labour agreements in the British recruitment policy, government officials from the English Department of Health who were involved in the negotiation of agreements became the key informants. Their interpretations were essential to understanding the reasons, functions and performance of agreements. Officials from two units of the Department of Health (England), Workforce Directorate and Global Health International Division, were interviewed. Although the latter is the main point of reference within the Department of Health on international matters related to health issues, in the early 2000s both of these units lead work on the conclusion of agreements with source countries (Ollier, 2007).

During interviews, consultants and officials in international organisations, UK professional organisations and trade unions, as well as researchers, presented external, ‘outside of government’, positions in relation to the agreements. Migrant nurses were not interviewed, as this research focused on the perceptions of political actors rather than the experiences of individual actors in the migration process. A list of interviews conducted is provided in the Appendix 4.

When conducting elite interviews, a number of issues emerged: securing access to elites; composing and adapting interview questions according to the expert’s background; ensuring anonymity and confidentiality; and assessing the trustworthiness of interviewees’ accounts. To address these issues, a number of sources of information on conducting elite interviews were consulted (Aberbach and Rockman, 2002; Berry, 2002; Tansey, 2007).

Access to the key informants involved the challenge of how to identify potential informants and how to establish primary contact with officials whose experience is relevant to the topic of inquiry. At the first stage, a list of potential candidates was created based on the following sources of information: policy documents, media reports and the web-sites of relevant organisations. Once the first contacts had been established, further interviewees were recruited through snowball/chain-referral sampling (Tansey, 2007). Another important channel in establishing these contacts was communication through the research and policy networks, including participation in academic conferences¹¹ and policy meetings¹², and contact with NGOs and research centres such as Migrant Workers’ Network, Overseas Nurses Network, Med Act and the King’s Fund.

The issue of temporality was key in researching the policy process in relation to gaining access to elites. By 2007, when I began planning this research, started my thesis, the active recruitment of foreign nurses had slowed down. Many of those government officials and recruitment officers who had been involved in this process moved to different positions, sometimes relocating to other countries. Searching for

¹¹ ‘Global Health and Human Rights’, Warwick, June 2008 and ‘Global Labour University’ Summer School, Berlin, September 2008.

¹² ‘Global Health: Current Issues, Future Trends and Foreign Policy’, London, April 2008. This conference was organised by the Royal College of Physicians. Apart from general agenda some policy documents were discussed at this conference: Lord Crisp’s ‘Global health partnerships: The UK contribution to health in developing countries’ and the Chief Medical Officer’s ‘Health is global: proposals for a government-wide strategy’ (Crisp, 2007).

contacts among these officials was conducted through public documents produced by the Department of Health and the NHS Employers, on-line sources such as professional social networks, and information provided by other interviewees.

Once the key interviewees and their contact details were identified, the fieldwork proceeded to the next stage of sending letters to interviewees with an introduction to the purposes of the research and an invitation to participate. These individual emails were sent to interviewees approximately 6 months prior to the commencement of the fieldwork. Most of the key interviewees were located in London, where the interviews took place. When informants were not available to participate in the face-to-face interviews, phone interviews and email communication was used.

The content of the semi-structured, open-ended interviews with officials at the national and international levels was defined by the research aims and previously collected material from policy documents produced by the Department of Health and international organisations, and from professional and academic journals. Prior to the interviews, information about interviewees and their role in the negotiation of agreements was collected through documentary analysis.

The list of pre-set themes discussed in the interviews included negotiation, conclusion and implementation of agreements; the organisation of international nurse recruitment; and implementation of the ethical recruitment policy. This array of themes became a framework for elite interviews. However, the questions asked during the interviews were not restricted to these pre-set topics. The composition of questions was adapted to each interviewee's position and involvement in nurse recruitment and the negotiation of agreements. The course of the interview followed the informant's narrative and this allowed new themes to emerge (see Appendix 5).

A number of ethical issues were considered when conducting elite interviews. Prior to the interviews, research information sheets and informed consent forms were distributed to all interviewees (see Appendices 6 and 7). These included statements about the research aims and methods of data collection, and the researcher's contact details. To ensure confidentiality of data and anonymity of interviewees, individual agreements were made about the use of direct quotations in my thesis. The

interviewees were offered three options for identification in the event of their responses being cited in the text: their full position being disclosed; only organisational affiliation being revealed; or complete anonymity. Most of the interviewees opted to be identified through their organisational affiliation. Some interviewees did not want precise identification of their positions. In these cases, following interviewees' requests, the titles of positions were changed to a more general wording (see Appendix 7). Finally, the issue of temporality in policy process research re-emerged when addressing the issue of the trustworthiness, plausibility and consistency of narratives in the elite interviews. As mentioned above, the interviews took place a number of years after the agreements were negotiated. The time distance, on the one hand, allowed interviewees to speak more freely about past events and policy issues which were no longer a priority of the policy discourse; and as many interviewees moved jobs, they were not directly involved in the international recruitment. On the other hand, the proposition that this time gap could have affected the interviewees' responses was considered. Two solutions were devised to resolve this problem. First, as mentioned above, triangulation of data sources was one of the methods used in this study as it brings together the perceptions of different political actors. Second, to respond to the issue of trustworthiness of interview data, a number of criteria were considered during analysis. These criteria, proposed by George and Bennett (2005) and Dexter (2006), included the following questions: who is speaking; what organisational/personal interests or values does the interviewee protect/project; and how does this information correspond with the accounts of other interviewees and other data sources such as policy documents? These questions became the filters and frame of reference during the interpretation of actors' perceptions at the stage of data analysis.

3.4 DATA ANALYSIS

Data from interviews and documents was analysed using techniques of qualitative content analysis (Miles and Huberman, 1994). Analysis of textual data was directed by the research questions and the concepts identified in the analytical framework: context, perceptions and functions (see Chapter 2). This type of

directed qualitative content analysis was organised around the key themes of types, selection and consequences of agreements; however, it also allowed categories to emerge from original data (Hsieh and Shannon, 2005). Analysis of data became a cyclical rather than linear process, which included the following procedures: reading through the transcripts of interviews and texts of documents, repeating such readings, highlighting words in the text that embodied key themes and concepts, making notes, creating an initial coding scheme, sorting codes into categories, and identifying themes in the emergent categories.

To systematise descriptive data from documents and elite interviews, a typification technique was used (Becker, 1940; McKinney, 1969; Dotty and Glick, 1994). This distinguished between the types of agreements, types of source-countries and types of functions that the Department of Health had implemented in each agreement. The role of the typologies developed was descriptive rather than explanatory (see Chapter 5).

At the next stage of developing an interpretation of actors' perceptions, the transcripts of interviews and the policy documents were analysed through the lenses of two questions: who were the actors; and what were their positions on the status and content of agreements, the reasons for their negotiation and the consequences of the agreements. This cross-text analysis revealed multiple positions expressed by institutional actors, which became an important element in understanding the role of agreements (see Chapter 6).

Finally, to conceptualise actors' interpretations of the consequences of policy tools, the concept of function was employed. In particular, it drew on Merton's distinction between manifest and latent functions. However, it is important to point out that the concept of function is applied here with certain adjustments to Merton's original definition, which are delineated in this section.

To begin with, functional analysis is applied in this research as a methodological, rather than explanatory, tool. Such an application is different from the classical functionalist explanation, which addresses the question of 'why' things exist by asking 'how' things exist or what their functions are (Kincaid, 1994). In orthodox functionalist logic, function becomes the cause of existence of a social phenomenon. In contrast, the present study draws on the interpretative tradition. This

tradition explains social phenomena through an understanding of the meanings of social actions, which originate in actors' interpretations (see Section 3.1, Chapter 3). The purpose of the present analysis is not to explain the origin of agreements through their functions but to categorise actors' interpretations of the consequences of agreements, using function as a tool of mediating notions employed by individual actors to theoretical constructs or in Schutz terms – social-scientific concepts (Schutz, 1966).

In the application of functional analysis in this study, the term *function* is used in a particular way. In order to clarify this use and how it developed in this research, a review of Merton's original works and critical responses to them, is presented.

Merton (1949, p.50) defined function as 'objective consequences' and distinguished them from 'subjective dispositions' such as motives and purposes. These two, he argued, should not be confused one with another. However, in his definition of manifest and latent functions, he referred to the terms 'intention' and 'recognition', which presume the presence of social actors and their subjective perceptions (1949, p.51):

manifest [functions] are those objective consequences contributing to the adjustment or adaptation of the system which are intended and recognized by participants in this system; latent functions, correlatively, being those which are neither intended nor recognized.

This observation raised the question of the extent to which Merton's distinction between objective consequences and subjective dispositions is coherent with his definition of manifest and latent functions. Another question emerged from the review of other scholars' critiques of Merton's analysis. Campbell (1982) argues that the distinction between manifest and latent functions, based on intention and recognition, is an ambiguous and conceptually weak approach. He purports that the vagueness in Merton's definition of manifest and latent functions resulted in the rare application of these concepts as explanatory categories in empirical research (Campbell, 1982). To address the problem of a lack of conceptual clarity, he adds two further types to Merton's original distinction between functions based on intention and recognition (Campbell, 1982). He introduces these types of consequences as 'intended but not recognised' and 'unintended but recognised'.

Although this is a valuable observation, which potentially contributes to the original distinction, the types proposed do not offer a means of overcoming the problems raised by Campbell himself in relation to the conceptual obscurity and practical relevance of the identified types. These problems are of a methodological character. How can research identify these types of functions in the empirical data? How can one distinguish between purposes and consequences? These questions about the relevance of the distinction between objective consequences and subjective dispositions in the definition of manifest and latent functions, as well as the value of these definitions for empirical research, became an essential basis for defining the terms on which functional analysis is applied in this study.

To begin with, it is important to define what the function is. In this study, I distinguish between a definition of function, as sometimes used by academics, as a normative, institutionally-defined obligation or a functional imperative of what the policy tool or institution has to do (Boswell, 2007) and Merton's understanding of a function as a consequence of action (Merton, 1949). However, contrary to Merton's distinction between objective consequences and subjective motives, the present analysis defines the function of agreements as consequences which are constructed and produced in the interpretations of social actors. These include both interpretations of actors' intentions in the negotiation of agreements and actors' interpretations of the performance of agreements. Following this definition, the analysis of functions in this study focuses on: how actors interpret their intentions in the negotiation of agreements; how they perceive the performance of agreements; and whether they recognise the fulfilment of their intentions in the implementation of agreements.

Merton's definition of manifest functions as intended and recognised consequences, and latent functions as neither intended nor recognised, is clarified in this research by addressing two questions: by whom the functions are intended and how they are recognised. The first question enables the identification of a distinction between policy-makers as those political actors who are directly involved in the design and negotiation of agreements, and a broader group of political actors who take part in the policy discourse about the recruitment of foreign health workers. The

second question, of how the functions are recognised, leads to a distinction between official policy discourse and informal communication.

This operationalisation of Merton's original concepts results in the definition of a *manifest function* as the consequences of agreements that are recognised by political actors in the official policy discourse (texts of agreements, official policy reports on implementation and public speeches) as intended and fulfilled. It should be noted that those consequences which are recognised by policy-makers as intended but not fulfilled are defined in this research as *dysfunction*.

Following Campbell's development of two more categories, the definition of the *latent function* in this research distinguishes between four types of latency. The first type of latent function includes consequences that were recognised by policy-makers as intended and fulfilled. However, contrary to manifest function, recognition of these consequences does not appear in the official policy discourse, but is expressed in informal communication (for instance, interviews). The second type of latent function contains those consequences that were not recognised by policy-makers at all (in the official or informal discourse)¹³ but that were identified by other political actors in the public discourse and interviews. The third type of latent function includes unintended consequences recognised either by policy-makers or political actors¹⁴. Finally, the fourth type of latent function is understood as consequences, recognised by neither policy-makers nor other political actors, but identified in the researcher's interpretations (see Section 3.1, Chapter 3).

This adjusted framework of functional analysis allowed me to formulate a number of questions, which I addressed during the analysis of my empirical data:

- Who were the actors?;
- What were their intentions in the negotiations?;
- How did these actors interpret the consequences of agreements?;
- How were these interpretations reflected in the official policy discourse and in the interviews conducted for this research?

¹³ It should be noted that in some cases of description of types of functions, I do not specify whether it is in official discourse or informal communication. In these cases, I refer to both.

¹⁴ Analysis of empirical data in this study did not reveal this type of latent consequences.

Once these questions had been defined, I started analysis of the texts of agreements, official statements and public speeches, and the transcripts of interviews with policy-makers. The aim at this first stage was to identify policy-makers' intentions which were articulated in the official policy discourse; and to reveal those intentions which did not appear in the public discourse but were expressed in the interviews. In the latter, it was important to distinguish between cases when policy-makers talked about their intentions in negotiations and whether these intentions were fulfilled. For this reason, attention was paid to how policy-makers talked about agreements, including what linguistic constructions they used. For instance, such phrases as 'we wanted' and 'we negotiated agreements to...' were associated with intentions; while such constructions as 'agreements were...' and 'they became...' pointed to the policy-makers' interpretations of the consequences of these policy tools. When analysis of the texts of agreements and interviews with policy-makers was completed, I conducted a cross-examination of this material to reveal those intentions of policy-makers that did not appear in the official policy discourse. This procedure allowed me to reveal latent functions, which were recognised by policy-makers in informal communication, but not in official policy discourse, as their fulfilled intentions.

My second step was to analyse the interpretations of political actors who were not directly involved in the design of agreements but who took part in the policy debate and practice of the international recruitment of health workers. This group of actors included practitioners employed by the Department of Health to implement agreements (international recruitment co-co-ordinators); international organisations (the Commonwealth Secretariat, the WHO, the ILO, the PSI and the OECD); trade unions; and professional organisations (the RCN and the UNISON). The perspectives of these actors became an important component in the identification of functions which were recognised neither in official documents nor by policy-makers in the interviews.

Finally, to reveal the consequences recognised neither by policy-makers nor by other political actors, the interview material and data from policy documents were cross-analysed within the frame of the policy context described in Chapters 5 and 6.

The textual data was repeatedly analysed by addressing a number of questions similar to those stated earlier in this section, but this time formulated in a more detailed manner:

- How do official documents define the objectives and the content of agreements?;
- How do political actors interpret the context of negotiations and the broader context of international recruitment of health workers in the early 2000s?;
- How do political actors define agreements?;
- How do policy-makers articulate their intentions in the negotiation of agreements?;
- How do policy-makers and a broader group of political actors (not involved in the design and negotiation of agreements) articulate the performance (consequences) of agreements?

These questions were used to identify agreement-specific and generic functions - or in Merton's terms, aggregate – consequences of these policy tools (see Chapter 7).

CONCLUSION

This chapter has discussed the key decisions that were made in the design of this research. It has explained the decision to conduct this study in the interpretative tradition, given the nature of the subject and research questions posed. The aim of the research was to develop an in-depth understanding of the meaning of labour agreements from the perspective of political actors in the country of nurse migrants' destination: the UK. A case study approach was chosen as a pertinent research method to explore, describe and explain these perceptions in the context of foreign nurse recruitment in Britain. This chapter has justified the choice of UK practice in the negotiation of ethical agreements as a single-case design with agreements as embedded units of analysis. It has demonstrated how the selection of time boundaries

from 1997 to 2007; the UK as geographical locale; and nurse migration among other health professions, strengthen the case in the research.

This chapter has also provided a detailed description of why document analysis and elite interviews became the methods of data collection, and how they corroborated with one another and contributed to the research process. Particular attention was paid to the problems of access to elite interviewees, the value of their narratives, and the role of time in studying the policy process. The latter became a particularly topical issue as the interviews were held a few years after the events of interest took place. The chapter has explained the value of the triangulation method in addressing this problem.

Finally, the chapter concluded by explaining how qualitative data analysis was performed in this research. It focused on the cyclical nature of qualitative text analysis and defining stages of data analysis. This section explained how the concept of function was applied in this analysis and how such analysis embodied the logic of hermeneutic explanation.

4. BILATERAL LABOUR AGREEMENTS: OVERVIEW

INTRODUCTION

The three previous chapters outlined the background of this research. They presented the research aims in the frame of previous empirical studies on health worker migration and policy tools literature, and described the methodology employed to study bilateral labour agreements.

The present chapter is the first in a series of chapters that present the empirical and analytical substance of this thesis. It begins with a description of the institutional knowledge accumulated by international organisations and national bodies about past and present practices in the negotiation of bilateral labour agreements across countries.

This chapter is divided into two sections. The first traces the history of policy tools back to the 1960s when bilateral labour agreements were actively employed by European countries. It defines the contemporary status of bilateral labour agreements and introduces the policy discourse around these regulatory mechanisms in cross-border labour mobility. In particular, this section summarises policy discussion on the definitions, types and objectives of past and present bilateral labour agreements. It also examines the position of bilateral labour agreements in contrast to that of unilateral and multilateral tools in the regulation of international labour migration. The first section concludes with a revision of the impacts of bilateral labour agreements that are recognised in the policy discourse today. The second section of this chapter narrows the analysis to bilateral schemes negotiated in the health sector. It then discusses the distinctive position of the UK among other countries in the negotiation of agreements. The agreements under investigation are those that were negotiated in the early 2000s on the cross-border mobility of nurses.

The data presented in this chapter is derived from a review of policy reports produced by international organisations (OECD, IOM, WTO, ILO and WHO), UK Government bodies (Home Office, Department of Health and Department for International Development), research centres (Aspen Institute, 2011), and individual scholars who examine bilateral labour agreements.

4.1 PAST AND PRESENT

4.1.1 HISTORY AND GEOGRAPHY

The negotiation of bilateral labour agreements is a well-established practice in international relations which dates back to the late 19th century when the earliest versions of labour recruitment programmes were initiated between countries (Organisation for Economic Co-operation and Development, 2004b). At that time, the pioneers in negotiation of such agreements were Germany and Switzerland. These countries, in fact, continued this practice throughout the 20th century when the negotiation of bilateral labour agreements reached its peak.

An active period in the negotiation of bilateral labour schemes occurred after the Second World War. In the 1950 and 1960s, many European countries experienced a significant labour shortage due to population decline, mass emigration and re-location induced by the war. Among other Western European states, Belgium, France, Germany, the Netherlands and Switzerland became active in the negotiation of labour agreements. These states operated a number of bilateral schemes with Ireland, countries in Southern Europe (Greece, Italy, Portugal and Spain), Turkey, the former Yugoslavia and countries in North Africa (Algeria, Morocco and Tunisia). The purpose of these agreements was to recruit low-skilled labour in the agriculture, construction, mining and catering sectors, through seasonal guest-worker employment programmes. Perhaps one of the most cited examples of bilateral agreements was the German *Gastarbeiter* programme, which brought around 3.6 million workers to Germany from Italy, Greece, Turkey and Yugoslavia, in the period 1960-1966 (Organisation for Economic Co-operation and Development, 2004b).

The mid-1970s became a turning point for bilateral labour agreements. The number of bilateral recruitment schemes concluded by European countries considerably declined after the oil crisis in 1973. Restrictive measures in the regulation of labour immigration were introduced in response to a reduced demand for labour in many European countries following economic downturn (Abella, 2004).

The re-emergence of bilateral labour agreements in Europe occurred in the 1990s and early 2000s, although with less intensity than the recruitment drive of the 1960s and 1970s. The growth of labour migration in Europe in the early 1990s was facilitated by the opening of borders with Central and Eastern European countries (CEEC). Among the most active co-signers of these 'second generation' bilateral agreements were Germany, Spain, France, and countries of Central and Eastern Europe such as Poland, Czech Republic, Slovak Republic and Hungary (Organisation for Economic Co-operation and Development, 2004b).

Two main differences can be observed between agreements negotiated in the 1960s and those negotiated in the 1990s. As mentioned above, the number of recruits via the 'second generation' agreements was smaller compared to those in the 1960s. Additionally, the type of the agreements transformed from primarily recruitment agreements in the 1960s, to readmission agreements, ensuring the return of migrant workers to their countries of origin, in the 1990s.

This section has thus far focused primarily on the European history of bilateral labour agreements. In fact, Europe was not the only region to negotiate labour agreements. These policy instruments were also common in East and South Asia, Sub-Saharan Africa, Latin America and the Caribbean (Abella, 2004; Go, 2007). For instance, one of the first labour agreements in the Americas was the Bracero Programme. Active from 1942 to 1962, it recruited over 5 million temporary farm workers from Mexico to the US (Trachtman, 2009).

The key negotiators of bilateral agreements in Asia were the Philippines, Thailand and Vietnam. Since the late 1970s, the Philippines has signed agreements with several states in the Asia-Pacific region (Bangladesh and Papua New Guinea); the Middle East (Jordan, Iran, Iraq and Qatar); Europe (Austria, Belgium, Cyprus, Greece and the United Kingdom); and Africa (Liberia and Libya) (Organisation for Economic Co-operation and Development, 2004b). It was estimated that by the year 2006, the Philippines had 11 bilateral labour agreements and 7 social security agreements (Wickramasekara, 2006). Bilateral agreements were negotiated in Asia between a number of countries¹⁵; however, the Philippines is the most distinctive

¹⁵ For example, there was a bilateral labour agreement between China and Bahrain; a social security agreement between China and Germany; MOU between Korea and Indonesia, Mongolia, the Philippines, Sri Lanka, Thailand and Vietnam; agreements between Malaysia and China, Indonesia,

case among labour exporting states as the overseas deployment of Filipino workers is institutionalised at the government level¹⁶ (see Chapter 5).

In Sub-Saharan Africa, South Africa has become the leading negotiator of government-to-government agreements on labour recruitment. Since the 1970s, it has been actively recruiting mine and farm workers from Mozambique, Botswana, Lesotho and Swaziland (South African Migration Programme, 2010). Two relatively recent examples of agreements on recruitment of health workers are those negotiated with Cuba and Tunisia in 1995 and 1999 respectively (Warby, n.d.).

In Latin America, about 150 agreements were concluded in the second half of the 20th century; half of them in the last decade. One of the main recruitment countries in this region is Spain, which has agreements with Ecuador, Columbia, Peru and Dominican Republic (Abella, 2004; Pinyol, 2009).

The list of bilateral labour agreements across the world can be further lengthened. Bilateral labour agreements are recognised as the most widespread method of recruiting labour. It is estimated that in 2004, there were more than 176 bilateral agreements and other forms of labour recruitment in force in OECD countries (Organisation for Economic Co-operation and Development, 2004b).

4.1.2 DEFINITIONS AND TYPES

As a component of the international legal system, the term ‘agreement’ emerged in the first decades of the 20th century. Gradually, it became a broadly used reference in many definitions of various forms of international co-operation. The United Nations (UN) distinguishes between generic and specific meanings of the term. Agreement, as a generic term, refers to international treaties. In its narrow meaning, agreement is applied to bilateral or restricted multilateral treaties of a technical or administrative

Bangladesh, Vietnam, Lao PDR, Sri Lanka and India; MOUs between Thailand and Cambodia, and Lao PDR and Myanmar; agreements between India and Qatar, and India and Lebanon; and finally, Taiwan negotiated bilateral agreements with Thailand and Vietnam, and MOUs with Indonesia and the Philippines.

¹⁶ The government of the Philippines adopted an international labour migration policy in 1974 as a temporary, ‘stop-gap’ measure to ease unemployment, economic stagnation and poverty. Gradually, this short-term practice was transformed into an institutionalised policy of deploying workers abroad. This culminated in 1995 when the ‘Migrant Workers and Overseas Filipinos Act’ was introduced to institutionalise the principles of overseas workers’ deployment and to establish a system which could protect the welfare of Filipino workers abroad (The Economist, 2011:50).

character, which are signed by the representatives of government departments but are not subject to ratification. Typical agreements deal with matters of economic, cultural, scientific and technical co-operation (United Nations, 1969).

Among these broad policy domains, bilateral agreements are commonly used in the regulation of the cross-border labour migration. This type of bilateral agreements is commonly referred to as bilateral labour agreements and defined as ‘...all forms of arrangements between countries, regions and public institutions that provide for the recruitment and employment of foreign workers’ (Bobeva and Garson, 2004, p.11). These agreements are instruments of public international law and included in the broad category of international treaties. In principle, the original aim of bilateral labour agreements was to provide privileged access to the national labour market to foreign workers with specified qualifications from the source country co-signing the agreement. As shown in the first section, bilateral labour agreements were originally negotiated to attract low skilled and temporary workers from source countries to work in agriculture, construction and the services sector (catering and hospitality). Gradually, recruitment capacity of these agreements was expanded to highly skilled professionals in the Information Technology (IT), engineering and health care sectors.

There is a variety of alternative names given to bilateral labour agreements. Among these are employment treaties, labour agreements, recruitment treaties, migration agreements, MoU and agreements for the exchange of labour. The legal status of such policy tools varies from binding agreements to voluntary ‘soft’ regulations. One of the often used terms in this array is the MoU. The MoU is defined by United Nations (2009, n.p.):

an international instrument of a less formal kind. It often sets out operational arrangements under a framework international agreement. It is also used for the regulation of technical or detailed matters. It is typically in the form of a single instrument and does not require ratification. They are entered into either by States or International Organizations.

Although the distinction between agreements and memoranda of understanding is quite vague, the latter are recognised as ‘softer’ mechanisms which express the

common grounds for action and intentions of two parties rather than their obligations (Wickramasekara, 2006). The legal status of MoUs is largely contextually defined in each particular case by the co-signing parties.

A number of typologies of bilateral labour agreements were developed based on various criteria. Based on the type of recruits and the duration of employment contracts, bilateral agreements are distinguished between ‘seasonal worker’ agreements, contract worker and project-linked worker agreements, guest worker agreements, trainee agreements, cross-border worker agreements, working holidaymaker schemes and other short-term training programmes (Chanda, 2008). The main characteristics of these agreements are summarised in Table 2.

Table 2 Bilateral schemes in labour migration

Type of the agreement	Duration	Type of recruited labour force	Sector	Conditions	Examples
Seasonal worker agreements	3 months - 1 year	Low skilled	Hospitality, catering, agriculture and construction	Quotas to limit the number of entries	USA and Canada with (Caribbean nations) ¹⁷ and (Mexico)
Contract worker and project-linked worker agreements	Depends on the project (normally short/medium-term)	Foreign workers who are directly employed, either by a foreign-based company or by a domestic firm carrying out work abroad	Varies	Facilitate access to work permits; The sending country distributes the quotas among firms	Germany
Guest worker agreements	1 year (possible extension for a further year)	Low skilled	Industrial sector	-	Germany
Trainee agreements, or other short-term training programmes	12 to 18 months	Young professional s/graduates	Varies	Entry requirements based on language and qualifications	Germany (Czech Rep.), Luxembourg, Switzerland Hungry (Romania)
Cross-border	Not specified	Not	Varies	Based on the	Austria (Czech

¹⁷ Supply countries are in parentheses.

worker agreements		specified		geographical proximity and regionalism of the labour markets	Republic and Hungary); Switzerland Luxembourg
Working holidaymaker schemes	6 months – 2 years	Students/young travellers	Service sector	Limited incidental employment during travelling time; Age limits; Requirement of a minimum level of funds to guarantee return to the home country	United Kingdom Italy Australia

Source: adapted from OECD, 2004b.

The table above indicates that bilateral schemes have focused largely on low skilled workers, occasional employees (travellers) and young professionals in the early years of their career. Among these, only cross-border worker agreements and contract/project-linked agreements provide privileged access to highly skilled and experienced professionals. The duration of bilateral agreements normally varies from 3 months to 2 years. They may include quotas regulating the number of recruits and requirements about the age and language skills of applicants.

Another typology, based on the legal power of bilateral agreements, distinguishes between binding arrangements and ‘soft’ law agreements on bilateral co-operation. Those bilateral labour agreements which have been approved by lawyers in respective countries constitute formal documents. They have a fixed time of validity and the conditions and obligations of both parties are clearly defined. The binding power of these regulations is determined by the presence or absence of clauses on mutual obligations, supervision, monitoring and sanctions. The tools of ‘soft’ regulation, including the above-mentioned MOU, Statements of Mutual Labour Co-operation and informal assurances, are normally not legally formalised. Their purpose is to define the intentions rather than the obligations of the parties in agreement. These tools are often referred to as framework documents which address the common concerns of co-signing countries (Wickramasekara, 2006).

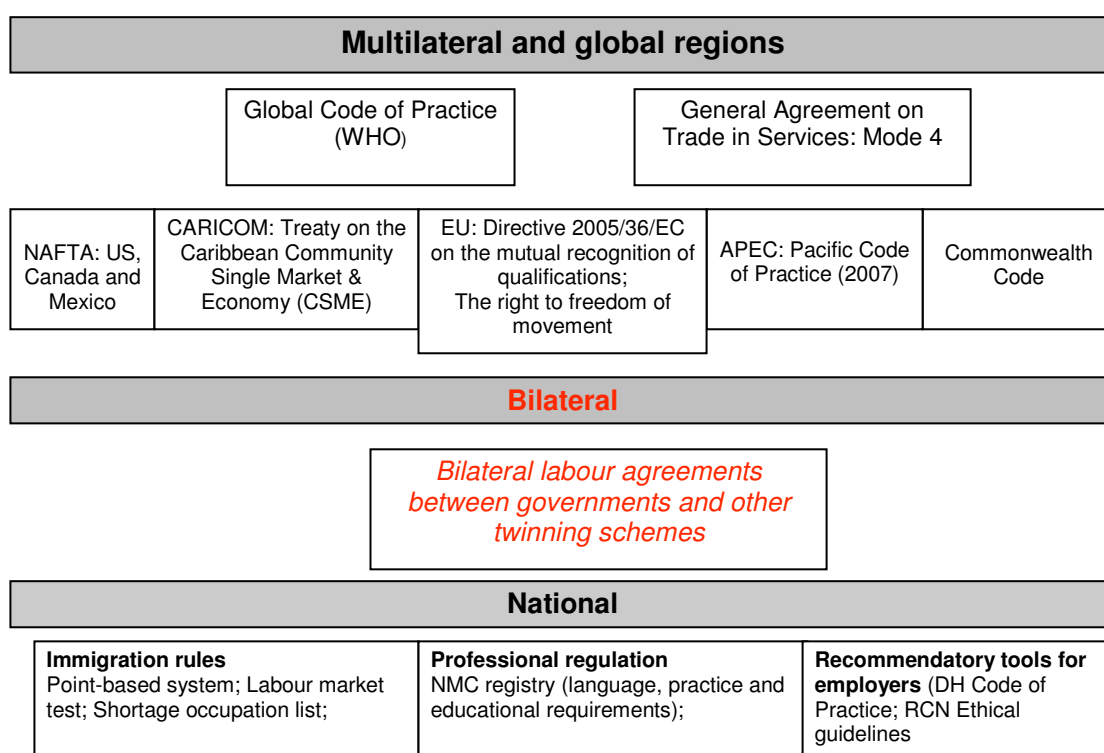
Finally, agreements are differentiated according to their content and objectives. A distinction is made between labour recruitment/hiring agreements, labour protection or social security agreements, re-admission agreements ensuring the return

of migrant workers and controlling overstays, anti-trafficking agreements and, finally, agreements to prevent illegal immigration (Wickramasekara, 2006).

4.1.3 THE STATUS IN THE REGULATORY FRAMEWORK

Bilateral labour agreements represent one of many mechanisms to regulate labour migration. Such mechanisms can be categorised according to their scope and coverage (multilateral, bilateral and unilateral); the type of institutional actor producing the regulation (international organisation, institution of cross-border governance such as the EU, national government, and professional organisation) and finally, the legal status of agreements ('hard' and 'soft' regulation). Figure 4 summarises the different types of tools employed in the regulation of cross-border labour mobility, using nurses as an example where appropriate.

Figure 4 Regulation of cross-border nurse mobility



As the figure above indicates, at the national level, the array of regulatory mechanisms affecting the cross-border mobility of nurses includes immigration rules,

professional regulation and recommendatory tools for employers recruiting from abroad¹⁸. Depending on political and economic contexts, immigration policy introduces mechanisms that either impede or encourage international labour migration. Mechanisms facilitating labour migration include the shortage occupation list, and sector-based and skill-based recruitment programmes. The shortage occupation list specifies professions that are in high demand and cannot be filled with the available native candidates. Employers for the listed occupations are not required to complete a resident labour market test (see next paragraph) (UK Border Agency, 2011a). This list is regularly revised in consultation with employers. For instance, in 2000, the UK Home Office included general nursing in the shortage occupation list to speed up nurse recruitment from abroad; a few years later in 2006, the shortage of nurses was eliminated and general nursing was removed from the list (Royal College of Nursing, 2010).

A different group of national mechanisms that impedes the labour migration includes the points based system and the resident labour market test. The former grants entry to migrant workers based on the assessment of their education level, professional experience, previous salary, and language proficiency. The resident labour market test allows employers to recruit foreign labour only for vacancies that were advertised for 28 calendar days and were not filled with suitably skilled native candidates (UK Border Agency, 2011b).

The next level in regulation of cross-border labour mobility is represented by bilateral mechanisms. By definition, bilateral mechanisms involve two parties at the level of government, region or institution, in two countries. In addition to the previously mentioned bilateral agreements between two governments, this group of measures includes twinning agreements between the hospitals and regional governments of two countries, joint commissions on labour, round table meetings and working groups between government officials in two countries (Baruah, 2003; Buchan and Dovlo, 2004).

At the level of global regions, tools in the regulation of labour migration can be either binding arrangements, which are normally the prolongation of trade related agreements, and non-binding agreements. The former is illustrated with examples of

¹⁸ In this table information about regulation at the national level is collated using the British experience.

the Caribbean Community (CARICOM) and the North Atlantic Free Trade Agreement (NAFTA). Examples of non-binding framework agreements, which involve collaboration between countries on the matter of health worker migration, include the Commonwealth Code of Practice (2002) and the Pacific Code of Practice (2007). Both types of agreements are described further below, based on the data reported by the International Organization of Migration (International Organization for Migration, 2010).

The primary focus of the NAFTA¹⁹ is the regulation of trade and investment in the North American region. It also contains clauses on the regulation of service providers' mobility within the region. It applies to citizens of the US, Canada and Mexico who are business visitors, traders, investors, intra-corporate transferees and professionals. The arrangements within the NAFTA reduce the restrictions imposed in the normal process of admission of foreign labour, such as requirements of labour market tests, work permits and the certification of qualifications. For instance, professionals need only work permits and do not have to undergo additional approval procedures. Despite these arrangements to facilitate labour migration within the NAFTA, this scheme is selective and focused on trade policy. It is mainly oriented to attracting business and investment to the US and at the same time protecting the US labour market by restricting labour migration.

The free movement of people is a critical factor in the integration process of the CARICOM²⁰. The Treaty on the Caribbean Community Single Market and Economy (CSME) abolishes discrimination on the grounds of nationality in all Member States, and grants professionals the right to move freely within the region. At present, the CARICOM framework covers university graduates, artists, musicians, media workers, sportspersons and suppliers of services. Although regional labour migration is liberalised, CARICOM does not create significant intra-regional migration flows as there are more attractive opportunities available in developed countries outside the region such as the US, the UK and Australia. Favourable conditions for labour

¹⁹ NAFTA is the North American Free Trade Agreement between the United States, Canada and Mexico.

²⁰ CARICOM is the Caribbean Community consisting of 15 members and 5 associated member countries. The 15 members are Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Montserrat, Saint Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago; while the 5 associated members are Anguilla, Bermuda, British Virgin Islands, Cayman Islands, and Turks and Caicos Islands.

migration between the Asia-Pacific Economic Cooperation (APEC)²¹ member states were introduced in 1997 under the Business Travel Card scheme. This scheme allows multiple entry for business visitors for between 60 and 90 days at a time, over a period of 3 years. It applies mainly to business trips, including exploration of business opportunities, attending meetings and conducting trade and investment activities, rather than migration for employment purposes. The scheme is the most limited variant of cross-border mobility arrangements in global regions.

The regulation of labour migration within the European Union is a distinctive case in comparison to the other global regions mentioned above. EU citizens are granted the fundamental right to freedom of movement. The free movement of workers in particular is laid down in Article 39 EC and further developed in Regulation 1612/68 (Council of the European Communities, 1968). The latter provides for the right of EU citizens to work in another Member State as an employee or civil servant. In contrast, trade-related agreements (such as the NAFTA) place conditions on the access of foreign labour; by specifying either the sectors or the skills of workers to be recruited, and by limiting the duration of their stay in the destination country. Furthermore, voluntary arrangements applied in global regions (such as the Commonwealth Code) are subordinate to national immigration systems.

Agreements negotiated within global regions often emerge either as the supplementary component to regional trade agreements or as 'soft' arrangements between countries which exercise no binding power. Regulatory tools at the level of global regions have a broader scope of application than bilateral agreements. The former intend to create favourable conditions for foreign workers to access labour markets across several countries, while the latter only involve two countries.

To conclude the description of regulatory tools affecting the mobility of health workers, this section introduces the mechanisms that operate at the international level. Like the tools that exist across global regions, these international mechanisms are divided into two types: trade-related agreements, such as the General Agreement

²¹ APEC has 21 members: Australia, Brunei Darussalam, Canada, Chile, the People's Republic of China, Hong Kong, Indonesia, Japan, Republic of Korea, Malaysia, Mexico, New Zealand, Papua New Guinea, Peru, the Philippines, Russia, Singapore, Chinese Taipei, Thailand, the United States of America and Vietnam.

on Trade in Services (GATS), and voluntary initiatives, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel.

GATS, and more precisely its Mode 4, recognises the temporary movement of persons as an important factor in the trade of services and allows persons of one member state to enter the territory of another member state and to supply a service (for example, accounting, health-care or teaching). At the same time, this agreement specifies that a member state remains free to operate measures regarding citizenship, residence and access to the labour market on a permanent basis (World Trade Organization, 1995b). Strictly speaking, GATS does not regulate labour migration itself but focuses on the trade in services component of migration. For instance, it uses the category of ‘service provider/supplier’ rather than ‘job seeker’²². While GATS commitments in general have a binding nature, the WTO members agreed to slow down some of its arrangements under the Mode 4, in particular those relating to health worker migration. These are recognised as threatening the public health sector on the one hand, and undermining the regulations of national immigration policies on the other.

Finally, there are multilateral arrangements at the international level that are not trade related mechanisms. Over the past five years, the WHO Global Code of Practice on the International Recruitment of Health Personnel has been among the most cited instruments of this type in the policy debate. It was adopted in 2010 after a long process of consultation between member states that started in 2008. The Code is voluntary in nature and serves ‘as a reference for Member States in establishing or improving the legal and institutional framework required for the international recruitment of health personnel’ (World Health Organization, 2010). The objective of this code is to discourage the active recruitment of health personnel from developing countries that face critical shortages of health workers, and to promote and disseminate best practices in health worker recruitment.

To sum up this revision of governance tools in the regulation of labour migration, bilateral agreements are not the only form of labour migration regulation. Many countries apply different schemes, including unilateral tools, global regional

²² Job seekers are people seeking access to the employment market regardless of sector, while service suppliers normally enter to provide a specific service in a given sector (that is, they have a contract for the delivery of a service upon entry).

arrangements and multilateral frameworks. Each group of arrangements has particular goals. National schemes use primarily immigration rules and professional standards to regulate recruitment of foreign workers. Labour migration schemes in the global regions vary, from those that provide the right to freedom of movement, to limited programmes available only for business and investment related activities. Some of these tools are components of trade agreements. The multilateral framework of GATS intends to provide free access to national labour markets for service providers. However, there is little evidence on its implementation since it was argued that GATS arrangements conflict with national migration and security policies. The ethical recruitment instruments, such as the WHO Code of Practice, are guidelines of a recommendatory character that intend to set up a framework ensuring good practice in the recruitment of a migrant labour force. Among this variety of schemes, bilateral agreements are tools with a distinctive status and objectives that are outlined in detail in the following section.

4.1.4 OBJECTIVES AND KEY ACTORS

Originally, bilateral labour agreements were negotiated as economic tools driven by the shortage of labour in receiving countries. However, over the past 50 years, these agreements have become instruments that perform multiple functions. They gradually transformed from largely recruitment schemes to readmission and social security agreements and instruments of international relations.

The initial economic goal of bilateral labour agreements was to improve the match between labour demand and labour supply in the national labour market. From the standpoint of receiving countries, the primary aim of bilateral agreements was to meet labour market needs by facilitating adjustment in the short-, medium- or long-term. Low-skilled workers were normally recruited via these agreements to address the labour shortage in the short-term (for example, seasonal workers); while highly skilled professionals were recruited to tackle the structural labour shortage in the medium- and long-term, in such sectors as health care, communications, and information technology. The economic and the labour market objectives of sending countries were to combat the unemployment rate and to use the remittances of

migrant workers to build the national economy. Today, these economic reasons for the negotiation of bilateral labour agreements are still present, however, some policy analysts argue that agreements are now underpinned by a broader array of objectives, of a mainly political nature (Organisation for Economic Co-operation and Development, 2004b).

Non-economic objectives of bilateral labour agreements reflect the political agenda of migration policies and international relations between countries. This group of objectives includes promotion of cultural ties and regional integration; readmission of migrant workers by their home country; development aid; and protection of the social welfare and labour rights of migrant workers (Garson, 2006; Solomon, 2006). These are discussed in more detail in turn.

Bilateral agreements continue and sustain historic and cultural ties between countries. For instance, agreements between France and Algeria, and the holidaymaker scheme between the United Kingdom and Commonwealth countries, continued post-colonial relations between these states. Employment arrangements between the Czech Republic and the Slovak Republic reflected the historic past of these countries as parts of the former joint state (Meduna, 2004).

Bilateral agreements also facilitate the integration process in global regions. For instance, during the establishment of the EU, bilateral agreements played an important role as tools assisting labour mobility, and thus the economic and political integration of European countries. Prior to the admission of 10 new members in the EU, Western European countries such as Germany, France and Austria concluded a number of bilateral labour agreements with some of the country-candidates, namely Hungary, Slovakia and Poland. These transition agreements became a preparatory stage for accession to the EU (Liebig, 2004; Organisation for Economic Co-operation and Development, 2004b).

Another important objective of bilateral agreements is the management and formalisation of labour migration. Bilateral agreements provide a regulatory mechanism to cope with illegal labour migration and overstays practiced by some migrant workers. For instance, some recruitment agreements include a clause on the repatriation (readmission) of illegal migrant workers back to their home country. These issues became especially topical in the 1990s and a number of receiving

countries, such as Italy and Spain, negotiated these agreements accordingly with Romania, Morocco and Ecuador (Organisation for Economic Co-operation and Development, 2004b).

Bilateral agreements are also negotiated to protect the social welfare and labour rights of migrant workers. In particular, sending countries now place greater emphasis on the rights and welfare of their nationals working abroad. For example, labour recruitment agreements between some receiving countries and the Philippines focus on the terms and conditions of employment of Filipino workers overseas (Go, 2004).

Finally, the development agenda of bilateral labour agreements focuses on aid programmes. Their aim is to build human capital in 'poor' countries by enhancing technology, knowledge and skills transfers through the provision of opportunities for training and employment in developed countries. Receiving countries, such as Switzerland, negotiate employment agreements with source countries to permit temporary access of workers to the national labour market. The vital component of these agreements is training and adaptation programmes aimed at improving the professional qualifications of labour migrants before they return home (Florez, 2004).

In terms of implementation, the recruitment of foreign labour through bilateral agreements may be centralised at the national level or managed through local authorities. When centralised at the national level, the recruitment process is governed by national labour offices. Typically, negotiations are organised between senior officials in employment, labour or immigration ministries or other relevant departments, in two countries. In the case of the regional management of bilateral agreements, recruitment functions are delegated to local authorities. The devolution of certain administrative and legislative powers to the level of regions has facilitated international recruitment at the local level (Bobeva and Garson, 2004). Regional bilateral agreements are practiced in France, Italy and Canada. For instance, the monitoring of labour shortages and overseas recruitment in Italy is supervised by regional employment offices. Another example is Germany, where the Federal Employment Agency recruits a foreign labour force through local employment services abroad (Bobeva and Garson, 2004).

Along with government authorities, other stakeholders are involved in the preparation, negotiation, monitoring and implementation of bilateral labour agreements. Among them are employers, trade unions, professional organisations and private recruitment agencies. For instance, employment organisations in Ireland, Portugal and the UK are involved in labour market assessment, identification of labour market shortages, checking eligibility of potential candidates and verifying their qualifications. Employers in destination countries may be involved in the organisation of training programmes for migrant workers in sending countries to prepare them to work abroad. For example, a training programme for Romanian nurses was organised and funded by Italian employers (Bobeva and Garson, 2004).

In addition to centralised and regional schemes, forms of decentralised recruitment managed by employers also occur within the framework of bilateral agreements. In this case, employers recruit staff individually or in groups through private recruitment agencies. Some scholars and practitioners argue that such decentralised recruitment provides more flexibility but simultaneously may be less secure for workers in comparison to government-led recruitment (Diminescu, 2004).

Although the role of private agencies recruiting outside of bilateral labour agreements has enlarged over the last 10 years, some of these agencies are involved in the government-led recruitment (Bobeva and Garson, 2004). For instance, in the nurse hiring agreement concluded between the UK and the Philippines in 2002, the selection and transfer of workers was administered by private recruitment agencies.

International organisations such as the WHO, the IOM and the ILO are involved in bilateral labour agreements for the purposes of either consultancy or monitoring. These organisations set up forums for discussion and knowledge sharing about agreements, consultation, monitoring, and technical support in implementation. For instance, the IOM was invited to assist in the implementation of recruitment programmes between Poland and the Netherlands; Spain and Ecuador; Spain and Columbia; and Italy and Albania. This assistance included selection and assessment of candidates, drafting of recruitment contracts, securing visa applications, and organising travel arrangements. The IOM also initiated monitoring and evaluation of the nurse recruitment from Poland to the Netherlands. Another international institution that has a long history of consultancy in bilateral labour agreements is the

ILO. In the 1949, it produced the Model Agreement on Temporary and Permanent Migration for Employment, including Migration of Refugees and Displaced Persons (International Labour Organization, 1949). This document advised on the major points that should be considered by parties in the negotiation of bilateral labour agreements. These included channels for information exchange; conditions for recruitment, testing and certification of applicants; specification of sectors, quotas, duration and renewal conditions; the content of employment contracts; provisions dealing with irregular migrant workers; procedures for dispute settlement; social security arrangements; return provisions; and jurisdiction and enforcement by joint review committees.

4.1.5 IMPACTS

Evaluation of bilateral labour agreements requires consideration of economic, political and socio-cultural criteria and the perspectives of both receiving and source countries. This section summarises the potential impacts of agreements and illustrates them with examples reported in the previous studies (Hars, 2003; Connell, 2007; Oliver, 2007; Go, 2007). These examples include evaluation of individual of cases in a single country (Blitz, 2005; International Organization for Migration, 2005a; Chanda, 2008, 2009) and cross-country analysis (Organisation for Economic Development and Co-operation, 2004b; Wiskow, 2006). The benefits and weak points of agreements identified in these studies do not necessarily correspond to all existing bilateral agreements. Rather, they are largely contextual and relate to the content and implementation of each particular agreement.

The OECD identifies a number of dimensions that could be applied in the evaluation of bilateral labour agreements. This includes the narrow perspective, which looks largely at the economic impacts of agreements on the labour market, and a broader view on the political effects of such agreements in the arena of international relations, migration policies, development aid provision and regional integration (Organisation for Economic Development and Co-operation, 2004b).

To begin with, policy reports often do not separate between economic impacts of labour migration and bilateral agreements, as one of its channels (Bobeva and

Garson, 2004). Therefore, the following points, presented in these policy reports about economic effects refer to both foreign labour migration and bilateral labour agreements as one of its channels.

The economic effect of foreign labour migration and bilateral labour agreements as one of its tools can be interpreted using a combination of two dimensions: the perspectives of source and destination countries; and positive and negative outcomes. It is recognised that in economic terms, agreements are valuable for source countries in a number of ways. First, they help to reduce the unemployment rate by sending the labour surplus abroad. Second, agreements become one of the means of increasing migrant remittances, which are crucial to the national economies of many developing countries. A typical example would be agreements negotiated by the Philippines, a traditional labour exporter (see Chapter 5). However, if agreements become a part of the national strategy, such as is the case in the Philippines, concern arises about the dependency of developing countries on labour export and the possibility that this reduces incentives to create jobs and improve working conditions locally.

The impact of bilateral labour agreements on the labour market in receiving countries is evident at two levels. At one level, these agreements resolve the problem of the labour shortage in destination countries in the short-term. At another level, there is a concern that these agreements may build up the dependency of destination countries on foreign labour and lead to an inability to train and retain a sufficient number of native workers (Bach, 2004b).

On a broader scale of the economic impacts of agreements on both receiving and source countries, policy analysts recognise the positive effects of these policy tools in facilitating trade and business relations between countries (Bobeva and Garson, 2004).

To conclude the overview of economic effects it is worthwhile mentioning that the labour market impact of bilateral agreements is decreasing. Today, there are more labour migrants arriving to destination countries using private recruitment agencies or directly responding to employers' job adverts than those arriving by means of bilateral labour agreements.

Contrary to the labour market effects of bilateral labour agreements, which generally correspond with the impacts of foreign labour migration, there are a number of distinctive outcomes produced by these policy tools in the political arena. It is recognised that bilateral agreements could potentially improve international relations; assist in the management of migration; provide a means for the implementation of development policies in poor world regions; and facilitate regional integration between countries (Organisation for Economic Development and Co-operation, 2004b). For instance, bilateral agreements could be used as regulatory tools to control and channel foreign labour migration by reducing the need to utilise commercial recruitment agencies; ensuring a more predictable and transparent process for both parties; and shifting the cost of migration from individual migrants to employers and governments of a recipient country (Bach, 2003).

Thus far it is clear there are both positive and negative economic impacts of bilateral labour agreements and that they hold a particular political value. However, a number of weak points are also recognised in reports on the implementation of government-led recruitment agreements. These refer mainly to the high financial and organisational costs of implementation (Organisation for Economic Development and Co-operation, 2004b). Recognition of the weaknesses of bilateral labour agreements is also expressed by the international trade and financial institutions, such as the World Trade Organisation. From the neo-liberal perspective, bilateral labour agreements are considered to be inefficient, bureaucratic and time-consuming mechanisms. They promote exclusive labour market access based on nationality which is inconsistent with the non-discriminatory principle of the Most Favoured Nations (MFN) (Nielson, 2006).

To sum up, negotiation of bilateral labour agreements is a dynamic process which, over the last 50 years, had peaks and troughs depending on the global economic climate and the changing priorities of receiving and source countries. Today, one of the common questions posed in the literature concerns the extent to which these agreements are efficient and relevant in the global labour market, where regulatory power is diffused between many actors (Organisation for Economic Co-operation and Development, 2004b). As the largest labour movement between countries takes place outside the channel of bilateral agreements (through

recruitment agencies, family links and social networks), bilateral agreements are considered to be old-fashioned instruments. Moreover, a comprehensive approach based on generic immigration rules is considered to be more effective in the longer term than bilateral agreements (Organisation for Economic Co-operation and Development, 2004b). Nevertheless, agreements are still acknowledged to be useful mechanisms in the management of cross-border labour movement. In particular, the negotiation of bilateral labour agreements is lobbied by major labour supply countries in Asia (the Philippines²³, Thailand and Vietnam). For these countries, agreements are still considered to be important mechanisms that can potentially protect the workforce abroad.

4.2 BILATERAL LABOUR AGREEMENTS AND MIGRATION OF HEALTH WORKERS

4.2.1 INTERNATIONAL PRACTICE

As previously discussed, bilateral agreements were originally negotiated to recruit low-skilled workers from abroad in sectors such as construction, agriculture, food manufacturing and hospitality. Although many countries use generic schemes such as the work permit or points based system to manage the migration of health workers, a number of labour agreements are negotiated between governments in the health sector (see Appendix 2).

Some of these agreements are negotiated in countries where bilateral labour agreements are common practice in the recruitment of overseas workers (for example, Germany and Switzerland). Other agreements are negotiated by governments that predominantly use generic schemes in the recruitment of foreign labour (for instance, the UK). Although information about labour agreements negotiated worldwide in the health sector is rather limited, some references appear in the policy documents and working papers of the International Labour Organization, the Organisation for Economic Co-operation and Development, and the International Organization for Migration (International Organization for Migration, 2004;

²³ For instance, the Filipino Government introduced a joint campaign with other sending countries to promote the negotiation of bilateral labour agreements (Go, 2004).

Wickramasekara, 2006; OECD, 2007). This section summarises these descriptions in brief profiles. The list of agreements, which is presented in Appendix 2, is not exhaustive but attempts to organise available data from international sources in order to map bilateral agreements negotiated worldwide in the international recruitment of health workers since the early 2000s. Identified bilateral agreements are divided into three groups: cross-border arrangements on the employment of health workers negotiated between EU countries; agreements between non-EU countries; and all other agreements where the UK takes part as a country of destination.

There are a number of bilateral and regional agreements set up within the EU to facilitate the employment of health workers. Many of them were described under the umbrella EU project Evaluation of Cross-Border Regions in the European Union (EUREGIO, 2004-2007)²⁴. In 2005, the French and German Ministries of Health signed an agreement on co-operation of health services in the border region. This agreement aimed at facilitating the use of ambulances and emergency staff on foreign territory, in order to improve emergency care in accidents. Further, it facilitated the co-operation of hospitals in the border regions through partnerships and the exchange of personnel and knowledge. The overall goal was to improve access of the population in the region to continuous care. Regional co-operation was also formally established in 2005 between Spain and France to manage health services in the cross-border region in Spain Puigcerdá. The objective of the project was to ensure the provision of medical care for the local population and the tourists coming into the region. For this purpose, a cross-border hospital was set up under a joint administration and management system in Puigcerdá, Spain. In addition to the basic provision of care, the hospital intended to provide special treatment (for example, dialysis) for the people of the region. Prior to this interregional co-operation, a bilateral recruitment agreement was reached with France to recruit nurses from Spain in 2002. The agreement led to the recruitment of 1,364 nurses and was closed in 2004 (Scheres, 2006).

²⁴ The Project 'Evaluation of Cross-Border Regions in the European Union' (EUREGIO) was carried out by a working group under the co-ordination of the Institute of Public Health North Rhine-Westphalia (Iögd), Bielefeld, Germany, with the financial support of the European Commission under the Public Health Programme.

The other type of recruitment agreements negotiated within Europe represents a case of collaboration between the 'old' EU members and the EU candidates or new EU members. These agreements were intended to speed up integration across Europe. For instance, an agreement between Poland and the Netherlands called the Covenant on Migrant Health Workers (CAZ) was signed in 2002. This project became a part of the integration program WHO Global Code me for Poland to the EU and ended in 2004 when it became an EU member state. The general framework for the CAZ agreement was established within existing Dutch regulations on foreign labour. The project addressed the nurse shortage in the Dutch health services, and aimed to improve the competencies of Polish nurses and promote recognition of their diplomas at the European level. It allowed employers to recruit foreign personnel for a maximum period of two years. The employment of foreign nurses as envisaged in the agreement was intentionally temporary. It was agreed that a maximum number of foreign personnel would be allowed according to the size of the employer's total personnel and demand. Employers were required to cover the recruitment and travel costs, and provide housing and professional supervision for foreign nurses. Nurses were required to sit a language exam (International Organization for Migration, 2005a). In total, 91 Polish nurses were employed by the project (19 returned before the end of the project), as nurse assistants in nursing homes. The nurses received pre-departure preparation and continuous educational opportunities during their stay.

The International Organization for Migration monitored and evaluated the programme (International Organization for Migration, 2005a). Their survey revealed that the majority of participating nurses went to the Netherlands to improve their financial situation. They expressed positive feedback about working conditions and relations at work in the Netherlands. The satisfaction of employers and nurses with the project process varied depending on the recruitment agency involved. One major problem faced was language difficulties, despite pre-departure language training, which created a further obstacle during occupational training. Most of the nurses thought that the continuous training provided had not added value to their professional skills. Employers in general were satisfied with the performance of the nurses. In general, evaluation of this project was positive and provided

recommendations on what should be improved at the operational level of its implementation (Wiskow, 2006).

Another bilateral labour agreement in health was negotiated between two EU countries in 2002. The Autonomous Region of Friuli-Venezia-Giulia in Italy initiated a programme to recruit nurses from Romania to address nurse shortages in Italy. At that time, Romania experienced growth in nurse unemployment due to restructuring of the hospital sector. It was suggested that the programme should simultaneously focus –on the needs of the destination country; protection of the workers’ rights; and prevention of a nursing shortage in the sending country. To improve and secure the recruitment process, an association was established under Romanian law with various stakeholders, including trade unions, to improve the quality of recruitment. In particular, the established association was involved in evaluation of candidates, preparation of successful candidates for expatriation and retraining of individuals. Five factors were distinguished in the OECD report as imperative for the success of the nurse recruitment programme: the facilitation of administrative procedures, such as expatriation and recognition of diplomas, in both countries; the facilitation of movement of several groups, including newly graduated nurses, unemployed nurses looking for work and employed nurses looking for work abroad; the on-site capacity to evaluate the professional abilities of candidates, in order to guarantee quality of care; the integration of foreign nurses into the broader socio-cultural environment; and the assurance of benefits for the sending country (Barbin, 2004).

Patchy information is available on labour agreements in the health sector negotiated in the early 2000s outside Europe. Identified cases include agreements between Kenya and Namibia and between China and Singapore. The government-led international recruitment of nurses in Namibia was explored in a number of research studies (Buchan and McCaffery, 2007). In response to the HIV/AIDS crisis, Namibia’s public health sector is carrying out a comprehensive strategy to hire and deploy professional and non-professional health workers with the aim of providing comprehensive care. In addition to the policies adopted at the national level, the government initiated a project on the recruitment of foreign health workers under which 100 nurses were recruited from Kenya in the early 2000s (Frelick and Mameja, 2006).

Bilateral relations between China and Singapore in the health sector began approximately 15 years ago when the Chinese Government sent a group of English-speaking nurses to work in Singapore and Saudi Arabia. The Chinese Government charged around 10–15 percent of each nurse's annual salary as the 'handling fee' for employment through the government arrangement. The contracts under this agreement usually lasted 2–3 years, and most nurses returned to work in their original hospitals afterwards. Temporary employment was required and clearly stated in the contracts (Fang, 2007).

4.2.2 BRITISH PRACTICE

It is crucial to this thesis to highlight that the negotiation of bilateral labour agreements is not a typical practice in the British labour immigration policy. British policy mainly involves on unilateral schemes allowing the temporary entrance of foreign workers to the UK labour market. Examples of such generic schemes previously practiced in the UK include the Seasonal Agricultural Workers Scheme (SAWS)²⁵, the Sector Based Scheme (SBS)²⁶, the Working Holidaymakers Scheme (WHM)²⁷, the Highly Skilled Workers Programme (HSWP)²⁸ and the Work Permit System (WPS) (Rollason, 2004).

In the late 1990s and early 2000s, the period on which this research is based, the overall trend of the UK labour immigration policy was influenced by an expanding economy and growing demand for skilled workers (Loizillon, 2004). Following the New Labour Government's intention to attract a talented and skilled labour force from abroad, a number of changes were introduced in the WPS from the year 2000 onwards. The major change was to lower the level of the minimum required qualifications for foreign applicants. As a result, international students studying in Britain were eligible to work upon their graduation. To facilitate

²⁵ The SAWS scheme was designed to employ foreign nationals for seasonal and agricultural work.

²⁶ The SBS was introduced in 2002 in recognition of the labour shortage in some sectors of the British economy. It is similar in many ways to the normal work permit scheme although it has several restrictions. It presently covers only the food manufacturing industry and applies only to the nationals of Romania and Bulgaria (aged from 18 to 30), who are allowed to work in the UK for up to 12 months.

²⁷ The WHM was introduced as a youth mobility scheme to enable young unmarried Commonwealth citizens aged 17-27 to stay in Britain for two years and to take up work incidental to their holiday.

²⁸ The HSWP was replaced with the Tier 1 in the new Points Based System.

employment of foreign skilled professionals primarily in sectors with a high labour shortage, the Home Office expanded the shortage occupation list to include specialists in the information technology sector and health workers. This revision exempted job applicants in the health sector, such as nurses, from labour market testing. Several schemes were also used to attract and retain international health workers in the UK. For example, health workers could obtain Indefinite Leave to Remain after 5 years of legal residence under the Work Permit Scheme or the Highly Skilled Migrant Programme (Organisation for Economic Co-operation and Development, 2007).

Apart from work permits, there was another mechanism employed to attract foreign employees in the health sector, namely the negotiation of agreements with a number of source countries. Previously, the British labour migration policy did not actively use these policy tools. According to the OECD, the UK has not concluded any significant bilateral agreements on labour migration in the past 40 years (Organisation for Economic Co-operation and Development, 2004b). Prior to the early 2000s, the only significant bilateral agreements signed by the UK in the field of migration are the Treaties in Illegal Migration with Bulgaria and Romania (Rollason, 2004). The post-colonial links between Britain and Commonwealth countries explain why migration schemes in the UK are not managed through bilateral agreements (Loizillon, 2004; Buchan and Dovlo, 2004). These scholars argue that post-colonial links have provided sufficient and regular inflows of labour migrants to Britain. Therefore, individual negotiations with countries were not required. However, a number of bilateral agreements were signed by the UK in the early 2000s to manage the cross-border mobility of health workers (see Appendix 3). Apart from the agreements with South Africa, Spain, India and the Philippines which are the focus of this thesis, the British Government negotiated agreements with China, Indonesia, Egypt and number of European countries.

The agreement with China²⁹ was signed in 2005 by the Ministry of Commerce of the People's Republic of China and Department of Health of the United Kingdom. The aim of this agreement is to regulate the recruitment of nurses from China to the

²⁹ The official title is the *Letter of Intent on Cooperation in Recruiting Health Professionals between the Ministry of Commerce of the People's Republic of China and the Department of Health of the United Kingdom of Great Britain and Northern Ireland*.

UK. It enables Chinese recruitment agencies to comply with the principles of the Code of Practice (Department of Health, 2004a) and to clarify the costs to be met by the agency and the employer in the recruitment and placement of foreign health workers. The document also lists private recruitment agencies in China that comply with the UK ethical recruitment guidelines.

A pilot agreement on the recruitment of nurses from Indonesia to the UK was concluded in 2002 and was valid until 2004. The objective of this agreement was to enhance the collaboration between the two countries in health-related issues (United Nations Department of Economic and Social Affairs, 2005). However, this pilot arrangement, as well as the agreement with China, was not developed further. The British government officials and recruitment coordinators recognised that nurses from Indonesia and China had significant problems with English language (Expert 3, Senior Official, Workforce Capacity, Department of Health, interview date 29.04.2009).

In 2001, The Anglo-Egyptian Medical Attachment was signed to offer two month fellowships in the UK to appropriately selected Egyptian doctors. The West Midlands Deanery and the London Deanery were asked to host the Egyptian doctors. The selection process (which involves an IELTS test and an interview) was completed in January 2002. The main purpose of the fellowship was to give the Egyptian doctors an opportunity to observe the clinical, management and educational structure of a large hospital in the NHS.

There were also a number of informal agreements between the UK and EU countries such as France, Italy, Germany and Poland, primarily to facilitate the inflow of medical professionals (Young et al., 2008).

CONCLUSION

This chapter has explored the organisational knowledge accumulated at the international and national levels, about practices in the negotiation of bilateral labour agreements. It has covered the histories of such practices, their present status and the current policy debate about their future prospects. The latter has become a topical issue with the globalisation of the labour market, the increasing influence of IT-based

recruitment, and the growth of private agencies facilitating labour mobility across borders.

Since the 1950s, the focus of bilateral labour agreements has gradually shifted from labour recruitment to multiple objectives which reflect political preferences and economic demands in the co-signing countries. This thesis further illustrates how the functions of bilateral agreements have proliferated, by using the case study of British practice in the negotiation of government-to-government agreements in the early 2000s. The negotiation of bilateral labour agreements on the cross-border mobility of nurses was a distinctive experience for the British Government, as it had not previously used similar arrangements. The novelty of this practice in the UK leads to a number of questions about the origin of these agreements, their types and their outcomes. These questions, which form the core of this thesis, are addressed in the Chapters 5, 6 and 7, which present, analyse and discuss the original data collected in this research.

5. UK AGREEMENTS: DESCRIBING CONTENTS AND TYPES

INTRODUCTION

This chapter provides descriptive accounts of the agreements between the UK and the governments of South Africa, Spain, India and the Philippines. It is divided into four sections. The first two sections describe the agreements with South Africa and Spain respectively, and the third section describes the agreements with India and the Philippines jointly. These descriptions follow a similar structure. They begin with a profile of the agreement containing information about the date of negotiation; the co-signing parties; and the objectives of the agreement as stated in official texts. The position of the co-signing source country in the global nurse labour market in the early 2000s is then illustrated. The status of the source country is outlined by observing conditions in the national nurse labour market; the government's position on the 'brain drain' problem; previous patterns of nurse mobility in the source country; and existing ties between the UK and other destination countries. Each country profile concludes with a description of the content of each agreement and organisational arrangements in its implementation.

The final section of this chapter summarises these individual descriptions of agreements and systematises them into three types: types of source countries, types of agreements, and types of responsibilities fulfilled by the English Department of Health. Identification of these types became a useful tool in organising the descriptive accounts of agreements. It contributed to a deeper understanding of recruitment patterns in the global nurse labour market and the diverse strategies applied by the English Department of Health, depending on the conditions and preferences of the source countries.

The empirical data employed in this chapter is derived from the interviews with officials in the English Department of Health who were involved in the international recruitment of nurses in the early 2000s; international recruitment officers in relevant source countries; representatives of the RCN and UNISON; and scholars involved in

research on the international recruitment of health workers. Policy documents, academic articles and media reports were also an important source of information.

5.1 SOUTH AFRICA

5.1.1 THE AGREEMENT AT A GLANCE

The government-to-government agreement between South Africa and the UK was signed in 2003. The official title of this document is *Memorandum of Understanding between the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the Republic of South Africa on the reciprocal Educational Exchange of Healthcare Concepts and Personnel*. It was signed by the Secretary of State for Health (England), Mr Alan Milburn, and Minister of Health in South Africa, Dr Tshabalala Msimang.

This agreement became a framework document that formalised dialogue between the two countries on the cross-border mobility of health workers. The official text of this agreement stated three main aims. The first was to enhance information exchange and expertise sharing on an array of issues in public health and health care policies. The second was to promote collaboration between institutions. The third was to create opportunities for the exchange of health personnel between the two countries, in the form of time-limited placements.

As will be illustrated further below, the agreement was negotiated neither as a recruitment scheme nor as a ban to stop individual applications from South Africa. Rather, it was intended to acknowledge a commitment to the ethical recruitment policy through the provision of educational and training opportunities for health workers in South Africa and for British nationals. As mentioned above, the agreement was signed in 2003. After five years of implementation, it was prolonged for a further five years and is scheduled for revision in 2013.

5.1.2 COUNTRY PROFILE IN THE GLOBAL NURSE LABOUR MARKET

In the late 1990s, South Africa became the key source of the nursing workforce for British employers. In 2001, almost 3,000 South African nurses practiced in Britain (Organisation for Economic Co-operation and Development, 2004b). Among other key receiving countries at that time, such as Australia, Canada and the US, the UK became the major destination for South African nurses (see Table 3).

Table 3 South African health-workers in OECD countries, 2001

Country	Practitioners*	Nurses and midwives	Other health professionals**	Total
Australia	1,114	1,085	1,297	3,496
Canada	1,345	330	685	2,360
New Zealand	555	423	618	1,596
United Kingdom	3,625	2,923***	2,451	8,999
United States	2,282	2,083	2,591	6,959
Total	8,921	6,844	7,642	23,407

Notes: *Doctors, dentists, veterinarians, pharmacists and other diagnostic practitioners; **Including assistants; ***Possibly including some assistant nurses.

Sources: *Eurostat employment survey* for the European countries, *Current Population Survey* for the United States, *Survey of Longitudinal Income Dynamics* for Canada and *Census* data for Australia and New Zealand. Provisional data for the United Kingdom and the United States (cited in OECD 2004b: 125).

Although the immigration of South African health workers to the UK was not a new phenomenon, in the late 1990s the number of South African nurses in Britain increased dramatically. As reported by the Nursing Midwifery Council (NMC), the number of South African nurses admitted to the professional register tripled in the period from 1998 to 2000 and exceeded the inflow of nurses from India and Philippines, both known as global suppliers of nurses (see Table 4). The rise in the number of South African nurses working in the UK during the mid-1990s reflects the overall change in the pace of professional emigration at that time.

Professional emigration from South Africa increased after 1994, following dramatic political transformation in the former British colony. The official figures estimated that the total number of professionals who left country between 1994 and 1997 reached 7,534 compared to only 3,721 over the four-year period prior to 1994

(Meyer et al., 2000). In the late 1990s, the global exporters of health workers, India and the Philippines, had a low representation in the nurse labour market in Britain. India was mainly specialising in the supply of medical doctors, while Filipino nurses predominantly chose to emigrate to the US rather than Britain (see Section 5.3).

Table 4 Overseas admissions to the NMC register by country

Country	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05
India	30	96	289	994	1,830	3,073	3,690
Philippines	52	1,052	3,396	7,235	5,593	4,338	2,521
South Africa	599	1,460	1,086	2,114	1,368	1,689	933

Source: Nursing and Midwifery Council, 2005

As can be seen in the above table this trend changed in 2000-01. At that time, officials in South Africa condemned the active recruitment strategies adopted by developed countries, especially the UK (see discussion later in this section). In this debate, South Africa was often portrayed as a developing country suffering from the active recruitment campaigns practiced by rich states to meet their national labour market needs (Swindells, 2006).

However, when referring to the accusatory rhetoric of the South African Government, one needs to acknowledge the dual position of this country as not only a source of, but also a destination for, many migrants (Meyer et al., 2000). During the early 2000s South Africa received health workers from neighbouring African states and the wider African region, although this received less publicity. Far from an exhaustive list, examples include recruitment of health workers from Ghana, Zambia and Zimbabwe, and doctors from Cuba (Padarath, 2003 et al.; Kingma, 2006). This reliance on overseas health workers, especially in rural areas, became a characteristic of the South African health care system. It is estimated that 22% of the total medical workforce and around 78% of rural physicians in South Africa in 1999 were foreign migrants (Martineau et al., 2002).

Despite many foreign health workers employed in South Africa, this country experienced a significant shortage of health personnel in the early 2000s. By 2001, almost a third of nursing positions in South Africa were vacant (Hall and Erasmus, 2003). Both internal (national) and external (international) factors contributed to this national shortage. The internal factors were quite typical for developing countries and included underinvestment in nursing education and training; poor remuneration; stressful working conditions; low job satisfaction and decreasing motivation of nursing personnel; and risk of HIV/AIDS infection (Organisation for Economic Co-operation and Development, 2004b). There was another internal factor specific to South Africa, which contributed to the growing demand in health workers in the late 1990s. Post-apartheid reformation after 1994, followed by the introduction of the national health system, required more health workers in practice, especially in rural areas (Hall and Erasmus, 2003). These plans in health service expansion were met with problems on the supply-side as the number of graduates was not sufficient at that time to satisfy the growing demand for health workers (Hall and Erasmus, 2003).

Among external factors which contributed to the health workforce shortage in South Africa in the late 1990s was the growing rate of professional emigration from the country after 1994 (Meyer et al., 2000). The outflow of health workers escalated with the health labour shortage in developed countries. Britain, for instance, eased immigration rules for foreign nurses, such as by including general nursing in the shortage occupation list, which allowed British employers to bypass the national labour market test when recruiting from abroad (Buchan et al., 2008). The out-migration of South Africans to Britain was also reinforced by long-term factors such as historic ties between the two countries; links between training institutions; similar professional standards; fluency of nurses in the English language; and family ties (Organisation for Economic Co-operation and Development, 2004b).

In response to this outflow of health workers in the late 1990s and early 2000s, South Africa took an active part in the international debate about unfair recruitment strategies implemented by developed countries like Britain. The government of

South Africa made a number of appeals to British officials and the international community, criticising the active recruitment campaigns adopted by developed countries (Bhorat et al., 2002; Organisation for Economic Co-operation and Development, 2004b). Some of these appeals were presented by a number of South African media reporters through the local press:

Ronnie Mamoepa, spokesperson for Dlamini-Zuma, explained that the minister was calling on countries such as Canada, Australia, New Zealand, and Britain to cease recruiting South African doctors because “we have a shortage of medical people, which makes it more difficult to redress the imbalances of the past” (Krost, 2000).

Provincial health secretary Ronald Green-Thompson [in South Africa] described Britain's recruitment policy as "immoral and unethical", saying that the resultant ‘brain drain’ was leaving many posts vacant in major hospitals. Complaints like these are a major blow to Health Secretary Alan Milburn, who is relying on foreign staff to turn around the National Health Service (Khan and Nikson, 2002).

Two strategies were employed by the South African Government to raise awareness about the problem of ‘brain drain’ in the health sector, namely individual appeals to destination countries and public speeches at international meetings. One of the first and most widely cited statements was made by Nelson Mandela during his 1997 visit to Britain. Mandela criticised the NHS for actively recruiting health workers from South Africa (Kingma, 2006). He claimed that this recruitment undermined the reformation of the post-apartheid health system and weakened measures taken to slow down the HIV/AIDS pandemic (Kingma, 2006). These public claims were hard to ignore, particularly as South Africa had become the centre of international attention as a unique political and historic case of the anti-apartheid movement and a new emerging democracy. Mandela’s appeal was supported by other government officials in South Africa, who expressed their criticisms during official visits to key recruiting countries as well as at the meetings held by the World Health Organisation and Commonwealth Secretariat. These meetings provided a forum for discussion of the ‘brain drain’ problem in the health sector, but also

offered an opportunity for informal consultations between officials from the UK and South Africa. One interviewee reflected on such meetings:

It was about 1997. He [Secretary of State for Health in Britain] was getting lobbied by Health Ministers from the Commonwealth. Many developing countries were criticising the UK stealing their nurses (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

These criticisms were supported by the trade unions and professional organisations in South Africa. Nelouise Geyer, the Deputy Director of the Democratic Nursing Organisation of South Africa, is reported to have said at the time:

There is no sense of making a difference to the health of people anymore. The shortage is felt in all the nursing skills as hospitals report that they cannot find nurses with experience running a medical or surgical ward. The recruitment (to the UK) makes staff shortages worse, particularly in the areas of specialised nursing such as intensive care, operating theatre, psychiatric nursing and paediatric nursing (Nelouise Geyer, Deputy Director of the Democratic Nursing Organisation of South Africa, cited in Swindells, 2006).

The dialogue between South Africa and Britain about the recruitment of health workers started during one of the meetings of the Ministers of Health organised by the Commonwealth Secretariat in 1998. The official in the Commonwealth Secretariat recollected that:

In 1998 there was a Commonwealth health ministers meeting in Barbados. And it was that particular meeting when the Caribbean health minister and South African health minister had a word with our Foreign Office secretary and raised the issues. And so, for that reason, there was a closer dialogue between those two regions (Expert 5, Adviser, Social Transformation Programmes Division - Health Section, Commonwealth Secretariat, interview date 25.04.2009).

The result of this meeting was a ban on the recruitment of health workers as requested by South African officials. However, this restrictive measure was not welcomed by individual health workers, professional organisations and trade unions in South Africa (Kingma, 2006). To neutralise the criticisms of such individuals and professional bodies, the Government of South Africa requested that the Government of the UK formalise co-operation in areas related to health policy, particularly the exchange of health personnel. The British Government positively responded to this request, as one of my interviewees described:

This agreement really came after a while, when the South African Government realised that restriction on the agreement was not popular with South African workers... this [MOU] came about from a South African request (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

Negotiation of the agreement with the UK was a part of the strategy taken by the South African Government to address the problem of 'brain drain' with other destination countries such as Canada, Australia and New Zealand (South African Department of Health, 2001). As reported by a Cape Times journalist:

Health Minister Manto Tshabalala-Msimang, who attended the assembly [World Health Assembly Meeting in 2003] had discussions with her UK counterpart about an agreement. The time has come to structure continued co-operation with a formal bilateral exchange. After her return, Tshabalala-Msimang instructed her ministry to accelerate government-to-government agreements, particularly with the UK. Discussions are also to begin on agreements with Canada, Australia and New Zealand (Terreblanche, 2003).

Conclusion of the formal agreement with Britain became the first illustration of successful bilateral co-operation and encouraged further attempts to follow the approach by other developed countries with similar projects. These ambitious aspirations of the South African Government were presented in the local press:

The Health Ministry is to give urgent attention to drawing up an agreement with Britain to curb its poaching of South Africa's health professionals. Health Director-General Ayanda Ntsaluba told parliament's health committee that the United Kingdom would be the

first of four Commonwealth countries targeted for such agreements (Terreblanche, 2003).

However, the MOU with UK is the only agreement of this kind that the South African Government has managed to achieve so far (Department of International Relations and Cooperation, n.d).

5.1.3 CONTENT AND ORGANISATIONAL ARRANGEMENTS

The MOU with South Africa focused on three main areas: exchange of information and expertise in the areas of health policy; time-limited placements for health workers in UK and South Africa; and collaboration between institutions and the establishment of training programmes between the two countries.

In relation to the first of these objectives, a number of streams were discussed by the UK and South African Governments, including public health and primary care; workforce planning and development; public-private partnerships; revitalisation of hospitals; twinning of hospitals; training in health care management; and professional regulation. As a part of the knowledge sharing practice, the UK Health Protection Agency and its counterpart organisation in South Africa organised a meeting in 2005. The agenda for this meeting included such issues as research on the resistance to HIV and TB therapies; developing emergency preparedness; and preparations for the World Cup in 2010 (Department of Health, 2003b).

A number of limited placements were organised for health personnel in both South Africa and the UK. A pilot cohort of 20 South African nurses was sent to the King's NHS Trust in 2003 (Department of Health, 2006). A few dozens of British health workers went to practice in South Africa, as revealed by an interviewee:

Between October 2003 and August 2004, approximately 70 British health professionals went to South Africa on short-term placements, followed by a further 259 from August 2004 to April 2005 (Expert 2, International officer, DH, interview date 29.04.2009).

Finally, there were several links established between the medical institutions in South Africa, and the National Institute for Excellence and the Health Protection

Agency in the UK. In addition, a twinning scheme was set up between the Oxford Radcliffe NHS Trust and South Africa's Kimberley Hospital. It allowed 30 South African nurses to be placed in Oxford for theoretical and practical training, while senior nurses from the UK worked in Kimberley hospital as mentors (World Health Organization, 2005).

The Department of Health (England), as a key negotiator of this agreement on the British side, was involved in setting up the framework of agreement and organisation of regular meetings to monitor its implementation. In particular, the Global Affairs Division became a lead department in this agreement. However, a number of other government departments were also involved in this agreement, including the Foreign and Commonwealth Office, the Department for International Development, and the Home Office. The Department of Health (England) assigned a contact person responsible for the information dissemination and monitoring of this agreement. All NHS Trusts were informed about available opportunities for collaboration with South Africa. The administrative costs in overseeing the MOU in the UK were covered by the Department of Health. A number of fact-finding visits were funded jointly by South Africa and the English Department of Health. As with the personnel exchange programmes, the participating NHS organisations covered most of the expenses related to professional personnel. Overall, as estimated by one of the DH officials, little financial support accompanied this agreement:

It was not that the MOU had a lot of money attached to it. It was based on good will and a desire of the two countries to communicate together (Expert 2, International officer, DH, interview date 29.04.2009).

The monitoring procedure of MOU included regular meetings between government officials from both countries. These meetings were held 2-3 times a year.

5.2 SPAIN

5.2.1 THE AGREEMENT AT A GLANCE

The government-to-government agreement between Spain and the United Kingdom in the international recruitment of health workers was reached in 2000. It was signed by the Health Secretary, Alan Milburn, and the Spanish Health Minister, Celia Villalobos. The agreement was approved by lawyers at the Foreign and Commonwealth Office and their counterparts at the Ministry of Health and Consumer Affairs (Ministerio de Sanidad y Consumo).

The programme started with recruitment of Spanish nurses in the NHS on a two-year employment contract. This project was later extended to include recruitment of other categories of health personnel such as cardiologists, GPs and radiologists. The original recruitment target was to bring 5,000 Spanish nurses to the NHS in the period 2001-2004. However, from 2001 to 2007, the programme managed to recruit only 1,300 nurses. These nurses were allocated to NHS trusts predominantly in the areas of North West England, South East England and London. The recruitment project was terminated in 2007 as the British demand in foreign-trained nurses declined gradually³⁰.

5.2.2 COUNTRY PROFILE IN THE GLOBAL NURSE LABOUR MARKET

Spain has a well-established reputation as a destination country which attracts labour migrants primarily from North Africa (Morocco and Tunisia) and Latin America (Ecuador, Peru and Colombia) (Salt et al., 2004). In particular, it is a well-known recipient country of doctors from Latin America (Wismar et al., 2011). However, in

³⁰ In 2007, the national supply of nurses finally reached a point where recruitment of nurses from outside Britain was no longer needed. The government decision in the late 1990s to increase investment in the training of more nurses resulted in so-called 'self-sufficiency': the national education system finally provided enough graduates to meet the national demand. The national demand had by that time fallen following the reduction in commissioning in 2005-06 (Buchan and Secomber, 2008). Moreover, by 2006, UK-trained nurses faced problems finding a job as there were not enough vacancies for new graduates. This situation was accompanied by public controversy about the foreign nurses who were already working for the NHS but facing job losses and return to their home countries as their contracts were not renewed by British employers.

the early 2000s, after signing the nurse recruitment agreement with the UK, Spain became a source country itself.

The labour market in Spain in the late 1990s was characterised by an oversupply of nurses (Blitz, 2005). Domestic commentators explained the nurse surplus from different perspectives. The positive picture, which was presented by the Spanish General Council of Nursing (SGCN)³¹, described nursing as a popular professional choice among Spanish young people for two reasons. First, since 1977, nursing had become a university-taught programme which attracted more students. Second, nurses in Spanish health care institutions were actively involved in the regulatory bodies and decision-making process. They had similar labour rights to civil servants and a high level of public recognition. In the opinion of the SGCN, these factors resulted in the increased intake of students in the nurse training programmes and the subsequent excess of graduates by the late 1990s (European Public Health Alliance, 2005).

A more critical explanation of the nurse surplus in the late 1990s was given by the Spanish Nursing Trade Union (SATSE). It asserted that the education and training systems produced as many nurses as was required, and that the gap between supply and demand had a structural cause (European Public Health Alliance, 2005). To set the background, in the early 2000s many new graduates in nursing were not able to find jobs in Spain. In fact, in the year 2000, Spain was the only country among the OECD members (excluding Slovak Republic) that reported nurse unemployment at a rate exceeding 5%, while other developed countries observed either marginal levels of unemployment or even a shortage of nurses (Simoens et al., 2005). The reason that many Spanish nurses were out of jobs in the early 2000s was found in the lack of employment stability for health workers (López-Valcárcel et al., 2001). First, industrial relations in the health care system were based on temporary employment contracts. Employers did not normally offer permanent contracts so as to avoid social security payments (Blitz, 2005). Moreover, nurse professional mobility was hampered by the points based system which gave priority to

³¹Spanish General Council of Nursing is a professional organisation representing over 200,000 nurses registered in Spain. The objectives of this institution are to regulate the practice of nursing profession, represent and protect the interests of nurses (La Organización Colegial de Enfermería de España, 2011).

experienced senior staff (López-Valcárcel et al., 2001). Second, conflicting employment regulations in the public health sector, which is decentralised in Spain to regional competences, also contributed to unstable employment conditions for nurses (European Public Health Alliance, 2005). To sum up the SATSE analysis, both structural barriers to career promotion and unstable employment conditions in the health sector, resulted in the high number of early career nurses facing difficulties in finding secure jobs in Spain.

5.2.3 CONTENT AND ORGANISATIONAL ARRANGEMENTS

As mentioned above, there was previously no significant health worker migration from Spain to Britain. Therefore, the Spanish infrastructure for sending nurses abroad was not well-developed and required centralised organisation and financial assistance. The official in the Department of Health, who was involved in recruitment of Spanish nurses, recollected that:

Now with Spain it was a complete 'cold' start. There was not a flow of people coming to the UK and therefore, we needed to learn much about each other...we had not quite a history of a relationship, which we had with India where the health and education system was designed very similar to the UK. In a way we were kick-starting it from the national level. We had money nationally to invest in organising all of that with Spain (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

In the beginning, the Department of Health in England played an active role in setting up this recruitment scheme. The Workforce Directorate was responsible for the implementation of the agreement. It prepared detailed recommendations on how the recruitment process should be implemented, which included advice on the dissemination of information and guidance for the allocation of recruited health personnel (Department of Health, 2000b). Jobs were advertised in the newspapers, professional journals and nursing schools in Spain. A group of local co-ordinators was set up in Spain to promote and facilitate recruitment on the 'ground'. One of the Spanish-based recruiters described her responsibilities as follows:

My objectives were to market opportunities for the Spanish health and social care professionals to work in England and to attract suitable candidates to fill vacancies in the NHS Trusts. For this purpose, I travelled around Spain visiting university schools of nursing and participating in the international job fairs, seminars and congresses organised in Spain...[also] I had to market our programme through the NHS Hospital Trusts (Expert 6, Local recruitment co-ordinator based in Spain, email communication, 08.02.2009).

NHS Trusts launched regular trips to Madrid and Barcelona, the main recruitment hubs at that time. Groups of three or four Trusts would normally co-ordinate their trips together to reduce the costs of recruitment. Panels for job interviews with Spanish nurses were held at least three times per year. In these recruitment campaigns, a significant amount of organisational burden and financial costs, such as marketing and communication with potential candidates, was covered by the Workforce Confederation in the English Department of Health. Individual Trusts were responsible for their own travel costs and accommodation in Spain:

Actually a lot of costs were covered by the Workforce Confederation. We did not need to spend any money on marketing, the actual process of responding to applicants, telephone calls and anything like that. Our expenses were on travelling out there, accommodation and obviously the working time of nurses who travelled out there (Expert 7, Senior Nurse, NHS Trust, interview date 18.05.2009).

The recruitment process of Spanish nurses was in many ways similar to the national recruitment procedure. Nurses were coming from the EU and they did not require work permits and checks of their immigration status. One of the interviewees, a senior nurse who was involved in recruitment of Spanish nurses for the NHS Trust in London, explained that:

...it was the normal recruitment process because [they were] European nurses. It was quite straightforward. It was like any other nurse and we didn't pay NMC registration (Expert 7, Senior nurse, NHS Trust, interview date 18.05.2009).

The process of selecting candidates comprised of two stages. In the first stage, the panel interview was held with British nursing professionals who represented the NHS Trusts. This was normally followed by the English language test facilitated by the British Council. On arrival in Britain, successful candidates were welcomed by recruitment co-ordinators in the NHS Trusts, who provided pastoral support, especially during the induction programme, and assisted with everyday affairs such as banking and accommodation.

In Spain, the British Embassy was involved in the implementation of this agreement. It dealt with enquiries and administrative issues such as processing paper work and registering nurses with the Nursing and Midwifery Council. It was also the responsibility of the British Embassy to keep in touch with Spanish nurses in Britain and to monitor their satisfaction with employment and living conditions. Assistance in the selection of potential candidates was provided by the Spanish public employment service (International Council of Nurses, 2001b).

Guidance on the allocation of nursing personnel was issued by the DH. It assigned new recruits to areas where nurse vacancies had been unfilled for at least six months and the recruitment of British nurses had not been successful. The five NHS Trusts in the North West, London and the South East satisfied these conditions. A survey of Spanish nurses who had come to the UK through the agreement to work in the NHS, demonstrated that the majority of recruits were single, young women with professional nursing grade D, an intermediate level of English, and little work experience in Spain (Ruzafa-Martínez et al., 2008).

As mentioned above, the Department of Health was actively involved in the first stage of the Spanish recruitment campaign. The array of responsibilities it held included the negotiation of the agreement, and the co-ordination and administration of the recruitment process. As identified by one of the DH officials, when the recruitment scheme was set up, the Department of Health withdrew from its recruitment duties and performed a largely supervisory role:

But actually after that we left employers to get on with that and take responsibility for recruiting either on their own or with the agency (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

The employment contract offered to Spanish nurses under the Anglo-Spanish recruitment project included:

- a two-year contract³²;
- 37.5 working hours per week, 8 days of public holidays and 27 days of annual holidays;
- salaries equivalent to 26,000 Euros a year;
- initial support with opening bank accounts and the provision of housing for the first six months of the stay;
- induction and language support on arrival (including 3-4 weeks of English classes);
- pastoral support;
- refund of the return flights.

5.3 INDIA AND THE PHILIPPINES

This sub-section discusses the two agreements that the British Government negotiated in the early 2000s on nurse recruitment with the Philippines and India. The similar positions of both countries in the global labour market, as recognised traditional exporters of health workers, explain my decision to describe these agreements together.

5.3.1 *THE AGREEMENTS AT A GLANCE*

In addition to the recruitment project with Spain in 2001 and a number of informal initiatives with other European countries such as Germany, France, Poland and Italy³³, the Department of Health negotiated two recruitment agreements in the early 2000s with countries outside of Europe, namely India and the Philippines.

³² This was a significant difference for Spanish nurses, who would normally have only short-term contracts from 3 to 6 months in Spain.

³³ The Department of Health agreed on the recruitment of mainly medics from these countries: GPs from France, consultants from Germany and Italy, and dentists from Poland (Expert 4, Former Senior Official involved in the international recruitment of healthcare professionals, interview date 17.02.2009).

The Department of Health concluded the agreement with the Indian Ministry of Health and Family Welfare in 2001. It was recognised as the first arrangement in nurse recruitment between Britain and a non-European country (Ahmed, 2001). This agreement was concluded in an informal manner, meaning there was no written document formalising the outcome of negotiations.

In 2002, the British Government negotiated an agreement on hiring Filipino nurses³⁴ (Embassy of the Philippines, 2002). It was signed by the Philippine Ambassador to the UK, Cesar Bautista, and Mr. David Amos, Deputy Director of International Recruitment of the Department of Health (England). This agreement was followed by a Memorandum of Understanding signed in 2003 by Cesar Bautista, Philippine Ambassador to the UK, and Sarah Mullally, the UK Chief Nursing Officer. The agreement reaffirmed the continuation of nurse recruitment from the Philippines to the UK and ensured compliance with the ethical principles which were stated in the Code of Practice for the international recruitment of healthcare professionals (Department of Health, 2004a).

As there was no systematic monitoring undertaken over this period, it is hard to ascertain the precise number of nurses recruited through agreements with India and the Philippines. Estimations provided by the policy-makers and researchers involved in the evaluation of the British international recruitment policy indicate that the agreement with the Philippines has brought more nurses to Britain than other similar recruitment schemes, such as those with India and Spain. It was estimated that the overall number of foreign-trained nurses registered with the NMC in 2001-2006 was around 68,000. Among these, 12,000 nurses came from India and 22,000 from the Philippines (Young et al., 2008).

5.3.2 COUNTRY PROFILES IN THE GLOBAL NURSE LABOUR MARKET

India and the Philippines are well-known as health workforce exporting countries (Aiken et al., 2004; Khadria, 2004; Healey, 2006; Imson, 2006). The Philippines is, perhaps, one of the few countries in which the export of labour is institutionalised at

³⁴ The official name of this agreement is the 'Recruitment Agreement between the Government of the Republic of the Philippines and the Government of the United Kingdom of Great Britain and Northern Ireland'.

the government level. Special government departments, the Philippines Overseas Employment Administration (POEA) and the Overseas Workers Welfare Administration (OWWA), are responsible for a number of issues related to Filipino workers employed abroad. In particular, the POEA is responsible for the negotiation of overseas employment contracts, licensing of recruitment agencies and facilitation of government-to-government recruitment arrangements with destination countries. The OWWA, on the other hand, focuses its work on social services and provision of social benefits to Filipino nationals employed abroad (Imson, 2006). In India, a labour force exporting policy is also widely adopted, though in the less formalised manner.

In both countries, the export of doctors and nurses has become an explicit government policy for economic reasons, which are reinforced by historic links with recipient English-speaking countries. In economic terms, international remittances³⁵ are one of the principal gains made by India and the Philippines from sending workers abroad. As estimated by the World Bank, these two countries remain the top recipients of international remittances in nominal terms among other developing countries³⁶. In 2008, the magnitude of remittances received by India and the Philippines reached 50 and 19 billion US dollars respectively (World Bank, 2008). India, in fact, is the largest recipient of international remittances in the world, with remittances comprising on average up to 3% of its GDP (Chishti, 2007).

The reliance of the Indian and Filipino Governments on labour exporting strategies has been reinforced by historic links and well-established migratory channels with the key destination countries such as the US and the UK. The colonial dependency of these two countries in the past (India being a former British colony and the Philippines being a dependent territory of the US) has resulted in close economic, political and cultural relations between them in the present. Such links are reflected in the recognition of English as the official language in both India and the

³⁵ Remittances are sums of money sent by migrant workers back to their families in home countries. International remittances, following the foreign direct investments, are the second largest capital inflow for many developing countries (Sander, 2003). These monetary transfers are considered to be a stable capital flow even during economic downturn. In 2008, officially recorded remittances to developing countries reached \$336 billion (World Bank, 2008).

³⁶ The World Bank provides data on recorded remittances annually in its Migration and Remittances Factbook, using a number of sources such as estimations based on migrant stocks, destination country incomes and source country incomes (World Bank, 2008).

Philippines, similarities in the education systems and long-established migration channels. For instance, the out-migration of Filipino nurses, predominantly to the US, started early in the 20th century when the first nursing education programmes were established in the Philippines in accordance with the US curriculum (Kingma, 2006). The outflow of Indian health workers, predominantly doctors, can be traced back to the 1960s and 1970s (Khadria, 2004).

Such factors as, the history of migration; proficiency in the English language; nurse education programmes consistent with professional standards in destination countries such as the UK and the US; and finally, the support of social networks of previous migrants abroad, became important factors which put Filipino and Indian nurses far ahead of many other nurses competing for international jobs (Ahmed, 2001).

Another factor which keeps the out-migration of nurses from both India and the Philippines at a high rate is the sharing of successful migration stories through social networks. These stories have changed the perception of nursing from a cleaning job to a profession which provides opportunity for immigration to developed countries; the latter are associated with a better life style, higher salaries and more attractive education opportunities for the children of migrants (Albuero and Abella, 2002; Kingma, 2006; Smith et al., 2006). The younger generations in India and the Philippines, as well as in many other developing countries, perceive qualifications in nursing as a starting point in the migration journey to developed countries. Often families save money or take loans to be able to send their children to nursing schools with the hope that in the next few years, a nursing student would find a job overseas which would allow them to not only pay the loan back but also support the family (Kingma, 2001, 2006; Adhikari, 2010). Such perceptions have increased the number of candidates applying for places in nursing training programmes. Growing demand has led to the expansion of educational facilities and recruitment agencies working across borders. For instance, in the Philippines, the number of nursing schools increased almost three times over the six years from 1990 to 1996, and reached 470 in 2005 (Galvez Tan, 2005). However, as recognised by some scholars in this area, the growth of educational facilities is often a ‘mushroom’ effect rather than a steady trend. Most of these schools appeared in the private sector, driven by a commercial

interest in training higher numbers of students in the short term. They often do not meet national standards and ignore the ethical principles in international recruitment (Kingma, 2006).

As a final point in this snapshot of the two countries' positions in the global nurse labour market, one must recognise that despite having national policies which favour the export of health workers abroad, both countries experience a shortage of health personnel (Oberoi and Udgiri, 2003). Professional organisations and trade unions in India and the Philippines have highlighted this problem numerous times (see Chapter 6).

5.3.3 CONTENTS AND ORGANISATIONAL ARRANGEMENTS

The two agreements described in this section are similar in certain aspects to the Anglo-Spanish nurse recruitment project. All three agreements were advertised by the Department of Health on its web-site as recruitment initiatives with source countries that experienced an exodus of the nursing workforce. All of these agreements shared the objective of bringing foreign-trained nurses to the British labour market. However, it would be simplistic to present all three agreements merely as recruitment schemes, and to disregard differences between them in terms of the political discourse and organisational arrangements employed. This section reveals the particularities of the agreements with India and the Philippines through a description of their content and implementation, and by comparing them with the Spanish recruitment project.

The first peculiarity of the agreements with India and the Philippines was that their content was broader and contained general statements about the ethical framework for the recruitment of health personnel rather than detailed organisational arrangements as in the case of the Anglo-Spanish project. For instance, contrary to the agreement with Spain, no specific recruitment targets were set in either the agreement with India or the agreement with the Philippines. An international recruitment co-ordinator based in India indicated that:

There never was a cap, there was no maximum number put on, nobody would say that this year we need to recruit this number and if

we've done this we need to wait until the next year... (Expert 8, International recruitment co-ordinator in India, interview date 25.05.2009).

The content of the agreements with India and the Philippines focused on the compliance of recruitment practice with the ethical recruitment policy adopted by the British Government. For instance, it was clearly stated in the text of the MOU between the UK and the Philippines that:

The contracting parties shall endeavour to cooperate in delivery of health care through the recruitment in the Philippines and employment of Filipino nurses in the UK in accordance with their existing laws and regulations (Department of Health, 2003c).

Although the agreement with India was not a written document, however certain points were discussed between governments in detail. For instance, a number of regions which experienced acute nurse shortage were agreed to be excluded from the recruitment sight of British employers, namely Orissa, West Bengal, Madhya Pradesh and Andhra Pradesh. This condition was translated to the level of employers and local co-ordinators:

...in the certain parts of India, we were not allowed to recruit. We were not allowed to recruit from those regions where nurses were on a low number (Expert 8, International recruitment co-ordinator in India, interview date 25.05.2009).

To facilitate co-ordination of the recruitment process in India and the Philippines, the Department of Health appointed local co-ordinators in both countries. Their functions mainly consisted of information dissemination, co-ordination and monitoring of the recruitment process. In comparison to Spain, where the Department of Health was actively involved in recruitment, especially at the outset of the programme, there was no need to intervene in the recruitment process in the Philippines. This is because in the Philippines, the process of recruiting nurses was well-established and facilitated by the government agency (the POEA) and many private agencies and, therefore, did not require centralised organisation from the

British side. The co-ordinator, who recruited nurses from the Philippines, described her responsibilities as follows:

... my responsibility was to set up the process. I did not do actually recruiting. It was up to the individual NHS Trusts. I just co-ordinated...I travelled to the Philippines not to recruit but to set up the process... did presentations in the POEA about work in the NHS, identified potential candidates, consulted the NHS Trust which candidates they wanted to recruit; then co-ordinated video conferences, faxing and everything (Expert 10, International recruitment co-ordinator in the Philippines, interview date 31.03.2009).

In the agreement with India, the situation was somewhat different. First, the agreement was never formally concluded in the written form. Both governments (the Indian and the British) acknowledged agreement through the exchange of letters. Annual meetings were conducted to update initial agreements according to the changing circumstances and preferences of the two countries (see further in this section).

Second, the responsibilities of the recruitment co-ordinator in India included more organisational duties than in the Filipino case at least at the early stage of project implementation. The international recruitment co-ordinator in India listed a number of duties she carried out:

My key responsibilities were to work with the Department of Health workforce team to see where the gaps were required. Then I worked with NHS organisations to see which ones were interested in recruiting from India. At that point we would put an advert in the papers. And then my main role was to actually receive all applications that came in on-line. I was involved in the long-listing and in the short-listing. I was involved in organising Trusts, informing them what we were doing. They used to come down on a day with me. For most of them it was a first time when they were travelling to India. It was also up-dating them about the nursing qualifications that the nurses in India had. And liaising with nurses as they were short-listed, to send them an invitation letter and once we have all set up we would travel with the NHS organisation to India (Expert 8, International recruitment co-ordinator in India, interview date 25.05.2009).

At the early stage of the recruitment from India, the DH implemented more responsibilities than it had in the scheme with the Philippines. However, contrary to the Anglo-Spanish programme, in both mentioned cases the role of the Department of Health was strategic rather than organisational. This strategic role included setting up the framework of the agreements, co-ordination and monitoring of the recruitment campaigns. The Department of Health was involved to a lesser extent in the technical procedures of the recruitment, which were mainly implemented by the Trusts through private recruitment agencies. As stated by the official in the Department of Health:

...most of the nurses' recruitment was organised by individual Trusts and in some cases Trusts would get together and work in particular localities on a co-ordinating basis. It was not a job of the DH to recruit international nurses. What our job to do was to set the framework within which the international recruitment took place (Expert 3, Senior Official, Workforce Capacity, Department of Health, interview date 29.04.2009).

The monitoring of the Indian and Filipino agreements was set up in a similar way and was organised in the format of regular meetings between government officials.

I used to meet with the ambassador [from the Philippines] in London about 2-3 times a year and he was saying how was it going and if there are areas that you would like us to train nurses (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

Along with the Department of Health, there were other government agencies involved on the British side in the preparation of both agreements. Among these were the Department for International Development (DFID), the Foreign Office (FO) and the British Embassies in both countries. The DFID, for instance, provided support in the establishment of the first contacts in India. These government agencies were identified by one of the interviewees:

They [DFID] helped to make the initial contact with India when I went out to India in order to establish whether they were happy for us to recruit on an active basis Indian nurses. And I am pretty sure that the Foreign Office and certainly the British Council helped to facilitate meetings with the Indian Minister and the government officials to get their opinion whether they were happy for us to recruit Indian nurses, which of course some hospitals were already doing, but it was a sort of piecemeal bilateral basis. And, in this situation, the Indian Government said 'yes they were very keen' and they would help facilitate it. They identified part of their administration to help organise it.

(Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

Having collaborated with the government agencies mentioned above at the stage of negotiation, the Department of Health went on to co-ordinate the monitoring of the agreements with British professional and trade union organisations such as the Royal College of Nursing and UNISON, particularly in relation to the issue of the violation of labour rights of migrant nurses in Britain.

And so, we worked very closely with the Philippines Embassy, the RCN and Unison to try to set up a system that would allow Filipino nurses to escape from jobs where they were exploited.

(Expert 3, Senior Official, Workforce Capacity, Department of Health, interview date 29.04.2009).

To mitigate some of the criticisms made by professional organisations in India and the Philippines of violation of migrant nurses' rights in Britain, the Department of Health established communication with these organisations as well. For instance, in India, the international recruitment co-ordinators employed by the Department of Health regularly organised meetings with the Indian Training Nurses Association, to exchange updates on the recruitment and employment of Indian nurses in Britain.

...also once we were in India we had a meeting with Trained Nurses Association in India, which is a professional regulation body, and we kept them informed about how many nurses we employed in which specialities. They would also get [to us] some feedback by some nurses, reports that they did not get conditions that they were promised.

(Expert 8, International Recruitment Co-ordinator in India, interview date 25.05.2009).

Drawing on the descriptive accounts presented above, the following and final part of this chapter categorises source countries, agreements and responsibilities of the English Department of Health in bilateral negotiations.

5.4 REFINING AND REVEALING TYPES

As a brief reminder, at the stage of designing this research and selecting agreements for in-depth study, the source countries which concluded agreements with the Department of Health were categorised as two groups: countries in the European Union and countries outside of Europe. As for the agreements, based on the examination of fragmentary data in the research literature, a distinction was made between the MoU and recruitment schemes, documented and verbal agreements (see Chapter 3).

The descriptive material presented in the first three sections of this chapter has provided rich data from which the types of source countries and the types of agreements initially identified at the stage of the research design can be refined. More importantly, the empirical data collected from policy documents and interviews with experts has contributed to revealing new types of responsibilities implemented in each agreement by the English Department of Health, which were not identified in the existing literature.

Categorisation of the source countries, agreements and responsibilities of the British Government has been a helpful instrument in the transition from descriptive accounts of agreements to analysis of their origin and consequences. In particular, refining types of source countries and types of agreements, and revealing types of functions of the Department of Health, has contributed to an understanding of the policy context in international nurse recruitment in the early 2000s, and the strategies the British Government applied in the negotiation of agreements. This section presents these refined and newly identified types, but before doing so, it explains

their purpose in this study, the mechanism by which they were classified (taxonomy) and its difference from another classification technique - developing typologies. The development of typologies has become a widely applied technique in the social sciences and comparative analysis. For instance, in health policy studies, typology of health systems, based on funding, governance and organisation of health care provision, is perhaps the most commonly used frame to analyse health policies in different national contexts (Burau and Blank, 2003). The principal consideration when developing typologies is their conceptual foundation, which is based on theoretical dimensions. The latter are identified by a researcher prior to the classification of empirical objects. Typologies allow researchers to move from specific and detailed data to a concise account of a phenomenon; from description to categorisation and explanation. The development of typologies has two related purposes: to present and categorise empirical data in an orderly conceptual manner, and to explain and predict the social phenomenon based on its categorisation (Doty and Glick, 1994). To stress the dual role of typologies, as a form of the theory building on the one hand, and a methodological tool on the other, McKinney defines typology as a composite theoretical-methodological device (McKinney, 1969). He distinguishes five steps in developing a typology: type construction in the theoretical framework; substruction (logical evaluation of typology); data collection; and comparison of initially developed constructions with empirical data. In this research, contrary to the theory-informed approach, construction of types (taxonomy) is empirically driven. Taxonomy is, in principle, different from typology. The former is empirical while the latter is conceptual (Bailey, 1994). In this research types of source countries and agreements were first identified at the stage of the selection of agreements for in-depth analysis (see Chapter 3). Refinement of the initially identified types and identification of the new types (such as government responsibilities) was then assisted by the empirical data collected in the interviews with experts and analysis of policy documents (see Sections 5.4.1-5.4.3).

It is important to recognise two limitations of these types, given that they were derived from the empirical data produced in this research rather than theoretical propositions. First, the development of a taxonomy for explanatory purposes was not a primary goal of this research. The construction of types has instrumental value in this study and is applied as a methodological tool for the purpose of systematisation of descriptive accounts. Taxonomies in this study are intended neither to explain nor to predict the origin and consequences of agreements. Second, the identified types are limited to this research. They are not universal and exhaustive categories applicable for all source countries supplying nurses or for all cases of concluded bilateral agreements.

Taking into consideration these limitations and the explorative nature of the types developed, it is worth mentioning that these types could be used in future research as a stepping stone to developing taxonomies of source countries and agreements on a larger scale (including more countries and agreements). For instance, they could be used to compare and explain the different types of country-suppliers in the global nurse labour market and/or to examine how employers' recruitment strategies and their outcomes might depend on the type of country-supplier.

5.4.1 REFINING TYPES OF SOURCE COUNTRIES

Refinement of the originally identified types of source countries was based on the cross-analysis of a number of characteristics. The choice of these characteristics was informed by two sources: empirical data, documents and interviews conducted in this study; and the review of literature on labour migration (Iredale, 2001; Zurn et al., 2002; Baumann et al., 2004; Buchan, 2006; Dumont and Zurn, 2007; Leblang et al., 2007; Kurowski et al., 2009).

Initial characteristics of source countries first emerged at the stage of the descriptive analysis of policy-makers' interpretations³⁷ of how certain source countries were selected for international recruitment and reflections of both policy-makers and practitioners on their recruitment experience and what criteria they felt should have been considered prior to recruitment campaigns in selected countries. These specific characteristics, identified by the interviewees, were then related and grouped into broader categories, such as historical, social, economic and political dimensions, which were examined in the previous studies listed above.

Before I present the results of this analysis, I would like to highlight that the purpose of developing this data-driven taxonomies was to identify types of source countries based on those characteristics of source countries that policy-makers account for in their decision-making process about international recruitment. Although this chapter pays attention to the characteristics of source countries considered by policy-makers, it is not assumed that these characteristics are the only factor influencing the selection of location for recruitment. Moreover, as Chapter 6 will show, this process is complex and involves a number of parameters which shape the policy-makers' decisions. However, developing such a typology here (and further in Chapter 6) is an important component in understanding why and how policy-makers take particular decisions about geographical locations for international recruitment and why, in some cases, they opt for such policy tools as bilateral labour agreements with source countries.

This section proceeds as follows. First, I introduce a summary of characteristics mentioned in the interviews with the British policy-makers. I then describe the types of source countries identified in these characteristics.

The first criterion, which was referred to by policy-makers in the interviews and policy documents, was the history of health worker migration. This was applied in the sense of observing whether there were previous waves of health worker migration from the selected source countries to Britain or other English-speaking countries. This criterion was closely related by interviewees to social factors such as proficiency in the English language, similar nurse training programmes between source and destination countries, and the presence of diasporas (social networks of

³⁷ In this case I refer to the British policy-makers who were involved in the international nurse recruitment to the UK from 2000-2005.

migrants) in a recipient country. The economic criterion referred to by policy-makers included characteristics of the nurse supply in the source countries in the early 2000s. Finally, attitudes of the government and other political actors in source countries to the international recruitment of health workers, were pointed out by policy-makers as an important characteristic of the country which needed to be considered as a potential supplier of the health personnel.

Based on these criteria, two major types of source countries were identified: the post-colonial long-term supplier and the new temporary supplier within the EU (see Table 5). The first type of source country, the post-colonial supplier, is characterised by well-established labour migration patterns which are inherited from the colonial era and reinforced by the post-colonial economic, linguistic, educational and socio-cultural ties with the countries of destination. Today, the relatively low wages and unsatisfactory working conditions compared to the country of destination remain strong push factors and ensure continuous labour emigration from this type of country-supplier. In this research, the post-colonial type of supplier is illustrated with the Philippines, India and South Africa. All of these cases are former colonies or dependent territories of English-speaking countries; the US and Britain, respectively. For at least the past 40 years, these source countries have been supplying the health workforce abroad. Today, fluency in English and education programmes which are coherent with British and American standards increase competitiveness and demand for Indian, South African and Filipino nurses in the global labour market. The socio-cultural integration of nurses from these countries is supported by well-established communities of previous migrants in the UK and the US.

Although South Africa, India and the Philippines were placed in the same category of post-colonial country-supplier, there is a clear distinction between these countries in terms of the political discourse they have employed around the outflow of health workers. An important factor which stimulates the outflow of the health workforce in India and the Philippines is an explicit government policy of exporting health workers. This long-term government strategy has created a favourable environment for the fast growing infrastructure of education institutions and many private agencies facilitating the migration process. As all are former colonies, similar historical and socio-economic factors reinforce the outflow of health workers in

South Africa, India and the Philippines. However, South Africa is notably different from India and the Philippines in terms of the contemporary position of the government to health worker emigration. In contrast to the labour exporting countries, it reinforces retention policies, which aim to keep health workers in the country of origin.

As seen from this description, the group of post-colonial source countries is not homogeneous. There are two sub-categories within the group of post-colonial labour suppliers which correspond to the government's attitudes to labour emigration. One is the post-colonial source country that intentionally exports health workers abroad, such as India and the Philippines; the other type is the post-colonial supplier that tries to curb the outflow of health workers and retain skilled workers in their homeland, such as South Africa.

The second major type of source country proposed in this study is the new temporary country-supplier within the EU. This type of supplier sends health workers abroad as a short-term strategy to cope with a provisional oversupply of labour in the national labour market. This type of country has neither previous large-scale out-migration of health workers, nor post-colonial ties with the country of destination. The coherence of the educational standards in the nursing profession between countries, despite the recently introduced EU Directive on the Recognition of Professional Qualifications (Council Directive 2005/36/EC), is met with concern by employers, practitioners and publics³⁸. The language barriers and relatively weak push factors, compared, for instance, to those in developing countries, restrain the potential of this type of source country in the provision of a stable, large-scale supply of health workers.

In the present research, this type is illustrated with the example of nurse recruitment from Spain. The recruitment project between the UK and Spain was a short-term initiative stimulated by the governments of the two countries. Spain is a developed country with relatively weak push factors compared to developing countries such as India and the Philippines. It has neither colonial ties with Britain, nor a history of migration of nurses to the UK. The recruitment of Spanish nurses in

³⁸ One of the recently discussed and reported cases in the UK, which raised concerns about automatic recognition of professional qualifications of health workers from EU, was of a German doctor giving a lethal dose of pain medication to a British patient (The Guardian, 2010).

the early 2000s was encouraged and channelled through the political agreement between the two governments, which recognised mutual benefits in the temporary employment of Spanish nurses in Britain. This recruitment campaign from a new country-supplier such as Spain, where the British employers had no previous recruitment experience, required substantial financial and organisational support from the country of destination; the UK. As some commentators have argued, the campaign was not economically efficient as the number of recruits was small. Nurses stayed in Britain for a short period of time and some recruits left before the expiry date of the employment contracts (see Chapter 8).

Table 5 Types of source countries

Dimensions	Historical	Social	Economic	Political	Type of supplier
Countries	Post-colonial ties	Language, education, diaspora	Nurse labour supply	Government positions in source countries	
Spain	<ul style="list-style-type: none"> - No colonial ties with English speaking countries; - Absence of previous experience in health worker recruitment in Spain. 	<ul style="list-style-type: none"> - Language barriers; - Educational standards in nursing (across Europe) still in the process of formation; - Weak/no diaspora ties. 	Short-term oversupply.	Positive reaction: Mutual benefits for the governments involved.	Temporary new supplier within the EU.
India/The Philippines	<ul style="list-style-type: none"> - Colonial ties with English-speaking countries (Britain, USA); - Recruitment in these countries is a long-standing tradition. 	<ul style="list-style-type: none"> - English is the official language; - Nurse education programmes consistent with the standards of the UK and other English-speaking countries; - Strong diaspora ties. 	Intentional overproduction for export.	Positive reaction: Labour export strategy contributes to the development of the national economy by means of remittances.	Post-colonial supplier producing for export.
South Africa			Chronic shortage of nurses collides with intense outflow.	Negative reaction: Criticisms of the active recruitment by developed countries.	Post-colonial supplier curbing outflow.

To summarise this section, the types of country-suppliers identified in this study contribute to an understanding of why different types of agreements were negotiated and how such negotiation depended on the background of the particular source country (see Chapter 6). In the broader research context, this typology could potentially be used to develop recommendations for policy-makers and employers planning recruitment from abroad. The following section continues with refining the types of negotiated agreements.

5.4.2 REFINING TYPES OF AGREEMENTS

Two criteria were applied to categorise negotiated agreements, namely the content of agreements and their form of documentation. The first relates to the key objectives of agreements and distinguishes between recruitment agreements and agreements on knowledge, information and skills exchange. Agreements of the first type, such as with Spain, India and the Philippines, establish the framework and organisational procedures in the recruitment of health workers from abroad. However, agreements of the second type, such as with South Africa, do not have recruitment aims as such. They focus on programmes for personnel exchange and development in both countries. They also establish co-operation schemes in the health sector involving knowledge and skills exchange, partnerships between health institutions and research collaboration.

The second criterion in the typology of agreements refers to the form of documentation and differentiates between the Memorandum of Understanding (agreements with South Africa and the Philippines); the contract agreement (Anglo-Spanish recruitment project and Recruitment Agreement with the Philippines); and the informal or verbal agreement (with India) (see Table 6).

Table 6 Types of agreements

Form Content	Memorandum of Understanding	Contract agreement	Informal (verbal) agreement
Recruitment	The Philippines	Spain/The Philippines	India
Knowledge and skills exchange	South Africa	-	-

As mentioned above, the agreements between the UK and South Africa and the UK and the Philippines³⁹ are Memoranda of Understanding. Although both were negotiated as framework documents, they have substantial differences in terms of content. The MOU with South Africa concerns knowledge exchange, whereas the MOU with the Philippines confirms the continuation of international recruitment practice in accordance with the ethical Code of Practice adopted in the UK in 2001 and revised in 2004 (Department of Health, 2004a).

The second type of agreement is the contract agreement. This is represented by the Anglo-Spanish recruitment project (2000)⁴⁰ and the recruitment agreement with the Philippines (2002). The contract agreement is more than a framework; it represents a detailed plan for action and specifies the organisational arrangements required. For instance, the Anglo-Spanish agreement set a target of how many nurses to recruit from Spain; identified employers who were potentially interested in recruitment; designed a pilot recruitment; and described in detail the organisation and timetable of the recruitment process. The Recruitment Agreement with the Philippines clearly stated the financial and administrative responsibilities of each co-signing party.

Finally, the third type of agreement includes informal or verbal agreement negotiated between the UK and India. Analysis of elite interviews concluded that this

³⁹ As there were two agreements negotiated between the UK and the Philippines (the recruitment agreement in 2002 and the MoU in 2003), a distinction should be noted here. In this case reference is made to the MoU signed in 2003. In occurrences that follow, when there is no other specification provided, the distinction is made with reference to the year of negotiation, for instance agreements with Philippines (2002).

⁴⁰ Although the text of the agreement with Spain was not available a number of complementary documents were obtained from the Department of Health for the purpose of analysis. These included the Joint Statement, information letters, and an update for Strategic Health Authorities and the NHS Trusts on recruitment from Spain.

agreement was reached between government officials in the two countries with the aim of activating nurse recruitment in India and establishing the ethical principles in international recruitment. The meeting between officials from both countries was formalised through the exchange of letters, however, there was no written document attached. As data from the elite interviews indicates, the agreement was not formalised following the request of the Indian government to avoid unnecessary paperwork. The verbal format of this agreement pointed to the duality of agreement's purposes. On the one hand, it became a framework which set up and ensured mutual understanding between officials from both countries regarding conditions for recruiting Indian nurses to Britain. On the other hand, both governments when concluding this verbal agreement took a fairly passive position which demonstrated action however did not require actual activities for its implementation as the former neither set nor required binding commitments.

5.4.3 REVEALING TYPES OF RESPONSIBILITIES

The final section in this chapter presents the types of activities which the Department of Health was involved in, in the implementation of agreements. Contrary to the types of source countries and the types of agreements which were identified at the early stage of the research and later refined, the types of responsibilities held by the DH emerged only at the stage of descriptive analysis of collected data.

The overall role of the Department of Health in the international recruitment of health workers in the early 2000s was defined by the government officials as setting up an ethical framework. Negotiation of bilateral labour agreements with source countries became one of the instruments used in the implementation of this goal. This was illustrated by of my interviewees:

What our job to do was to set the framework within which the international recruitment took place. And because we could see that it was going to be quite a significant level of international recruitment, we wanted to make sure that recruitment was done both ethically from the point of view of both countries, who were sending nurses and the nurses themselves. And also, that it was done effectively and

efficiently (Expert 3, Senior official, Workforce Capacity, Department of Health, interview date 29.04.2009).

A number of verbs were identified in the interviews with officials in the Department of Health, which characterised their involvement in these agreements. Thematically, these verbs fell into two categories and were differentiated according to strategic and administrative functions. The strategic functions category included official representation of the British Government in the negotiations and definition the content of agreements. The administrative functions category included organisation, co-ordination and assistance in the implementation of the agreements.

The composition of strategic and administrative functions of the Department of Health in each agreement depended on the type of agreement. For instance, in the case of the Anglo-Spanish agreement, the Department of Health did not only define the content of the agreement, including the number of recruits and employment conditions, but also was actively involved in the implementation of this agreement. This level of involvement was necessary as the recruitment infrastructure was not developed in Spain and the British employers had little experience of recruiting Spanish nurses (see Section 5.4.1).

In contrast to the Anglo-Spanish recruitment project, implementation of agreements with India and the Philippines did not demand the active participation of the British Government in the administration of the recruitment process⁴¹. The role of the government was to ‘send signals’ about opportunities in international recruitment and to encourage employers and recruitment agencies to follow the ethical principles in foreign nurse recruitment.

Finally, in the case of South Africa, the role of the Department of Health was somewhat similar in format but different in content to that which it took in concluding agreements with India and the Philippines. The MoU with South Africa was also about setting up an ethical framework. However, in contrast to the agreements with India and the Philippines, it was not a framework for recruitment but for knowledge and personnel exchange and co-operation in the broader range of

⁴¹ Although one of the agreements with the Philippines (2002) was negotiated in a similar format to the Anglo-Spanish project, it did not require much administration from the British side. The main part of organisational work was implemented by the POEA, a government department in the Philippines, which is directly responsible for the implementation and supervision of bilateral labour agreements.

issues such as professional regulation, strategic health workforce planning, public health and primary care.

In sum, the Department of Health primarily performed two functions in the agreements: establishment of a framework of agreements and administration of the recruitment campaign (see Table 7).

Table 7 Department of Health: Responsibilities in agreements

Country	Establishment of a framework for...		Administration of the recruitment campaign
	Recruitment	Knowledge and personnel exchange	
Spain	+	-	+
India and the Philippines	+	-	(mainly in India)
South Africa	-	+	-

To conclude, this section has provided descriptive accounts and identified types with a summary of the key aspects of specific agreements. As Table 8 shows, the agreements were negotiated in the period from 2000 to 2003. All were concluded in the form of either the MOU or recruitment agreements, with the exception of the Indian agreement, which was an informal arrangement between the Indian and British Governments.

Agreements negotiated with Spain, India, the Philippines and South Africa have been categorised as either recruitment schemes or framework agreements for the knowledge sharing and health personnel exchange. It was difficult to provide a quantitative estimate of how effective the agreements were, as there was no monitoring of numbers of nurses involved. However, estimates obtained from the interviews with the experts and analysis of the data on the NMC register indicates that the majority of nurses came through the framework agreements with the Philippines and India⁴². The number of recruits was noticeably lower in the agreement with Spain. In the case of South Africa, it is more appropriate to refer to

⁴² One must be careful when relating these high numbers of recruits from India and the Philippines solely to the effect produced by the negotiation of agreements. As was stated earlier, the NMC data indicated registrations of all foreign nurses who were recruited both through agreements and by private agencies. The NMC data did not include the number of foreign-trained nurses who came to Britain to work as care assistants in private nursing homes.

the number of health personnel who participated in the exchange programmes than the number of recruits (see Table 8).

Table 8 Summary of facts about agreements

Country	Date	Type	Number of recruits/ placements	Main points
UK-Spain	2000	Recruitment agreement	1,300	Recruitment
UK-South Africa	2003	MOU	18 South African nurses in UK (2003); 70 UK health workers in RSA (2003-2004); Since 2004, approx. 259 British placements in RSA annually.	Personnel exchange and training
UK-India	2001	Informal agreement	9,972*	Encourage recruitment/ensure ethical recruitment
UK-Philippines	2002/ 2003	Recruitment agreement and MOU	24,135*	Confirm continuation of recruitment/ensure ethical recruitment

Note: *Estimated using data from the NMC registration from 2000 to 2005. There is no distinction between recruitment through the government agreements and individual applications through private agencies.

CONCLUSION

This chapter has presented descriptive accounts of the four agreements negotiated by the Department of Health with Spain, South Africa, India and the Philippines. The first three sections described the positions of the source countries in the global nurse market, and the content and organisational arrangements of each agreement. The fourth section of the chapter refined the types of country-suppliers and the types of agreements initially introduced in the Chapters 3. Using the empirical data collected from the interviews with experts and analysis of the policy documents, the original types were clarified and enriched. Further to refining the initially identified types of source countries and types of agreements, this chapter also revealed new types of responsibilities that the British Government implemented in each agreement.

The source countries in this study were categorised into two main types, according to characteristics, identified in policy-makers' reflections, of the nurse supply in the early 2000s, the political context and the history of labour migration. Spain was identified as a new temporary supplier in Europe. India, the Philippines and South Africa were recognised as post-colonial long-term suppliers of the health workforce. Within this group, depending on the position of the government, a distinction was also made between exporting supplier countries (India and the Philippines) and supplier countries aiming to curb the 'brain drain' from the health sector (South Africa). By refining these types using a composition of criteria, the importance of post-colonial ties and the contemporary government position in determining the magnitude and stability of labour supply to the global labour market, was highlighted.

Agreements were also categorised into two main types according to their content: recruitment agreements and agreements on the exchange of knowledge and personnel. In relation to their format, agreements were seen to represent three types: those negotiated in the form of the MOU, project agreements and informal agreements. Finally, the Department of Health fulfilled two major functions in these agreements: strategic, setting up the framework either for recruitment of nursing personnel or for knowledge and personnel exchange; and administrative.

The typology developed in this study contributes to the systematisation of the empirical data and provides the background for in-depth analysis of the origin and the consequence of these agreements, which is presented in the following chapters 6 and 7. Moreover, the types developed are crucial to later discussion of the advantages and potential problems employers might face when recruiting nurses from different types of source countries. Their relevance to the current policy debate in health worker migration is revealed in more detail in the final chapter of this thesis.

6. THE ORIGIN OF THE UK AGREEMENTS

INTRODUCTION

This chapter explores the origin of bilateral labour agreements that were negotiated between the governments of Britain and four source countries. It addresses the question of why the British Government negotiated a number of agreements on cross-border nurse mobility by examining the policy context, the political actors and their claims in the debate on the recruitment of foreign nurses to the UK.

This analysis draws on the analytical framework of cognitive and contextual factors in the selection of policy tools, which was developed by Linder and Peters (Linder and Peters, 1989) (see Chapter 2). The application of this framework enables an appreciation of how the policy context and conflicting interests within and between institutional actors affected the selection of government-to-government agreements.

The chapter begins by describing the political actors who were involved in debate on the cross-border mobility of health workers in the early 2000s. It shows in particular how international nurse recruitment was problematised in the policy discourse by government bodies, trade unions, and professional organisations in source countries and in Britain; and further, how the institutional framework of human rights, the GATS and the Millennium Development Goals shaped this debate. The chapter continues with analysis of the national context in the UK. It examines how the ethical dimension in the British foreign policy, which was introduced by the New Labour Government, shaped the discussion of foreign nurse recruitment in Britain. The second part of this chapter explores the role of cognitive factors in the selection of bilateral labour agreements. It describes how the problem of international nurse recruitment was interpreted by the British officials in the Department of Health; what their self-perceptions in relation to this policy problem were; and how they perceived the government-to-government agreements as one among a number of policy tools that were discussed in relation to the problem of foreign nurse recruitment. This chapter concludes by demonstrating how the problematisation of international nurse recruitment in the language of human rights

and the conflicting claims of political actors affected the perceptions of policy-makers in the Department of Health and influenced their choice in favour of bilateral labour agreements with source countries.

6.1 MAPPING POLITICAL ACTORS AND THE DEBATE'S ORIGIN

To introduce my analysis, I present quotes from a number of the interviews with policy-makers which set the background for describing the context in which the agreements were negotiated.

The UK has been constantly approached by a number of countries who want to have agreements, that happens constantly (Expert 2, International Officer, DH, interview date 29.04.2009).

South Africa wanted an exchange scheme, Spain wanted a campaign to encourage nurses to apply here, the Philippines wanted recognition that we welcome Filipino nurses and to some extent organise employers to come there and recruit. In India we went in order to establish whether they were happy for us to recruit Indian nurses on an active basis (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

if there was a country with a surplus where it would have been a comfortable fit for both countries then the possibility of agreement was there. That happens with India, the Philippines and Spain. South Africa at that time obviously had concerns and we wanted to talk about their concerns... There are those, who want to promote bilateral agreements everywhere...but the UK can't have bilateral agreements of that nature with every country (Expert 2, International Officer, DH, interview date 29.04.2009).

A number of ideas emerged from these quotes and directed my analysis. First, the reasons for negotiation of agreements should be considered together, as components of a complete policy, rather than as separate initiatives. Second, if the British Government has been constantly approached by source countries to negotiate agreements, what were the contextual conditions that facilitated the negotiation of such agreements in the early 2000s in particular? And furthermore, what were the reasons for the British Government to accept requests from source countries at that

time? Finally, the policy-makers' interpretations of the reasons for negotiating agreements as 'source countries wanting and requesting them' overlooks the wants and needs of the British Government in such bilateral schemes. These comments of the policy-makers highlight the importance of addressing the question of the origin of these agreements at a broader scale. To this end, this chapter considers the policy context at the international and national levels, and the composition of political actors involved in the debate around health worker migration in the early 2000s.

The 'brain drain' debate on the international recruitment of health workers, which first appeared in the 1970s, re-emerged in the late 1990s. This revival can be traced back to 1997, when Nelson Mandela first criticised Britain for its active recruitment from South Africa (Bhorat et al., 2002; Kingma, 2006). Gradually, these accusations developed into a complex argument of contrasting opinions presented by political actors at the international level, in both source and destination countries, including international organisations, governments, professional organisations, trade unions, the media and political parties.

The first wave of criticism, as mentioned in Chapter 5, appeared at the national level in source countries. Apart from South Africa, other countries suffering from a chronic shortage of nurses condemned targeted recruitment campaigns organised by developed countries, in particular the UK (Dean, 2005).

Along with objections from the governments of source countries, negative responses were expressed by the professional organisations, trade unions and research institutions in source countries. Among these were the Democratic Nursing Organisation of South Africa (DENOSA), the South African Democratic Nursing Union (SADNU), the National Institute of Health (the Philippines), and the Training Nurses' Association of India. The claims of these organisations were channelled through the local media (*The Manila Times*, *Cape Times* and *India Today*) and the British press (*Guardian*, *Independent* and *BBC*):

The chief officer of Denosa, the South African nurses' association, reported at the annual Royal College of Nursing congress about the shortages in nursing and constant loss of 300 nurses a month, which is enough to destroy a rural maternity service or Aids clinic (Carvel, 2004).

Sadly, this is no longer brain drain, but more appropriately, brain hemorrhage of our nurses. Very soon, the Philippines will be bled dry of nurses. (Dr. Jaime Z. Galvez-Tan, vice chancellor for research at the University of the Philippines in Manila cited in Adversario, 2003).

In Britain, a similar stance could be observed. From 1999, the British press constantly produced headlines such as: *UK fuelling global nurse shortage*, *UK hospitals draining Third World nursing talent* and *Nursing recruitment is international disgrace* (BBC News, 1999a, b, 2000, 2004 a, b). These critical comments primarily came from the British Medical Association, the Royal College of Nursing and UNISON. A number of non-government organisations and charities such as Save the Children and Med Act launched advocacy campaigns to raise awareness about the international recruitment of nurses. Moreover, some British political parties, such as the Liberal Democrats, brought up this issue through the press and in the House of Commons.

Such expansion of nurse numbers, as there has been, is entirely accounted for by overseas nurse recruitment, some of which is blatant poaching of much-needed Third World staff (the Liberal Democrat health spokesman, cited in Wright, 2003).

The problem was also widely discussed in professional journals such as the *Lancet*, *Nursing Times* and *Nursing Standard* (Bevan, 2005; Thomas, 2001).

Gradually, the criticism, which initially emerged in source countries, appeared at the international level. It was channelled through the meetings of the Commonwealth Secretariat and the WHO, and the networks of national professional organisations and trade unions with their umbrella organisations at the international level, such as the International Council of Nurses and the Public Service International. Meetings at the international level organised by the Commonwealth Secretariat and the World Health Assembly were used by the government officials of developing countries to underline the problem of health workers leaving their countries in response to active recruitment by developed countries. An official in the Commonwealth Secretariat traced the origin of these discussions to the late 1990s:

This issue within the Commonwealth countries was raised in 1998 at the Commonwealth Health Ministers Meeting. Developing countries were concerned with the level of migration of health workers (particularly nurses) to more developed countries (Expert 5, Adviser, Social Transformation Programmes Division - Health Section, Commonwealth Secretariat, interview date 25.04.2009).

As shown above, there a number of actors were involved in discussions around the recruitment of overseas health workers in Britain. The following table summarises examples of institutional actors at the international and national levels who actively participated in the debate on the cross-border migration of nurses in the early 2000s (see Table 9).

Table 9 Debate on health worker migration: Key participants

Actors at the national level	Source countries	UK
Government and political parties	Ministries of Health	DH, DFID Liberal Democrats.
NGOs and research institutions	The Institute of Health Policy and Development Studies (the Philippines).	Save the Children; Med Act; King's Fund.
Professional organisations and trade unions	Democratic Nursing Association of South Africa; South African Democratic Nursing Union National; Nurses' Union of Spain (SATSE).	BMA; RCN; UNISON.
International organisations	ILO; CS; WHO; IOM; PSI; ICN; Realizing Rights: the Ethical Global Initiative.	

These actors made claims about the positive and negative outcomes of migration of health workers. Better career opportunities for foreign health workers in developed countries and remittances for the economies of developing countries were seen among the positive impacts of the cross-border labour mobility (International Organization for Migration, 2008). The negative consequences of the active recruitment were also purported. The loss of a valuable health workforce was seen as one of the main factors hindering access of the population to healthcare providers in developing countries (Boseley, 2005). At the same time, the dependency of

developed countries on overseas health workers was related to their inability to address the problem in the national workforce of planning and training health personnel. The need for international recruitment was considered to be a sign that insufficient measures had been taken by developed countries to motivate and retain their health workers (Unison, 2006). Critics of the active international recruitment in source countries also frequently reported cases of discrimination and violation of migrant workers' rights through the local press.

Life in Britain is not always easy for foreign nurses, especially if they have darker skin. Most do not complain much, but some leave within six months, unable to suffer the discrimination in the system (Bhasi, 2001).

Interestingly, there was no clear distinction between those actors supporting the cross-border mobility of health workers and those opposing it. On the one hand, the governments of countries supplying a nursing workforce acknowledged the benefits of the international migration of health workers who were sending remittances back to their home countries. For instance, the governments of India and the Philippines supported the out-migration of health workers as they saw it as an economic strategy to increase their countries' income through remittances. On the other hand, some source countries, such as South Africa, advocated to slow down, and at some point altogether halt, the international recruitment. The positions of government officials were often channelled through the media, as follows:

The minister of foreign affairs [in South Africa], Nkosazana Dlamini-Zuma, has called on governments of wealthy First World countries to stop actively recruiting (Krost, 2000).

Professional organisations and trade unions in source countries supported the right of health workers to leave their country of origin in search of better career opportunities. However, they also condemned the practices of employers in developed countries who were actively recruiting workers from developing countries. For instance, despite explicit government support for labour emigration, professional organisations and trade unions in the Philippines and India expressed criticisms of the recruitment of their health workers (Galvez Tan, 2005). Concerns

were centred on the existing shortage, especially in rural areas, as well as the violation of migrants' rights by recruitment agencies and employers in Britain:

It has been publicised that India has large-scale nurse unemployment and, therefore can afford to lose thousands of nurses. To anyone working on the ground, this position is problematic. Even in Delhi, an urban centre relatively well-supplied with nurses, hospitals routinely function with nurse to patient ratios of one to fifty or sixty (Healey, 2006).

The RCN and Unison, the professional nurse organisation and trade union in the UK respectively, were concerned with the reliance on international labour and the inability of the national workforce to reproduce sufficient numbers of workers to meet local needs. The RCN officer expressed this argument in the following way:

I think the UK needs to think about how to develop its own workforce and we need to make sure that nursing is still an attractive career for school leavers in the UK (Expert 12, International Officer, RCN, interview date 13.05.2009)

However, these organisations simultaneously welcomed foreign nurses, and acknowledged the diversity of cultural backgrounds and the rights of foreign labour:

...there was a view that we should not massively recruit from developing countries and that was the view that we shared but we also needed to balance it with professional aspiration of individuals to get different developmental opportunities by working in different countries (Expert 13, Senior Officer, Department of International Relations, UNISON, interview date 11.05.2009)

Finally, on the one hand, the international organisations such as the WHO and the Commonwealth Secretariat were concerned with the aggressive recruitment strategies of developed countries, which contributed to the shortages of health workers in developing countries. On the other hand, these organisations recognised that health workers should not be restricted in pursuing careers abroad if they wished to. An officer at the Commonwealth Secretariat stated that:

...if international recruitment is taking place then it should be done within the framework which respects migrant workers' rights and the rights of the countries and its citizens to health (Expert 5, Adviser, Social Transformation Programmes Division - Health Section, Commonwealth Secretariat, interview date 25.04.2009).

The following table summarises the conflicting aims of political actors in the debate on health worker migration (see Table 10).

Table 10 Health worker migration and political aims

Actor	Aims
UK Government	Continue international recruitment when needed in order to provide health service for British citizens
	Protect image and reputation of the NHS as ethical employer, avoid accusations in targeted recruitment from poor countries
Governments of source countries	Receive economic benefits from migration (remittances, reparations from developed countries)
	Slow down international recruitment/establish restricted conditions for recruitment
Professional organisations/ trade unions in source countries	Advocate for health workers' rights to freedom of movement and their labour rights abroad
	Encourage health workers to stay in their countries of origin
Professional organisations/ trade unions in the UK	Encourage sustainability of national health workforce (avoid international recruitment if possible)
	Demonstrate solidarity with counterparts in source countries protecting the right to freedom of movement for health workers
International organisations	Protect rights to freedom of movement for health workers from source countries
	Ensure implementation of rights to health for patients in source countries

As this section has detected, the arguments 'for' and 'against' the international migration of health workers were articulated by various actors at the international and national levels, in both source and destination countries. The following section discusses in more detail how these claims were shaped in the establishment of international norms and the ethical dimension of the British foreign policy.

6.2 INTERNATIONAL AND NATIONAL POLICY CONTEXTS

6.2.1 THE GLOBAL HEALTH ETHICS AND THE NEO-LIBERAL DISCOURSE

The arguments of the institutional actors in favour of and against international migration were shaped by two competing and, as shown further in this section, overlapping discourses. One originated in the neo-liberal paradigm, while the other was rooted in the framework of global health ethics and social justice.

In the neo-liberal discourse, health labour migration was portrayed from two standpoints. First, it was discussed within a broader discourse which promoted migration for development. The increasing cross-border labour mobility was seen as a win-win situation for developing and developed countries. It was argued that for the countries of destination, labour immigration helped to address the demographic problem of ageing, compensate the skill shortage, and create new investment opportunities (Nielson, 2006). For source countries, temporary and circular labour migration was perceived as a means of economic and social development. The benefits were seen in skills and technology transfer; development of networks for trade and investments; relief from labour market pressures; and finally, remittances sent by foreign health workers back home, as one of the tools facilitating the development of poor global regions (International Organization for Migration, 2008).

Another neo-liberal standpoint within which the discussion of health worker migration was liberalisation of the market for health services. The supporters of liberalisation in health services argue that it stimulates a more cost-effective health service provision of a higher standard, which has the potential not only to improve the health status of the population worldwide but also to increase employment opportunities for health workers who cannot find a job in their countries of origin (Kingma, 2006). To promote these ideas, the WTO introduced GATS in 1994 (World Trade Organization, 1994a). Its Mode 4, in particular, was intended to liberalise the cross-border mobility of service providers; in relation to the health sector, it focused on the provision of health services by individuals from another country on a temporary basis. However, this mode specifies that it does not apply to the 'natural

persons' of one member state⁴³ seeking access to the labour market of another member country or to measures regarding employment on a permanent basis leading to citizenship and the right to permanent residence (see Chapter 4).

Along with the neo-liberal discourse, another predominant theme at that time in the policy discourse on health worker migration was global ethics. The origin of this term relates to two conceptual shifts in the academic literature since 1970. First, the contemporary understanding of ethics in medicine has expanded from discussion of the ethical issues in health at the individual level of the doctor-patient relationship, to collective rights and social inequalities in health around the world. Second, the terminology has gradually changed from 'international health' to 'global health', to acknowledge the importance of actors beyond the government in health issues (Wright et al., 2008; Daniels, 2009).

The theme of global health ethics in the context of health worker migration was apparent in the claims of institutional actors questioning the fairness of health worker recruitment from poor countries. Concurrently, discussion about the international migration of health workers from the perspective of global health ethics developed into a recognition that restricting health workers' mobility is not ethical, as workers have right to safe working conditions and decent salaries. Interestingly, the discourse of global health ethics, promoting the right to freedom of movement for health workers, was notably similar to the neo-liberal framework promoting the cross-border mobility of health service providers in the framework of GATS. Another relevant observation is that political actors framed their neo-liberal arguments or claims for global ethics in the language of human rights, with references to the right to health and the right to freedom of movement in particular. One can argue that this dominance of human rights language in the problematisation of health worker migration was reinforced by the introduction, in the year 2000, of the health-related Millennium Development Goals (MDG). One of the crucial goals of the MDGs was to strengthen a human-rights based approach in the reduction of poor health conditions and poverty related problems at the national level. Among other organisations, the WHO vocalised concerns about the potential of health worker migration to hinder the realisation of the MDGs:

⁴³ GATS distinguishes between two formulations 'natural person' and 'juridical person' where the former is defined as a national or permanent resident of a given country (WTO, 1995b, p. 303).

Migration of health workers also undermines the ability of countries to meet global, regional and national commitments, such as the health-related United Nations Millennium Development Goals (World Health Organization, 2004, p.1).

The MDGs are a blueprint agreed to by countries and leading development institutions to meet the needs of the world's poorest people. The health-related MDGs aim to reduce child mortality, improve maternal health, combat HIV/AIDS and other diseases such as tuberculosis and malaria, and ensure access to essential medicines. The health worker shortage has been a major impediment to making progress on meeting these goals (World Health Organization, 2006).

The essence of debates between some stakeholders promoting neo-liberal ideas, and others urging for global ethics in health worker migration, was expressed in two research reports commissioned by the Med Act and funded by the British Medical Association (BMA) and the charity Save the Children UK, respectively (Mensah et al., 2005; Mesquita and Gordon, 2005). These two reports demonstrated how the positions of collective actors reflected these institutional norms of the human rights approach.

The migration and recruitment of health workers was seen as a controversial process causing a conflict between the right to health⁴⁴ of patients in source countries, and the right to freedom of movement and protection from exploitation of health workers. In the debates around the ethics of international recruitment, the right to health appears in the rhetoric of various stakeholders at national and international levels (see Figure 5). International organisations considered active international recruitment to be one of the key factors affecting the right to health of patients in developing countries (World Health Organization, 2004). The implementation of the right to health was reinforced by the General Comment 14 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which emphasised that protection of the right to health is an obligation of national governments (United

⁴⁴ The right to health in this human rights dilemma was understood as physical, information and economic accessibility of health facilities, goods and services (United Nations Economic and Social Council, 2000).

Nations Economic and Social Council, 2000). According to the ICESCR, States should implement policies that lead to available and accessible health care for all, and ensure that third parties conform to human rights standards. This interpretation of the right to health was actively used by governments, trade unions and professional organisations in source countries to accuse developed countries of 'poaching' health workers (Stilwell, 2009). Those making such accusations further demanded that active recruitment be stopped and that developed countries compensate the loss of valuable human resources either by direct financial transfers or through investment in the training of health workers in developing countries. Many of these demands were directed at the British Government, whose public and private institutions actively recruited foreign doctors and nurses in the late 1990s and early 2000s.

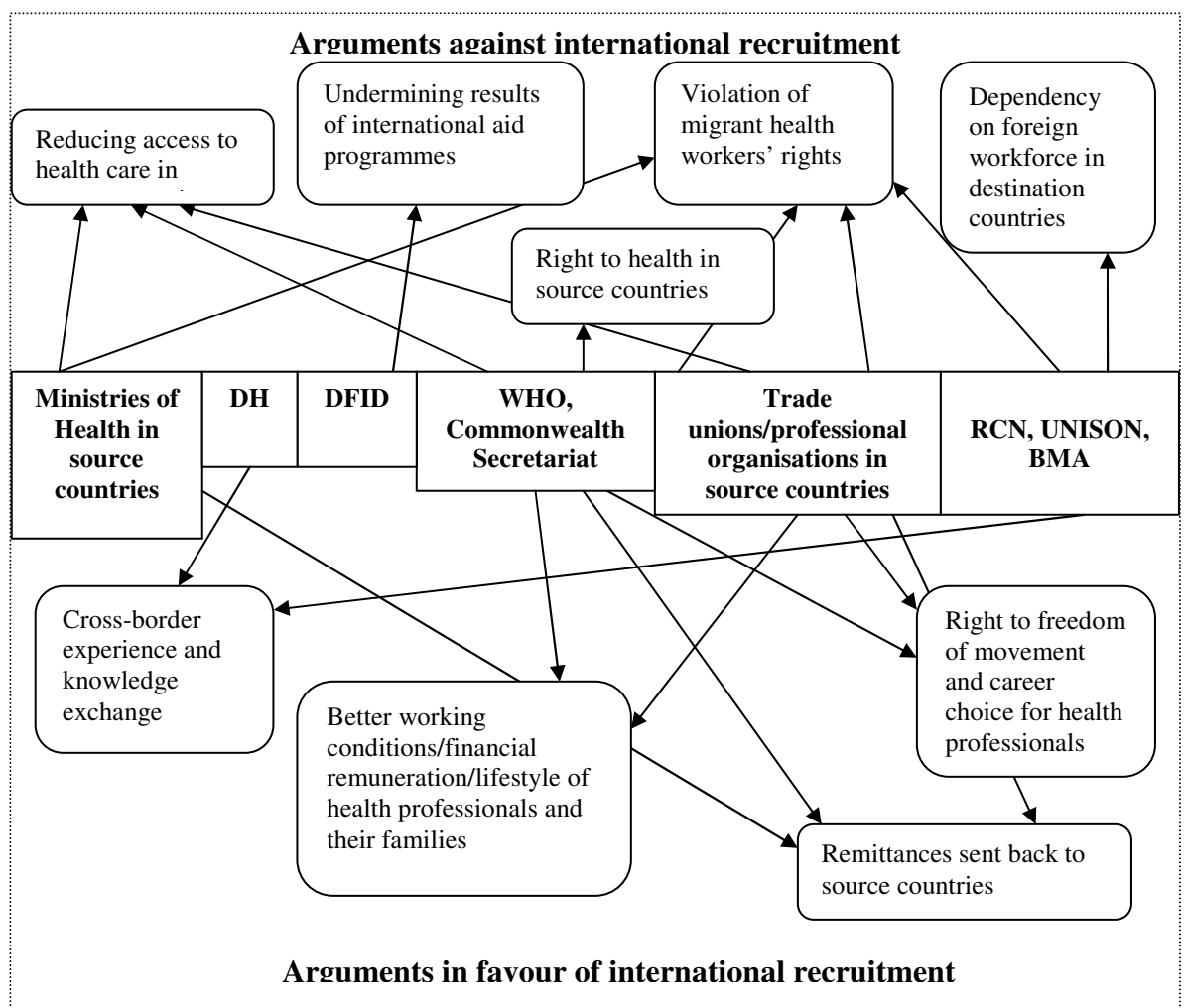
British trade unions and professional organisations also raised concerns about the situation of the public health sector in developing countries. They proposed several ways of strengthening the Code of Practice, such as by requiring the private sector to comply with the principles of ethical recruitment, and encouraged the development of partnerships with the relevant institutions in source countries, which would address the negative impacts of the health worker migration (Unison, 2006).

The second component of the human rights dilemma refers to migrant health workers' right to the freedom of movement and labour rights. References to these groups of rights were made by international organisations and relevant stakeholders in Britain and source countries (the Philippines, India and South Africa). British professional organisations, trade unions, and non-governmental organisations played a significant role in the realisation of the human rights approach at the national level of policy implementation. The key arguments put forward by these stakeholders were related to the targeted recruitment in developing countries and the violation of migrant health workers' rights (see Figure 5). Trade unions revealed several cases of the violation of labour rights of overseas professionals, including poor working conditions, inadequate payments, an underestimation of their professional skills and racial discrimination (Unison, 2006).

Despite the fact that professional organisations and trade unions in Britain supported the right of health workers to work abroad, they also criticised the

dependency of the NHS on the skills of foreign doctors and nurses. They argued that such dependency resulted from the poor planning and human resource management in the national health system. For instance, professional organisations in the UK (the British Medical Association and the Royal College of Nursing) as well as the British public service trade union (Unison), expressed concerns about dependency on the international workforce and the lack of self-sufficient workforce planning (Unison, 2006). These concerns were shared by the political opposition (Boseley, 2005).

Figure 5 Health worker recruitment in the UK: Conflicting arguments



In sum, in the early 2000s, the problem of the international migration of health workers was interpreted as a human rights dilemma. On the one hand, it was recognised that international migration undermined the right to health in source

countries; on the other, international migration was seen as a realisation of health workers' right to freedom of movement. This debate, which was framed at the international level in the language of human rights, corresponded with the promotion of ethical principles in the British foreign policy from the late 1990s onwards.

6.2.2 ETHICS IN THE BRITISH FOREIGN POLICY

In response to the aforementioned criticism of its active recruitment of health workers from developing countries, the UK introduced a number of measures. First of all, the British Government demonstrated a commitment to slowing down the active recruitment from abroad and improving staffing numbers at the national level, primarily by training more health personnel, increasing earnings and improving working conditions (Department of Health, 2000a). Second, the Department of Health introduced the Guidance on the International Nursing Recruitment (Department of Health, 1999), a Code of Practice (2004) for the international recruitment of health workers which disallowed active recruitment campaigns in developing countries with a critical shortage of health workers. Concurrently, the Department of Health negotiated government-to-government agreements in the recruitment of nurses with Spain, India and the Philippines. An agreement was also concluded with South Africa on co-operation, personnel exchange and the training of health workers.

These policy tools of ethical recruitment - the Code of Practice and the government-to-government agreements - were the products of a more general trend that emerged at the time in the British policy context. The Labour Government introduced principles of ethical foreign policy. It was proclaimed that:

...foreign policy must have an ethical dimension and must support the demands of other peoples for the democratic rights on which we insist for ourselves. The Labour Government will put human rights at the heart of our foreign policy and will publish an annual report on our work in promoting human rights abroad (Cook, 1997 cited in Select Committee on Foreign Affairs, 1998).

In respect of the recruitment of health workers from developing countries, the ethical dimension of the British foreign policy manifested in the Code of Practice and bilateral labour agreements with source countries. Both the Code and the agreements were tools in the implementation of the ethical recruitment policy, promoted among NHS employers in the early 2000s. For this reason, the following few paragraphs describe in detail the content of the Code and its relation to agreements.

The first Code of Practice in the international recruitment of health workers was issued by the Department of Health in 2001. The Code of Practice set standards and promoted best practice for NHS employers in the ethical recruitment of health workers. It included recognition of the negative impact of active international recruitment on developing countries; provided guidance on international recruitment for employers; and listed countries which should not be targeted with active recruitment campaigns. Then in 2003, jointly with the Department for International Development (DFID), Department of Health produced a list of developing countries in which shortages of health workers had reached a significant level (NHS Employers, 2009). As a result, NHS employers were not allowed to target such countries with active recruitment campaigns. In 2004, a revised version of the Code of Practice was issued, which encouraged private agencies to subscribe to these ethical principles (Department of Health, 2004a). This renewed Code also listed private agencies approved by the Department of Health.

Two discourses were detected in the content of the Code: the discourse of human rights and the managerial discourse. The discourse of human rights was expressed in the Code as the protection of the rights of migrant health workers and the discouragement of active recruitment in developing countries with a shortage of health workers. The Code recognised the right to freedom of movement and promoted the principle of non-discrimination in the employment of health workers from overseas (Department of Health, 2004a). However, no direct reference was made in the Code to the right to health of patients in source countries. The Code stipulated that NHS employers:

...may not target low-income countries for health staff, nor approach agencies that do so, unless there is a government-to-government

agreement that allows recruitment in that country under certain conditions (Department of Health, 2004a, p. 7).

The second theme apparent in the Code was the managerial discourse. This reflected the NHS managerial culture that was based on the principles of quality of service; the development of human resources; efficiency; and accountability. These principles were effectively applied in the early 2000s to reduce the negative effects of active international recruitment. In many instances, the Code evoked the corporate codes of conduct introduced by many private corporations to monitor working conditions in their global production chains (Pearson, 2001). The Code promoted best practice in the management of international recruitment; controlled the quality of health services provided by foreign health workers; and necessitated accountability among NHS organisations in recruiting from abroad. It also encouraged NHS employers to ensure cost efficiency of the international recruitment (Department of Health, 2004a).

The Code of Practice, along with similar managerial tools adopted at that time in NHS institutions such as the *Code of Conduct for NHS Managers* (Department of Health 2002) and *A code of Conduct for Private Practice* (Department of Health, 2002; Department of Health, 2004b), are examples of the use of 'business' language in health service provision. The origin of the managerial culture in NHS institutions can be traced back to the introduction of general management in the 1980s (Griffiths, 1983); the 'internal market' in the 1990s; and the reorganisation of the health service in the 2000s, which included organisational reform, priority setting, performance management and resource allocation (Traynor, 1996; Baggott, 2004). The key managerial principles in the NHS were based on business excellence, financial rationale, quality of service and empowering individual patients through informed choice (Department of Health, 2007b). The expansion of the NHS managerial discourse at the international level is reflected in the fact that the Code of Practice covers the issues of cross-border health service provision, international recruitment and the employment of health workers.

The managerial discourse in the Code served several functions. First, it presented the NHS as a global employer, which helped to maintain its reputation as a responsible actor at the national and international levels. Second, it ensured the

dissemination of good practice in international recruitment with a stress on ethics in management. There were several actors mentioned in the Code. It primarily set guidelines for NHS employers. It was also acknowledged that the Code would have less impact on recruitment agencies and private employers as it had no enforcement mechanisms to control this sector (Buchan, 2002). However, the revised version of the Code encouraged private recruitment agencies to adhere to the principles of ethical recruitment and employment.

To recap, the Code of Practice was not intended to limit individual applications from foreign health workers but rather to address the ‘pull factors’ of migration, encouraging ethical recruitment practices of employers and agencies. As a managerial tool within the NHS, the Code of Practice became an instrument in agenda-setting and informing employers’ decisions about international recruitment. As pointed out by one of the DH officials, the Code was applied as one of the instruments in the evaluation of the NHS overall employment performance:

We had the annual cycle of the checks that included a range of standards not only about employment practice but obviously the most important thing was the quality of patient care. So if international recruitment as part of the employment practice was not ethical then you [NHS employer] would not get your registration as a health care organisation, if you were non-compliant [to the Code]. There was an incentive to follow rules because you might not get your registration as an organisation (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

The Code discouraged active international recruitment as an explicit government policy; provided guidelines for employers; and promoted ethical principles among the private recruitment agencies. However, its potential to invoke the right to health of patients in source countries remained restricted as this was not explicitly expressed in the text of the Code. Numerous critics argued that the Code failed as a tool to stem the outflow of health workers from source countries (Mesquita and Grodon, 2005; Mensah, 2005; Buchan et al., 2009). They regarded it as an ineffective tool in the regulation of private agencies, which were still recruiting nurses to work in care homes and other private health institutions. Moreover, criticisms pointed at the growing phenomenon of ‘back-door recruitment’, where

nurses initially recruited to work in the private sector were subsequently moving to the NHS. As one official in the South African Department of Health pointed out:

They say they don't [advertise], but the fact of the matter is that they've got agencies that work for them . . . It's no longer the NHS directly recruiting but agencies that are recruiting and doing placements for various NHS Trusts. So, rather than doing it directly, they are doing it indirectly (Senior Official in the South African Department of Health, cited in Bevan, 2005).

Concurrently with the Code, the Department of Health negotiated bilateral labour agreements with a number of source countries. These agreements, as stated in the Code, became complementary tools in implementation of the ethical policy in the recruitment of foreign health workers:

The World Health Assembly resolution (57.19) urges the use of government-to-government agreements as a strategy to manage the migration of healthcare workers. The UK Government supports this resolution and has government-to-government agreements with a number of other countries. It is expected that all NHS international recruitment should be undertaken through these agreements as these promote recruitment in an ethical and sustainable manner. These intergovernmental agreements have been created to offer benefits to all participating countries and support ethical standards in the recruitment of international healthcare professionals. These agreements also support the professional development of all healthcare professionals through the exchange of knowledge and skills. (Department of Health, 2004a, p.14).

What were the policy-makers' perceptions of these policy tools? How did the problematisation of the international nurse recruitment as a human rights dilemma affect their subsequent choice of these agreements? These questions are explored in the next section.

6.3 COGNITIVE FACTORS IN AGREEMENTS' SELECTION

International norms, national regulations and the policy debate between political actors all play an important role in the process of policy tool selection. However, the final decision over which tools are used belongs to the policy-makers and depends on

their perceptions of the policy problem; their self-positioning in the problem situation; and their perceptions of the proper instrument to do the job. This section describes each of these components using evidence from interviews with officials in the Department of Health who were involved in the design, conclusion and implementation of the government-to-government agreements.

For the British Government, the recruitment of foreign nurses in the early 2000s was a policy problem with conflicting dimensions. There was a clear need for more nurses on the ground. A number of measures were taken to address this national shortage, such as increasing training places for nursing students and improving the national retention policy (Department of Health, 2000a). However, the Government was concerned that these long-term measures would take time to produce results. It was therefore decided to recruit nurses from abroad in order to fill the national vacancies while national education institutions were training new cadres. This rationale was expressed by one of the DH officials working at that time in the international recruitment team:

In the early 2000s we had shortages in general nursing, specialists, GPs, radiologists and consultants. But it takes 7 years to train a doctor and 4 years to train a nurse. So, the decision was taken in favour of the international recruitment as a short-term strategy while the results of the long-term policy in expansion of the national workforce pool were on the way (Expert 4, International Recruitment Officer, Department of Health, interview date 17.02.2009).

However, the active international recruitment undertaken by NHS employers was recognised as an undesirable and unethical practice. As previously discussed, this recognition was the result of concern originally expressed by source countries, about targeted recruitment campaigns and the exploitation of migrant health workers in Britain.

A lot of developing countries were criticising the UK stealing their nurses (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

There were many concerns about the scale of recruitment from the Philippines and about exploitation of Filipino nurses...there was evidence that some Filipino were exploited in the sense of salaries they were paid and the duties they were expected to perform (Expert 3, Senior Official, Workforce Capacity, Department of Health, interview date 29.04.2009).

The British Government faced a policy dilemma: on the one hand, it needed to continue to recruit foreign nurses but on the other hand, it was essential to avoid criticisms and address concerns about the violation of migrant workers' rights. This understanding was summarised by a number of government officials:

You would find documentation that, on the one hand, indicated that the country [UK] was very keen to have international recruitment and, on the other hand, you would have documentation saying that recruitment is just contributing to a 'brain drain' (Expert 2, International Officer, DH, interview date 29.04.2009)

For recruitment of the international workers, of course, you have a background of the human rights and the international trade agreements and services that allow people the right to work where they want to work. The UK wanted to improve its health service and an easy way to do that was actively recruiting which was a policy at that time. But there was a recognition that we need to do it in a sustainable way and also to address some concerns about the brain drain given our long-standing interest in international development (Expert 11, Global Health International Division, Department of Health, interview date 06.05.2009).

The government's self-perception in this controversial policy situation was yet another important component which influenced the choice of bilateral labour agreements to address the problem of foreign nurse recruitment in the UK. In the ambivalent formulation of the policy problem, which was interpreted in the international debate as a dilemma of human rights, the Department of Health identified its role in setting a framework for ethical recruitment. This framework was supposed to respect both the right to health and the right to freedom of movement; and in fact to help resolve the policy bind for the British Government itself, which needed to recruit from abroad but could not continue doing so actively. The

government self-positioning in this policy problem was expressed by one of the DH government officials as follows:

What our job to do was to set the framework within which the international recruitment took place ...we wanted to make sure that recruitment was done both ethically from the point of view of both countries, who were sending nurses and the nurses themselves. And also, that it was done effectively and efficiently (Expert 3, Workforce Capacity, Department of Health, interview date 29.04.2009).

This statement indicates that there was no intention at that time either to stop recruitment from traditional exporters of health workers, such as India and the Philippines, or to limit individual applications from health workers elsewhere.

The policy-makers' perceptions of the policy problem, as well as their self-positioning in relation to this policy problem, had an impact on their preferences of which tool would best do the job. As shown earlier in this chapter (as well as in Chapter 5), along with bilateral agreements, source countries also requested that the British Government introduce a ban on international recruitment and pay reparations for recruited health workers. For the British policy-makers, a ban on international recruitment was considered to be an inappropriate measure. One of the DH officials explained that its introduction could have potentially reinforced accusations of violating the right to freedom of movement of foreign health workers:

...if they say, on the one hand, that we don't want international opportunities in the UK or opportunities for the international migrants in the UK, then when it is not so easy for people to get in, then we got complaints that it has been shut (Expert 2, International Officer, DH, interview date 29.04.2009).

The payment of reparations was another potential policy measure that was only fragmentally mentioned by British policy-makers in relation to the problem of health worker migration. Reparations became a controversial and debated issue in the policy discourse on the international recruitment of health workers. It came up in discussions of the Commonwealth Code in particular (Commonwealth Secretariat, 2003):

You probably know that there was a Commonwealth Code, which I think came initially as an inspiration from Caribbean countries. I think that the issue there was that they wanted a sort of reparation...and that always was quite a difficult area (Expert 3, Senior Official, Workforce Capacity, Department of Health, interview date 29.04.2009).

Finally, the British policy-makers were more receptive to the government-to-government agreements than they were to either the ban on the international recruitment or the payment of reparations. The agreements were seen as a useful instrument and a comfortable fit for destination and source countries. A DH official listed a number of positive characteristics of these agreements:

Bilateral agreements, if you are actively recruiting in someone's else country, are useful as two countries come together and take a decision of whether it is appropriate or not and we believe it is – to set up a framework strategy that will be fair and beneficial to everyone participating (Expert 2, International Officer, DH, interview date 29.04.2009).

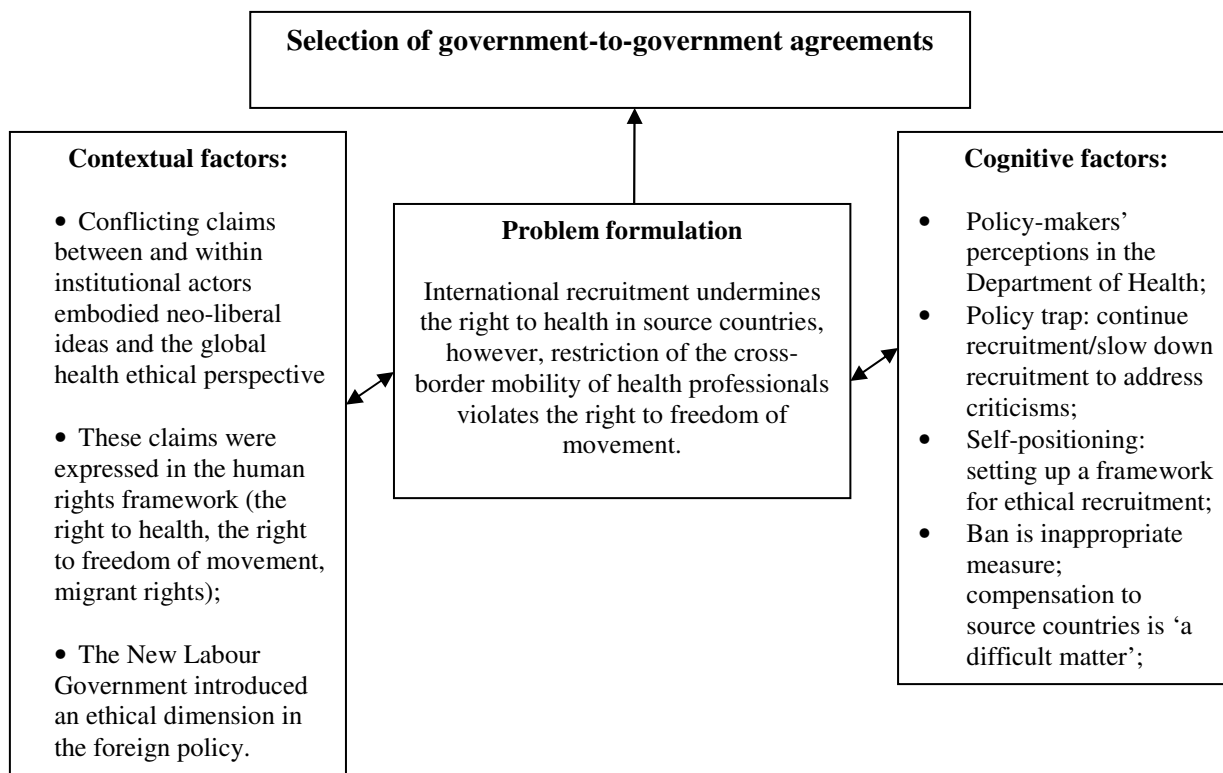
As previously noted, the British Government faced a need to respond to the continuous accusations from source countries and the concerns of international organisations, trade unions and professional organisations regarding the negative impact of the active recruitment of health workers from low-income countries in the early 200s. However, the British Government also had to secure its own interests through international recruitment, at least in the short-term, in order to be able to fill the nurse vacancies at the national level. To resolve this policy dilemma, the government therefore had to introduce policy tools that would simultaneously accommodate the conflicting interests of political actors; respond to the international policy framework of human rights; and attain sufficient national staffing levels in the NHS. Framed in the contextual conditions, these policy-makers' interests created a space to introduce bilateral labour agreements that were flexible enough to integrate the conflicting interests of the involved parties and effectively respond to the policy problem of the international recruitment of health workers formulated as a human rights dilemma.

CONCLUSION

This chapter addressed the question of the origin of the government-to-government agreements by examining contextual and cognitive factors in the policy tools selection. It explained how the problematisation of international recruitment in the human rights language created a space for these bilateral labour agreements, which were previously unusual for the overseas labour recruitment policy in the UK. The chapter revealed how the selection of policy tools was influenced by the perceptions of policy-makers, which were in turn shaped by the context of global health ethics, ethical principles in the British foreign policy and conflicting interests of political actors involved in the debate around the migration of health workers.

To conclude this chapter, I return to the framework proposed by Linder and Peters for the analysis of policy tools selection (see Figure 6). The figure presented below is a reconstruction of the initial Figure 2, which was introduced in Chapter 2. This revised variant identifies the interconnection of contextual and cognitive factors in the selection of policy tools through the category of problem formulation. It summarises components of the policy context; how the problem of foreign nurse recruitment was stated in the policy discourse, and what policy-makers' perceptions and responses to this problem were.

Figure 6 Selection of ethical agreements in Britain



This figure summarises the analysis presented in this chapter. It explains that the context within which agreements originated was characterised by conflicting claims expressed by various political actors at the national and international levels. These claims were framed in the language of human rights and referred to both neo-liberal ideas and the discourse of global health ethics. The theme of ethics emerged at that time both on the international agenda and at the national level in the British foreign policy. Within this context, international nurse recruitment was problematised as a dilemma of human rights. On the one hand, it was seen as unethical to actively recruit health personnel from poor countries as this would deprive the citizens of their right to health, and on the other hand, it was regarded as unethical to stop individual health workers migrating to developed countries as this would restrict their right to freedom of movement. The convergence of this formulation of the policy problem and the interests of the British Government to continue recruitment created a space for the negotiation of bilateral labour agreements with source countries; the policy tools which, in fact, were not common in the previous practice of the British labour immigration policy.

This chapter has two main conclusions. First, the introduction of bilateral labour agreements in the cross-border mobility of nurses by the Department of Health in the early 2000s was part of the ethical policy in the international recruitment of health workers. The latter emerged in response to the critical concerns of institutional actors at the national and international levels. In particular, the choice of government-to-government agreements between the UK and a number of source countries was conditioned by specific problem formulation constructed by actors in the framework of human rights. It was framed as a matter of international ethics, exposing the dilemma between the right to health in source countries and the right to freedom of movement of health workers.

The second conclusion of this chapter is that the shortages during the early 2000s in the health sector of the British labour market created a need to continue the international recruitment of health workers. However, in order to continue such recruitment, the British Government had to respond to accusations that this practice undermined both the right to health in source countries and the rights of overseas health workers. In these circumstances, the British Government made the decision to introduce mechanisms that would simultaneously respond to the conflicting claims of political actors; the international agenda of global health ethics; and their own interests.

7. REVEALING FUNCTIONS

INTRODUCTION

This chapter addresses the final question posed in this study: what are the consequences of agreements? The chapter discusses the consequences of agreements using Merton's distinction between 'manifest' and 'latent' functions. It uses function as a conceptual tool to categorise actors' interpretations of the consequences of agreements. It then draws on these interpretations to develop an interpretative explanation of the role agreements played in the British policy for the international recruitment of nurses. As the methodology employed in this analysis was introduced earlier in this thesis (see Chapter 3), this chapter begins with a presentation of findings. First, it discusses the objectives of agreements, as stated in their official texts, and the intentions of the policy-makers who negotiated them, as expressed by such individuals in the interviews. Second, the chapter examines the consequences of agreements, as stated in the policy documents reviewed and expressed in the interviews with policy-makers and a broader group of political actors involved in the debate about the recruitment of foreign nurses in Britain. Finally, using the logic of hermeneutic explanation (see Chapter 3), the chapter concludes by revealing the consequences of agreements based on an interpretation of actors' perceptions.

7.1 MANIFEST, LATENT AND DYSFUNCTIONAL CONSEQUENCES⁴⁵

7.1.1 *THE MOU WITH SOUTH AFRICA*

The official text of the agreement between the UK and South Africa stipulates four major objectives: 1) consolidation and strengthening of friendly ties and reciprocal understanding between the parties; 2) promotion of mutual knowledge, experience and understanding of their respective human and development needs in the field

⁴⁵ This and the two sections that follow describe actors' interpretations of each agreement, starting with official objectives, continuing with manifest functions and dysfunctional consequences, and concluding with latent functions.

covered by the MoU by means of friendly co-operation between them; 3) enhancement of bilateral relations in respect of public health and health care policy, and; 4) exchange programmes for the officials of each party, and that professionals selected to join the programme have an opportunity to enhance clinical/technical skills and explore best experiences (Department of Health, 2003a). These objectives were also articulated in the interviews with officers in the Department of Health, and in public speeches of the South African Minister of Health and other government officials. Both parties highlighted that the agreement was intended neither to encourage nor limit the cross-border mobility of South African nurses. The Health Director-General in South Africa stated that:

The issue here is not to stop the movement of professionals, but to manage it and to open lines of dialogue between countries (Terreblanche, 2003).

This was also confirmed by a senior official in the Department of Health in England:

The MOU with South Africa was not really about recruitment but about supporting them and exchange. Although we had nurses, who came over on the exchange programme, but it was really rooted in the exchange of information and intelligence (Expert 3, Workforce Capacity, Department of Health, interview date 29.04.2009).

The official status of the MOU was defined as a scheme for the exchange of knowledge and health personnel. The agreement between the UK and South Africa aimed to promote a reciprocal relationship and collaboration in the health sector:

[T]he Parties wish to enhance their bilateral relations in respect of Public Health and Health Care Policy, promoting to the greatest possible extent the mutual knowledge, experience and understanding of their respective human and development needs in the field covered by this Memorandum of Understanding by means of friendly co-operation between them (Department of Health, 2003a).

To stress the mutual benefits of the agreement, government officials from both countries frequently used the following vocabulary: mutuality, reciprocity, co-

operation, development, exchange, assistance and two-way benefits. The South African Health Minister at that time stated that:

the Governments of the Republic of South Africa and United Kingdom are signing this Memorandum of Understanding on the reciprocal educational exchange of healthcare personnel and concepts that are of mutual benefit (Ministry of Health, 2004).

This view was shared by the government officials in the UK:

It [the agreement] was based on the good will and a desire of the two countries to communicate together... It was purely an MOU about sharing skills and expertise between two countries (Expert 2, International Officer, DH, interview date 29.04.2009).

The implementation of these intended objectives of building co-operation between the two countries in health related issues, was reflected in a report prepared in 2008 on the results achieved over the five years since the agreement was signed. During this period, there were a number of bilateral meetings organised between the British Health Protection Agency and its counterpart in South Africa. Discussions were held on joint research into resistance to HIV and TB therapies; developing emergency preparedness in such cases as flu; and health issues in the organisation of international events such as the World Cup and Olympic Games (Department of Health, 2006).

These manifest functions, recognised by the policy-makers in the official policy discourse as intended and fulfilled consequences, were also observed in the statements produced by international organisations. A number of international organisations, such as the WHO, the ILO and the IOM, referred to this bilateral scheme as a model agreement created for co-operation between source and destination countries. For instance, in its monthly Bulletin, the WHO referred to the agreement as:

[A] good role model for managing migration. It provides for exchange programmes to allow South African health professionals to gain experience by working for a specified period in organizations (Nullis-Kapp, 2005).

The IOM recognised that:

Bilateral partnerships between governments of countries of origin and destination, such as reflected in the Memorandum of Understanding between the UK and South Africa which sets the terms for temporary migration of health workers to fill gaps in the UK labour market and provides opportunities for potential migrants to acquire skills that would benefit their home country upon return, can be crucial in reversing the 'brain drain' (International Organization for Migration, 2005a).

In particular, one of the components of the MOU, the twinning scheme between English and South African hospitals, was defined by international experts as a positive exemplar of co-operation between institutions:

[I]n 2005 the Department of Health in Gauteng province, South Africa, developed a scheme that enabled nurses (and others) to have a two year period of work overseas and return to a secure post with no loss of benefits. Such schemes, like the MOUs, offer possibilities for nurses to acquire incomes overseas, return with new skills and experience and not suffer the disadvantages that return migrants have suffered in some other contexts (Connell, 2007).

Although several positive outcomes of the agreement were praised at the national and international levels, a number of dysfunctional consequences were recognised by policy-makers in its implementation. In particular, the challenges of implementation were observed in relation to the management and organisation of the personnel exchange programme between the two countries. As summarised by government officials in the DH (England), the British employers were concerned with the organisational and financial costs of such exchange projects:

People may have thought that it was a good idea but King's Trust put a huge amount of time and effort into making colleagues feel welcome and putting a lot of support for them. As a result, many Trusts were very worried of taking anymore groups because it was actually a lot of work to do it (Expert 2, International Officer, DH, interview date 29.04.2009).

...all of these require a lot of organisation and you can't just sort of do it as a part of your daily job. This needs a lot of programme

management to involve all the stakeholders, the educators, the recruiters, the employers, the individual staff, their families. And I think the model [of bilateral labour agreements] is yet to be improved to be put in practice. And probably could not be managed at the level above the employer. It required two motivated employers [hospitals]: one in South Africa and the other in England, where there is a twinning and common interest where they have other connections like the research, management exchanges – so quite a lot of bindings together, it is a part of the deeper connection, because without that - it is very difficult to impose from above (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

One of the factors which slowed down the collaboration between South Africa and the UK was associated with the different organisational potential of the two countries. As mentioned by one of the government officials in the DH (England):

The downside was that it was labour intensive because different countries have different ways of operating. In some countries, the processes will happen reasonably and smoothly and in other countries, things can take different periods of time ... infrastructure in South Africa is a little slower and things sometimes get a long time to get up and running (Expert 2, International Officer, DH, interview date 29.04.2009).

Apart from these dysfunctional consequences, policy-makers in the interviews referred to a number of latent functions: consequences which they recognised as fulfilled intentions, but which did not feature in the official policy discourse. As stated by one of the British officials in the interview, the agreement became an instrument which gained credentials for both governments. For South Africa, the agreement was a tool demonstrating the success of attempts by government officials to lobby the British Government, as in the early 2000s the UK was one of the key destination countries actively recruiting foreign health workers. The DH official stated:

South Africa wanted, for political reasons, to be able to say that now they have this formal agreement with the UK which set up what they do and what we do (Expert 11, Global Affairs, Department of Health, interview date 06.05.2009).

Moreover, from the perspective of the British officials, the South African Government used the MOU, which allowed for the time-limited placement of South African nurses in Britain, as a tool to balance the interests of individual health workers who wanted overseas work experience and the needs of the public health care system to keep health workers in the country. As expressed below, the agreement was used as a retention mechanism:

South Africa ...we went to see them in 2000-2001, they stated very clearly that they did not want international recruitment. But then they at the later date felt that overseas opportunities could be a retention factor and so their position slightly changed (Expert 2, International Officer, DH, interview date 29.04.2009)

Latent functions of these negotiations were spotted not only by British policy-makers but also by those political actors who were not involved in the design and conclusion of agreements but became active participants in the debate around international nurse recruitment. For Britain, this agreement was recognised as a mechanism to advertise, rather than implement, the ethical recruitment policy. As expressed by a policy analyst:

...they [MoU] do not create any legal obligations on the parties, which means no sanctions, no ability to And it [agreement] does not appear to be underpinned by any form of appeal process. It does not have a form of the legal instrument at all. They are simply general principles. Their format is not legal anyway. It would not be in a form of international treaty even any kind of convention which would have these provisions for appeal. So I think that it is very typical for the UK reaction to these issues. They would be extremely avoidant to legal binding agreements (Expert 15, OECD consultant, interview date 12.05.2009).

To sum up, the manifest function of the MOU between the UK and South Africa was defined as the establishment of the framework agreement, which set up a dialogue between the two countries, and promoted partnership and co-operation. In relation to implementation of this agreement, a number of positive results were achieved. Regular meetings were held between government officials from the two countries, and collaborative relations were established between South African

partners and the British National Institute for Clinical Excellence and Health Protection Agency. However, policy-makers identified dysfunctional consequences, in the form of challenges in the implementation of some of the components of this bilateral scheme, such as the health personnel exchange programme.

Some latent consequences of the agreement were expressed in the interviews with policy-makers and other actors, in relation to political benefits for both governments. For the South African Government, the MOU was a tool to raise its political prestige in the international arena, as the conclusion of bilateral agreements with destination countries is rare. Moreover, negotiation of the agreement with the UK protected the South African Government against criticisms at the national level about the ban on international recruitment, which was previously discussed by the government as a measure to stop the outflow of health workers.

For the UK, negotiation of the agreement with a source country like South Africa helped to advertise its ethical recruitment policy in the international recruitment of health workers.

7.1.2 THE ANGLO-SPANISH AGREEMENT

As stated in the official documents, the objective of the Anglo-Spanish agreement was to recruit nurses from Spain. The policy-makers involved in the design and negotiation of the Spanish agreement declared that it had a clear labour market target, to fill the gap in the British health workforce by bringing nurses from Spain:

A historic agreement was signed today with the Spanish Government to recruit up to 5,000 highly trained Spanish nurses to the NHS to help plug short term staff shortages (Department of Health, 2000b).

On a broader scale, the agreement aimed to improve collaboration between the two countries on a number of issues in the health care service. Taking into account the Spanish expertise in running public-private partnerships in the health sector, the British officials visited a number of Spanish hospitals to deepen their knowledge and observe the practice of the private management of publicly-owned hospitals.

In the public discourse, a number of positive consequences of this agreement were recognised. First of all, policy-makers expressed satisfaction with the agreement, as it brought a few hundred Spanish nurses to Britain. Second, the agreement was seen by the British Government as a helpful instrument in setting up a formal process and supervising the recruitment of Spanish nurses, as no similar practice previously existed:

Moreover, the signing of official agreement was an important mechanism formalising recruitment process between countries where there was no such practice before (Expert 4, International Recruitment Team, Department of Health, interview date 17.02.2009).

The agreement was perceived as a tool which centralised a recruitment campaign and provided secure and beneficial conditions for both British employers and Spanish nurses:

...it is no longer necessary to contract with commercial recruitment agencies in order to source healthcare professionals from Spain. Apart from the obvious advantages of these arrangements in terms of quality and standards, there is of course no placement fee for recruiting staff from Spain through this initiative (Dwight, 2001).

Finally, the function of the agreement was recognised as a demonstration of how recruitment between two countries should be done, in an ethical and efficient way:

Spain was a pilot and big exemplar of how things could be implemented. In the case of Spain, with no visas and with automatic registration, as well as cheap air travel to and from Spain, I think our system was ethical, quality assured and efficient (Expert 4, International Recruitment Officer, Department of Health, interview date 17.02.2009).

Policy-makers perceived the manifest consequences of the agreement as bringing a new labour force to the British labour market and strengthening collaboration between the two countries. They perceived the latent function of the

agreement as demonstrating the efforts of high-ranking politicians to tackle national problems in both countries. This perception is reflected in the two following quotes from interviews with DH officials:

The reason to reach an agreement with Spain was that the Ministries of Health met and negotiated on a wider scale of the issues (Expert 4, International Recruitment Officer, Department of Health, interview date 17.02.2009).

From Spain's perspective, they were sorting out unemployment, from our perspective to staff health care posts with Spanish doctors and nurses. And it [Spain] did not have complications of being a country outside the EU and not being a developing country where we were keen not to recruit (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

As seen from the above quote from the interview with one of the DH officials, for the Spanish Government this agreement was a mechanism to resolve the national problems of unemployment of newly graduated nurses. For British policy-makers, recruitment from Spain became a secure way to cover the undersupply of health workers with nurses from Spain, a developed country where recruitment was less likely to provoke accusations of contributing to 'brain drain'.

Policy-makers, as well as other actors, also identified the dysfunctional consequences of this agreement. About 1,300 nurses were actually recruited, which was approximately five times fewer nurses than the initial plan of 5,000. There were a number of problems identified which made recruitment from Spain a less straightforward task than was expected. First, despite freedom of movement for European nurses within the EU, the implementation of this agreement required significant financial, organisational and administrative investments. Compared to traditional country-suppliers such as India and the Philippines, the infrastructure for the recruitment of Spanish nurses was underdeveloped as there was no prior outflow of Spanish nurses to Britain.

Now with Spain it was a complete 'cold' start. There was not a flow of people coming to the UK and therefore, we needed to learn much about each other. We have not quite a history of a relationship, which

we had with India where health and education system design was very similar to the UK. In a way we were kick-starting it from the national level. We had money nationally to invest in organising all of that with Spain (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

Therefore, to achieve the recruitment target of 5,000 nurses, the British Government provided administrative, organisational and financial support for the recruitment campaign in Spain, which was at that time a new country-supplier in the global nurse labour market. However, as mentioned above, the initial target was not achieved. Fewer than 1,300 nurses were recruited. Moreover, some nurses left before their employment contracts expired. Some of the British practitioners involved in the recruitment of Spanish nurses explained that this drop-out resulted from the problems Spanish nurses experienced with English and integration (see below in this section).

The outcome of fewer nurses being recruited than expected was concerns about ‘value for money’ among DH officials and international recruitment co-ordinators in Britain:

In general, there were about 1,000 nurses recruited and 60 GPs and hospital consultants. It was definitely not about the profit, but about good practice (Expert 4, International Recruitment Team, Department of Health, interview date 17.02.2009).

A sense of unease was also expressed about a mismatch between employers’ expectations, and the professional experience and skills of Spanish recruits. The government officials recognised that the English language skills of nurses were not sufficient to fulfil their professional duties:

I think that the Spanish agreement certainly brought over many hundreds of nurses if not...more than a thousand. But the big issue there was English language skills of the nurses. English language skills sometimes were not simply high enough (Expert 3, Senior Official, Workforce Capacity, Department of Health, interview date 29.04.2009).

Concerns about the insufficient language skills of Spanish nurses, problems with integration and differences in training programmes were also reported by local

recruitment co-ordinators and NHS staff involved in the recruitment of Spanish nurses.

...the recruitment process went not that easy. Yes, the immigration status of nurses from Spain allowed them to come to UK 'quicker' than nurses from India or African countries. But the problems started upon their arrival, namely with integration, language and actual medical practice. Training programmes are not similar, differences in terminology, drugs' names and etc. (Expert 12, Local Co-ordinator in International Recruitment, interview date 26.01.2009).

At that point we were looking specifically for experienced nurses who had acute former experience and when we came back, we came back only with two nurses and those two nurses did not fit our specification. So we no longer went to Spain. That was 2003. It was part of the government-to-government agreement... There was a lot of newly qualified nurses with no experience. We met only 2 nurses with some clinical experience. The main issue we had was language. Only some nurses had very basic communication skills. A majority have no virtual communication skills. Even of the basic yes and no. We went there only once (Expert 7, Senior Nurse, NHS Trust, interview date 18.05.2009).

British employers were looking to recruit personnel for at least medium term contracts, however, many nurses left before their contract expired; some of them only a few months after their arrival.

There was a feeling that European nurses were easier to recruit. But there was no clear understanding that nurses were not staying for a long time. Their intention was to learn English (Expert 13, Project Co-ordinator 'Oversees Professionals into Practice', interview date 17.03.2009).

I understand that the agreement with Spain is a bit of a failure because people did not stay (Expert 9, Scholar involved in evaluation of the international recruitment initiatives, interview date 30.04.2009).

Moreover, the automatic recognition of qualifications within the EU was questioned by recruitment officers and policy-makers in Britain, as the practice of recruiting Spanish nurses revealed that there were educational and organisational differences in the nursing profession between the two countries:

For developed countries, there is a free market, which is too free. There is an automatic recognition of qualification, which I think is overly risky. Just because you are in the EU, the assumption is that you have the training and education which is similar and that the nurse could start without any conversion is being too risky (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

As noted by one of the interviewees, recruitment from Spain was more challenging than recruitment from nurse labour exporting countries such as India and the Philippines, where the education programmes are similar and English is an official language (see Section 7.1).

The challenges of the Anglo-Spanish government-led recruitment project reinforced the practice of some NHS Trusts to use private agencies in international nurse recruitment. As stated by a local co-ordinator in international recruitment:

Compared to private agencies, the government-to-government agreements are much less efficient because it is a public scheme, non-profit programme while private agencies are interested in profit and work for the result. MOU requires many efforts. MOUs are ambitious documents, time and money consuming procedures (Expert 12, Local Co-ordinator in International Recruitment, interview date 26.01.2009).

In addition to such critical comments on the technicalities of the recruitment process, concerns were expressed about the recruitment of Spanish nurses by the Spanish stakeholders, such the Spanish Nursing Association (SATSE) and the General Council of Nursing Colleges (GCNC):

José Martos, general secretary of the SATSE organisation, accused Villalobos of “sorting out problems of foreign countries when Spain doesn’t fulfil the nurses [patient] ratios recommended by the WHO” (Bosch, 2000).

These concerns were supported by the General Secretary of the Confederacion Nacional de Sindicatos Medicos, when the possibility for recruitment of Spanish doctors was discussed between government officials:

[D]ue to a complete absence of health planning by the ministry, the possibility remains that in the future doctors are exported to the UK who are actually necessary here in the public sector (Carlos Amaya, General Secretary of the Confederación Nacional de Sindicatos Médicos, cited in Bosch, 2000).

On the British side, the RCN, the British nursing professional organisation, reacted quite positively to the recruitment campaign in Spain. However, it criticised the growing dependency of the NHS on a foreign health workforce in general:

The government's recruitment campaign [with Spain] is a good start, but we have to remember that there are 17,000 vacancies. We can't fill these simply by recruiting in the UK (Spokesman for the Royal College of Nursing, cited in BBC News, 2000)

To summarise, in the beginning, the idea of recruiting nurses from Spain was positively accepted by policy-makers and stakeholders for a number of reasons. First, Spain was a developed country and therefore accusations of encouraging the 'brain drain' problem were less likely to emerge. Second, due to the right of EU citizens to freedom of movement, it was expected that recruitment from Spain would be an easier option than recruitment from countries where nurses would have to fulfil immigration requirements in order to working Britain. However, the technical implementation of the agreement raised many questions about the future prospects of similar recruitment projects. In practical terms, the agreement did not bring as many nurses as expected. Despite the dysfunctional elements in the recruitment itself, the negotiation of the agreement came to be seen as an exemplary model in the policy discourse of the international recruitment of health workers. This is because it was perceived to demonstrate fair and ethical recruitment from another developed country rather than from poor regions of the world.

The latent function of the agreement, as recognised by the policy-makers in the interviews, was to show that politicians were making efforts to tackle the national problems in both countries.

7.1.3 AGREEMENTS WITH THE PHILIPPINES AND INDIA

The text of the recruitment agreement with the Philippines, negotiated in 2002, stated that ‘the parties agree to facilitate the recruitment and promote employment opportunities of Filipino health professionals’ (Recruitment Agreement between the Government of the Philippines and the Government of the United Kingdom of Great Britain and Northern Ireland, 2002, n.p.). This intention was reinforced a year later in another agreement: the MOU between the Philippines and the UK. However, this time, in response to multiple complaints about the violation of labour rights of Filipino nurses in the UK, the agreement had a rather moderate formulation and placed emphasis on the expansion of bilateral relations; the exchange of knowledge and expertise; and the recognition of opportunities for Filipino health workers to enhance their skills in British health care institutions. The text of this MOU stated:

...to continue the recruitment project with a view to sustainable recruitment and employment of nurses...to intensify exchanges of policy thinking with regard to nursing workforce developments and best practice in the delivery of healthcare (Department of Health, 2003c, n. p.).

As for the agreement with India, although there was no written document, the objectives of the agreement were openly stated by British Government officials in press releases and policy documents. For instance, the DH information letter distributed through the NHS Career web-site stated that:

The Department of Health in England is looking for suitably qualified general and mental health qualified nurses who wish to work in the National Health Service (NHS) in the United Kingdom. Interviews will be held in Bangalore and New Delhi in March/April 2004 followed by a possible Autumn Campaign in November 2004 (NHS Careers, 2004).

In both the interviews with policy-makers and the policy documents reviewed, the agreements with India and the Philippines were referred to as recruitment schemes (Buchan, 2003; Department of Health, 2004a; International Organisation for

Migration, 2004b). However, contrary to the Anglo-Spanish project, the agreements with India and the Philippines were not about the organisation of centralised government-led recruitment. The manifest functions of these agreements were acknowledged by policy-makers as follows. First, these agreements were about ‘opening up gates to existing suppliers and giving messages to the countries overproducing nurses, countries with similar training systems, English-speaking countries’ (Expert 1, Human Resources, Department of Health, interview date 06.04.2009). As recognised by the government officials in the DH and reported in the press, the agreement with the Philippines, in particular, secured the continuity of international recruitment practiced by British health care institutions since the 1990s.

...a memorandum of understanding - was signed this past August thereby putting an official seal of approval on the migration of Filipino nurses to the U.K. Bautista explained that the exodus of nurses is not considered a problem in the Philippines because the country currently harbours a surplus. He added that this was a ‘win-win situation’ for the two countries (Ching, 2005).

In contrast to the agreement with the Philippines, which was negotiated to sustain recruitment, the Indian agreement was intended to encourage the recruitment of Indian nurses, as few were coming to Britain at the time:

meetings with the Indian Minister and government officials [were organised] to get their opinion whether they were happy for us to recruit Indian nurses which of course some hospitals were already doing but it was a sort of piecemeal bilateral basis (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

The second manifest function of both agreements recognised by policy-makers was to set a framework for ethical recruitment and establish communication channels for monitoring preferences of these source counties in the international recruitment of nurses. As stated by a DH official, both agreements attempted to ensure

compliance of recruiting organisations with ethical standards in the recruitment of health workers from abroad.

...and we were very worried of exploitation of nurses because there was a bad practice going on where nurses were charged huge amounts of money. Their passports were confiscated and we felt that we need to step in and encourage a more organised process for them (Expert 3, Senior Official, Workforce Capacity, Department of Health, interview date 29.04.2009).

It was purely to make sure that the UK and Philippines follow the ethical process and there's no underhand recruitment happening and that all was properly organised, making sure that nurses were save (Expert 14, Recruitment Co-ordinator in the Philippines, interview date 31.03.2009).

And as stated above, both agreements were used as instruments to open channels of communication and monitor the international discourse around recruitment and changing priorities at the national level in source countries.

I used to meet with the [Filipino] ambassador in London about 2-3 times a year and he was saying how was it going and if there are areas that you would like us to train nurses. [For instance], there was a situation with criticism of the European employers stealing Filipino nurses. The ambassador contacted me the next day saying that '... we don't think that you are stealing our nurses. It is good for our nurses, it is good for the economy' (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

The latent function of the agreements recognised by policy-makers in the interviews was the diversion of active recruitment from sub-Saharan Africa to labour exporting countries in Asia, such as India and the Philippines:

They [the agreements] were successful and an integral part of the ethical recruitment process because they pointed would-be recruiters away from sources like South Africa (Expert 4, International Recruitment Officer, Department of Health, interview date 17.02.2009).

If you look at the numbers coming through the NMC register you will see that there was a big increase in numbers of nurses coming from the Philippines and India. Those two routes were both stimulated by the work that was done in that kind of agreement (Expert 3, Senior Official, Workforce Capacity, Department of Health, interview date 29.04.2009).

In an attempt to reveal the dysfunctional components of these agreements, I asked policy-makers and other actors involved in the international recruitment from India and the Philippines to reflect on the performance of these two bilateral schemes. Their responses did not point to the dysfunction, but rather exposed a positive perception of the agreements in both quantitative (the number of recruits) and qualitative (the quality of recruits) terms.

In respect of the numbers of recruits, the agreement with the Philippines was recognised by policy-makers and stakeholders as the most successful:

The Philippines was the most successful agreement in terms of the number of recruits (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

According to data from the NMC register, the number of nurses recruited from the Philippines between 2001 and 2005 was 19,687, compared to 9,587 from India during the same period and 1,300 from Spain during a slightly longer period⁴⁶.

Local recruitment co-ordinators involved in the recruitment also recognised the higher quality of the Filipino and Indian nurses when judged against recruits from other countries.

The most effective recruitment in terms of applicants' language sufficiency has happened from India and Philippines because they have studied at home in English (Expert 12, Local Co-ordinator in International Recruitment, interview date 26.01.2009).

⁴⁶ Data on the number of Spanish nurse recruits to Britain was obtained from the interview with the Local Recruitment Co-ordinator and corresponds to the period 2001-2007.

In sum, the analysis presented in the three preceding sections has identified the manifest and latent functions specific to each agreement, as well as dysfunctional consequences of these policy tools (see Table 11).

The manifest functions identified were: the maintenance of recruitment in the Philippines; the encouragement of recruitment in India; the encouragement, organisation and technical support of recruitment in Spain; and the exchange of personnel and knowledge in South Africa.

The latent functions detected were: the fulfilment of government interests for both countries in the case of the South African agreement and the Anglo-Spanish recruitment project; and in the case of the agreements with India and the Philippines, the diversion of recruitment practices from source countries whose governments did not support the outflow of health workers (such as South Africa) to traditional labour exporters.

Two dysfunctional elements of the agreements were identified. In the MOU with South Africa, problems with setting up the health personnel exchange scheme between the two countries were recognised. As for the Anglo-Spanish project, the original recruitment target was not met and substantial financial and organisational investments were required. In the case of the agreements with the Philippines and India, no dysfunctional elements were identified. This is perhaps because the agreements were general framework schemes rather than projects with specific organisational components such as setting up personnel exchanges or fulfilling recruitment targets.

The analysis of functions in the following sections takes a broader perspective, looking across the four cases to reveal generic and aggregate functions of the agreements as a component of the ethical recruitment policy.

Table 11 Agreement-specific functions in actors' perceptions

	Manifest function	Latent function	Dysfunction
MOU with South Africa	Exchange of health personnel, knowledge and best practices	Political interests of governments in both countries to show their efforts in addressing national problems	Problems in implementation of the personnel exchange programme
Anglo-Spanish recruitment project	Encouragement, organisation and technical support for recruitment		Fewer recruits than expected; high recruitment costs of the government-led campaign
Agreements with the Philippines and India	Recruitment encouragement (India) and sustaining (the Philippines)	Divert recruitment from developing countries in sub-Saharan Africa	Not identified

7.2 THE ROLE OF AGREEMENTS

7.2.1 CROSS-CUTTING FUNCTIONS

In 2004, by which time all four agreements were concluded, their manifest generic consequences (functions) were recorded in the revised version of the Code of Practice for the International Recruitment of Healthcare professionals. It stated that:

...intergovernmental agreements have been created to offer benefits to all participating countries and support ethical standards in the recruitment of international healthcare professionals. These agreements also support the professional development of all healthcare professionals through the exchange of knowledge and skills (Department of Health, 2004a, p.14).

Analysis of the elite interviews revealed that both policy-makers and a group of political actors involved in the debate on international nurse recruitment also referred to the generic functions of agreements, presenting them as the components of the ethical recruitment policy. This observation stimulated further analysis of the cross-cutting functions of agreements as a consistent, unified policy rather than individual

policy tools. These functions were identified, based on the terms actors used in their interpretations of the implementation and performance of the agreements. Identified terms were categorised into six groups: model example, communication, collaboration, regulation of recruitment, protection of institutional reputation and simulation of activity.

The categories of *model exemplar*, *collaboration*, *communication and regulation (putting in order and stimulation)* were identified as cross-cutting manifest functions, which were recognised by policy-makers in the official policy discourse as intended and fulfilled. *Protection of the international reputation, regulation (diversion) and simulation of activity* were classified here as cross-cutting latent functions as they were not expressed in the official policy discourse but emerged in the interviews with policy-makers and other policy actors involved in debate on the international recruitment of nurses in the UK.

The cross-cutting manifest function of these negotiated agreements was to present a model in bilateral relations between countries on the matter of the cross-border mobility of nurses. The function of collaboration between countries was explicitly articulated by policy-makers in the official documentation as their fulfilled intention. Agreements were used as a tool to establish a reciprocal relationship based on mutuality of benefits and interests:

It is an instrument to enable both countries to come together and identify areas of key interest (Expert 2, International Officer, DH, interview date 29.04.2009).

The key terms used by interviewees to characterise collaboration were: *'exchange and co-operation around health care issues'*, *'exchange of staff'*, *'share skills and expertise'*, *'good working relationship'*, *'working together'* and *'come together'*. As seen from this range of terms, *collaboration* was understood by government officials in a broad sense as a good working relationship based on mutual assistance; learning from each other; sharing information about recruitment opportunities and changing national priorities in international recruitment; and the exchange of personnel, skills and expertise. This was summarised by one of the officials in the DH who was involved in the negotiation of these agreements:

...certainly back in 2000 and 2002 there were a number of agreements with countries which covered the exchange and co-operation around health care issues (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

The function of agreements as tools of *communication* was used to improve understanding across borders; to listen to, recognise and respect other countries' positions in international recruitment.

It was important to speak to countries directly, establish the facts and hence develop a good working relationship...bilateral agreements, if you are actively recruiting in someone's else country, are useful, as two countries come together and take a decision of whether it is appropriate or not ...and we believe it is – to set up a framework strategy that is fair and beneficial to everyone participating (Expert 2, International Officer, DH, interview date 29.04.2009).

As tools of *communication*, the government-to-government agreements 'gave signals' to political actors (government officials in Britain and source countries, employers, professional organisations and trade unions) about recruitment opportunities and the preferences of source countries in recruitment.

The *regulatory function* of the government-to-government agreements was expressed by policy-makers in the broad sense of regulation which not only restricts, but also activates, manages and diverts international recruitment, depending on the national circumstances in donor and recipient countries. The empirical data illustrated that the *regulatory functions* of agreements included stimulation, management (putting in order) and diversion of recruitment practices according to the policy context and labour market conditions. Moreover, it is important to mention that policy-makers often avoided the term 'restrict', instead using 'manage', 'putting in order' and 'not targeting'. The following quotes from the interviews with the policy-makers in the Department of Health illustrate the usage of these terms:

To some extent, agreements were giving a bit of organisation and profile and encouragement to a labour market (Expert 1, Former

Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

First of all, we had a policy of not targeting the Sub-Saharan Africa. Also we worked with recruitment agencies to ensure that they comply with the policy of ethical recruitment. We signed an agreement with South Africa which included a wide range of issues in health policy including co-operation, personnel exchange programmes and ethical recruitment (Expert 4, International Recruitment Officer, Department of Health, interview date 17.02.2009).

The types of regulation named by policy-makers as stimulation and management of recruitment were recognised in the official policy discourse. However, regulation (diversion) as a consequence of the agreements was not expressed in the official policy discourse but appeared in the personal communication with policy-makers. Therefore, regulation (diversion) as one of the consequences of agreements was classified among latent functions. Apart from this, other latent functions, which were not explicitly expressed in the official discourse but were identified by the political actors in the interviews, included *image protection and activity simulation*.

The conclusion of agreements was used as a mechanism to mitigate criticisms of targeted recruitment campaigns in developing countries and to *promote the image* of the NHS as a global ethical employer. As mentioned above, this function was neither documented nor recorded, however, it was expressed in the interviews by a few policy-makers and political actors involved in the policy field of the international recruitment and migration of health workers:

The UK did not want to have a bad image. It was always to present the model. It is a view of not wanting to be seen to be doing wrong (Expert 9, Scholar involved in evaluation of international recruitment initiatives, interview date 30.04.2009).

Simulation of activity, rather than a response to actual problems of international recruitment, was seen as another latent function of agreements, as a generic policy. Reference to the symbolic consequences of agreements was made by one of the DH officials:

And we did sign the agreement ...that helped politicians to show that they were making efforts (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

Another reference to the symbolic consequences of agreements was made by the OECD consultant, who was involved in the evaluation report prepared for the OECD about the bilateral agreements in Britain. He defined the status of agreements as soft law tools with no legal power, and limited potential in enforcement and implementation:

They have no status. They are nothing more than informal agreements where parties agree to be bound by general principles in MOU. It does not have a form of the legal instrument at all. They are simply general principles (Expert 15, OECD Consultant, interview date 12.05.2009).

Furthermore, the symbolic nature of agreements became apparent in one interviewee's statements about the role of agreements as tools of international etiquette:

That is the nature of international relations. Countries like to do agreements with each other, politicians like to shake hands signing the agreements (Expert 1, Former Official involved in the international recruitment of health personnel, Human Resources, Department of Health, interview date 06.04.2009).

Other references to *activity simulation* in the interviews were mainly linked to critical comments about the weak points of agreements, such as their being time consuming, labour intensive, less efficient than services provided by private agencies, bureaucratic and poorly monitored:

Talking about the MOU, nobody did really have time for its proper implementation. Compared to private agencies, MOU are much less efficient because it is a public scheme, non-profit programme while private agencies are interested in profit and work for the result. MOU requires many efforts. MOUs are ambitious documents, time and money consuming procedures. But not really working instruments. Moreover, the negotiation of the MOUs is pretty much a matter of low-level politics. It is dependent too much on personal perceptions and

individual decisions (Expert 12, Local Co-ordinator in International Recruitment, interview date 26.01.2009).

In theory, these agreements are about good relationships with other countries. They intend to standardise the recruitment process and illuminate corruption. But in practice they are invalid. They do not work better than private agencies. In a way, they implement only half of the necessary functions. They don't back up the service. No monitoring (Expert 12, Local Co-ordinator in International Recruitment, interview date 26.01.2009)

7.2.2 AGGREGATE FUNCTION

The final section of this chapter discusses those functions that were not recognised by either policy-makers or other political actors in the debate and practice around the recruitment of foreign nurses. This type of latent function emerged in the researcher's interpretation of policy actors' perspectives, analysed in the context of the international recruitment of health workers in the early 2000s. The manifest and latent functions identified by actors, which were introduced in the previous sections, became a resource for the researcher's interpretation of the role of agreements and its implications at the policy level.

Once the functions of agreements had been identified as giving a model example, collaboration, communication, regulation, image protection and activity simulation, the following questions were posed: What do these functions, as a whole, mean for the British policy in the recruitment of foreign nurses? How do these functions respond to the conflicting interests of actors and the human rights dilemma, which in the early 2000s became a common reference in the policy discourse on international nurse migration? To address these questions, I discuss the functions identified by actors in the framework of conclusions developed in Chapter 6, which analysed how international nurse recruitment was problematised by actors at the international and national levels, and how agreements originated in the context of conflicting claims and the policy discourse of human rights and ethics.

To begin with, I return to the earlier stated argument that the negotiation of bilateral labour agreements between the UK and source countries was a holistic

policy, which the British Government undertook in the early 2000s to demonstrate its commitment to ethical principles in the foreign policy, where the recruitment of foreign nurses became one of its dimensions. This important argument of my thesis indicates that functional analysis of each individual agreement is valuable but not sufficient. Detecting what Merton referred to as the aggregate of consequences, is vital to understanding the role of agreements in the British policy for the recruitment of foreign nurses (Merton, 1949).

In the early 2000s, the British Government, on the one hand, needed to continue international recruitment in order to fill vacancies in the NHS, as the results of domestic policies such as retention and an increase in student intakes were yet to be seen. On the other hand, following the commitment of the New Labour Government to ethical foreign policy, it was also important to avoid accusations from the international community of targeted recruitment of nurses from abroad. The adoption of the ethical recruitment policy allowed the British Government to achieve both of these goals, by legitimisation of the recruitment practice through adherence to ethical policy. Bilateral labour agreements, along with the Code of Practice, became the tools of implementation of this ethical recruitment policy. The role of bilateral agreements was to contain the contradicting interests between and within political actors in the international recruitment of health workers, in particular to satisfy and monitor the diverse and changing preferences and demands of the source countries such as South Africa, Spain, India and the Philippines. The British Government used bilateral agreements as instruments to establish collaboration and communication with source countries and, based on the exchange of positions and preferences in the international recruitment regulate the process. Moreover, the agreements sustained the image of Britain in the international area as a destination country which adhered to ethical principles in international recruitment, and recognised and promoted human rights at the national level (see Table 12).

Table 12 Aggregate and cross-cutting functions of agreements

Legitimisation							
Manifest				Latent			
Model example	Collaboration	Communication	Regulation		Regulation	Protection of the institutional reputation	Activity simulation ;symbolic
			<i>Putting in order</i>	<i>Stimulation</i>	<i>Diversion</i>		

To sum up, the manifest and latent functions identified by actors contributed to the implementation of the aggregate function of these agreements, which was identified in this study as ‘legitimisation in order to continue’ the international recruitment of nurses in the context of conflicting claims made by many political actors.

CONCLUSION

This chapter has discussed how actors perceived the performance of agreements by using Merton’s distinction between manifest and latent functions, and dysfunctional consequences. Using these categories as a conceptual framework, this chapter first identified the specific and cross-cutting manifest and latent functions of agreements, as well as their dysfunctional components. Based on these groups of functions, the aggregate function of agreements (their role) was interpreted as the legitimisation of international recruitment in the policy context of conflicting interests between and within institutional actors.

The fulfilment of this role became an aggregate of both manifest functions, in terms of setting a model for ethical recruitment, establishing communication, developing collaboration with the governments of the source countries, regulating the volume and the pace of the recruitment depending on the source countries’ requests; and latent functions, in terms of diversion of recruitment, activity simulation and image protection.

This conclusion suggests two themes for further discussion and research (see Chapter 8, section 8.4). The first is the kind of tools the government uses to legitimise its actions, and how a combination of the manifest and latent outcomes

contributes to the legitimisation of its actions. Second, the analysis presented in this thesis identified the transformation of bilateral labour agreements from mainly labour recruitment tools which facilitate recruitment, to ethical instruments which legitimise recruitment. This observation poses a second question: what is the future of these policy tools in the regulation of cross-border labour mobility?

Chapter 8, the final chapter of this thesis, is dedicated to a summary of the key findings and a discussion of the contributions of this study as well as and proposes prospects for further research.

8. DISCUSSION AND CONCLUSION

INTRODUCTION

This final chapter summarises the key findings of this thesis and discusses their relevance to the contemporary policy discourse, and their theoretical and methodological contributions.

The chapter begins with a summary of the findings of this research. It outlines what types of agreements were identified in this study; how they originated; and what their functions were. Inquiry into these questions concludes by revealing the role of agreements in the British policy for the recruitment of foreign nurses in the early 2000s.

The second part of this chapter presents the relevance of this research to current policy discussion about the changing role of agreements and their future prospects.

The chapter then turns to a discussion of the theoretical and methodological value of this research. It reveals the theoretical contribution of this study to the policy tools approach, in particular by refining Linder and Peters' model that explains the selection of policy tools. The potential of the manifest-latent terminology, when applied in the methodology of interpretative study to conceptualise actors' interpretations, is also proposed.

Finally, the chapter concludes by drawing attention to a number of themes, which emerged in this study but were not developed, and therefore could be addressed in future research.

8.1 SUMMARY OF FINDINGS

As stated earlier, this thesis argues that to understand the role of agreements in the British policy for the recruitment of foreign nurses, a number of questions should be investigated: what types of agreements were negotiated, in what policy context did they originate, and what functions did they perform? Following this logic, the present study analysed bilateral labour agreements through the prism of

three dimensions: types of agreements, the policy context of their origin and their functions.

8.1.1 TYPES OF AGREEMENTS

To begin with, two criteria were applied to reveal the types of bilateral labour agreements negotiated by the British Government in the early 2000s. First, depending on their content, agreements were distinguished between recruitment agreements (Spain, India and the Philippines) and co-operation programmes (South Africa). Second, according to the type of formalisation, agreements were categorised as legally binding contracts, MOUs and informal (verbal) agreements. A combination of two criteria, content and form, produced the following categories: 1) legally binding recruitment contract; 2) MOU and informal agreement permitting recruitment; and 3) MOU about co-operation and personnel exchange.

The legally binding recruitment contract specified the number of recruits, and the terms and conditions of their employment. This type of agreement was signed with Spain to organise a centralised government-led recruitment campaign where the government bodies were directly involved in recruiting Spanish nurses.

The second type of bilateral agreement is the MOU and the informal agreement, which permit and acknowledge recruitment in the source country. Such agreements were negotiated with the Philippines and India, respectively. Contrary to the legally binding recruitment project, which organised a centralised government-led recruitment campaign, these agreements were negotiated to set up a framework and inform the relevant stakeholders about opportunities and conditions on which recruitment in source countries was eligible.

The last type of the bilateral labour agreement identified in this study is an MOU, which was not principally about recruitment, but rather the establishment of channels for co-operation and exchange of knowledge and health personnel between two countries. This was the type of agreement signed with South Africa.

Identification of these diverse types of agreements contributed to the development of the second question of this thesis, which concerned the origin of these policy tools.

8.1.2 ORIGIN OF AGREEMENTS

To understand the roots of diverse types of agreements, this study described the policy context and detected the political actors involved in the policy discourse on international nurse migration in the early 2000s. In particular, the research identified the key layers in the policy discourse and examined the positions of actors in relation to the recruitment of foreign nurses. Analysis of these components revealed that agreements originated in the discourse of ethical recruitment. This discourse exposed the contradictory interests between and within political actors: source countries, the British Government, international organisations, trade unions, and professional organisations in the UK and the countries of origin. The claims of these political actors were shaped by the agenda of the Millennium Development Goals; expressed in the human rights language; and reinforced by the ethical foreign policy promoted by the New Labour Government in the late 1990s.

The international recruitment of nurses was problematised in the early 2000s as a dilemma of human rights. On the one hand, international recruitment was recognised as a factor undermining the right to health of citizens in developing countries; on the other, the potential restriction on international recruitment was portrayed as a violation of the right to freedom of movement for health workers. There were a number of interplaying layers behind this formulation, including conflicting interests between and within political actors. For instance, some source countries (such as South Africa) criticised active recruitment campaigns organised by employers and agencies from Britain. Conversely, other so-called traditional exporters of health personnel, such as India and the Philippines, were interested in continuing the practice of international recruitment (except from some regions with a critical nurse shortage). The reason for this position of promoting the outflow of nurses was that the remittances sent by health workers working abroad

represented a significant contribution to the national economies of these countries (Buchan, 2003; Stilwell et al., 2004).

Ambivalent positions on international recruitment were expressed by professional organisations and trade unions in both source countries and Britain. Professional organisations and trade unions in source countries supported the right of migrants to freedom of movement and protection from exploitation; in this way, they secured overseas career opportunities for health workers and protected their working conditions abroad. Nonetheless, these organisations became concerned about the constant outflow of skilled workers to developed countries and therefore joined others in criticising the active recruitment strategies of developed countries (including Britain).

Trade unions and professional organisations in Britain also expressed a duality of interests in international recruitment. Whilst they showed solidarity with their counterparts in source countries and in principle supported the right of overseas health workers to work in Britain, they also criticised the heavy reliance of national health care institutions on foreign workers. They pointed out the reasons for this dependency, namely poor remuneration and working conditions which discourages local talent.

International organisations tried to counterbalance this debate, appealing to both groups of rights. Initially prioritising the right to health in source countries, they also acknowledged the rights of health workers to freedom of movement and decent employment conditions abroad.

As for the British Government, it found itself in a policy trap. The New Labour Government needed to continue international recruitment in order to fill the gap in the national workforce and fulfill a commitment to the expansion of public health services by bringing more doctors and nurses into practice (Deeming, 2004). However, it also had to slow down active recruitment from developing countries to stop accusations of 'stealing' health workers.

Such a policy environment, where political actors expressed conflicting arguments in favour of and against the recruitment of foreign nurses, created a space for bilateral labour agreements, which, in fact, had not previously been common practice in the British labour immigration policy.

8.1.3 FUNCTIONS OF AGREEMENTS

The third question in this research addressed the consequences of the agreements. To respond to this question, this study applied the terminology of manifest-latent functions originally developed by Merton. Following the logic of hermeneutic explanation, an analysis of the functions of the agreements was conducted in two stages. First, actors' interpretations of the outcomes of agreements were examined. Second, the researcher's reflection on actors' perceptions and the policy context of foreign nurse recruitment produced interpretations of the meaning of these agreements in the British policy for foreign nurse recruitment.

The manifest functions of agreements, which were recognised by policy-makers as intended and fulfilled, were to set up a model example of collaboration between two countries on the controversial issue of international nurse recruitment; to establish communication channels; and to regulate recruitment based on ethical principles and the preferences of governments in source countries.

The latent functions of these agreements, as recognised from the communications with policy-makers and other political actors presented, were to divert the active recruitment drives from the least developed countries; and to protect the image of the government in both source countries and Britain by demonstrating that the government was taking action to address the problem at a global scale. The aggregate of these manifest and latent functions was formulated by the researcher as legitimisation of the international recruitment in order to continue this practice.

To conclude, investigation into the three areas of types of agreements, their origin and their functions, led to formulation of the central thesis of this study, as follows. The British Government negotiated a number of bilateral labour agreements with source countries on the cross-border mobility of nurses. These agreements were negotiated in different formats, including recruitment projects and health personnel exchange schemes; MOU and legally binding documents; and written and verbal agreements. The various formats of these agreements reflected

the diverse positions of source countries on the recruitment of their nurses. These positions were framed in the language of human rights, and reinforced by the MDGs and the New Labour Government's ethical agenda in foreign policy. To balance the conflicting claims of many stakeholders at both ends of the migratory process, the British Government introduced an ethical recruitment policy, in which the government-to-government agreements became an important component. The role of these agreements was to contain conflicting interests between and within political actors, in order to legitimise the recruitment of foreign nurses in the context of averse publicity about Britain's contribution to the 'brain drain' problem in developing countries.

8.2 THE RELEVANCE TO CONTEMPORARY POLICY DISCOURSE

This section discusses the relevance of the findings of this research to the current policy discourse and its transformations and future prospects. As Chapter 4 demonstrated, a number of policy reports on bilateral agreements have been produced by national bodies and international organisations. The major issue addressed in these reports is the status and prospects of government-to-government agreements in the global labour market, where the vast amount of labour migration is facilitated by private agencies (see Chapter 4). This study contributes to this discussion by tracing how the functions of bilateral agreements have changed since the 1960s; what their current status is; and whether and how these policy tools will perform in the future.

Three major trajectories were observed in the development of bilateral labour agreements over the past 50 years. First, the coverage of agreements has broadened from recruitment of primarily low-skilled workers in the 1960s, to recruitment of skilled labour migrants such as professionals in the health sector and IT in the 1990s. Second, the format of bilateral labour agreements has transformed from primarily legally binding recruitment contracts to the 'soft' voluntary agreements commonly seen today. Finally, the role of agreements as primarily labour recruitment tools has potentially diminished, providing scope for a broader array of functions, such as setting up a policy framework and establishing channels for international

communication and co-operation between countries. As existing policy reports have identified (see Chapter 4), since the 1960s, the functions of agreements have gradually diversified. Agreements have become tools, which reinforce regional integration, establish economic links, strengthen cultural ties, protect the welfare of migrant labour workers, and ensure their return after contracts expire. In addition to this group of functions, this thesis reveals another role of bilateral agreements as components of the ethical recruitment policy, which legitimise the practice of international recruitment and balance a contradictory policy discourse.

These observed changes indicate the diversification of bilateral labour agreements, in terms of both their format and functions. This transformation has led contemporary policy analysts to address the problem of evaluation of such various forms of agreements and to explore their future prospects (see Chapter 4). This study contributes to this policy discussion by examining agreements from the interpretivist perspective. It develops an understanding of the meaning of contemporary bilateral labour agreements in the contentious context of cross-border labour mobility today, which facilitates projections about their future prospects. These projections are discussed and illustrated below with interview data.

First, these agreements will potentially secure their role in international relations as diplomatic instruments promoting good relations between governments.

I think politically they are very significant. That is the nature of international relations. Countries like to do agreements with each other, politicians like to shake hands signing the agreements (expert 1, Human Resources, Department of Health, interview date 06.04.2009).

Second, for the destination country, in this case Britain, the negotiation of bilateral agreements was a temporary measure taken to respond to a particular problem situation. In other words, there was a policy bind, where, on the one hand, the New Labour Government committed itself to expand the NHS by increasing the number of health personnel; but on the other hand, the UK active recruitment, used in the early stages to quickly implement this commitment, was

condemned as ‘stealing’ health workers from poor countries. Since 2005, the need to recruit foreign nurses has declined. This is because the number of the British-trained graduates in nursing has increased, following the policy measures which were taken by the British Government in the early 2000s to improve self-sufficiency in health personnel. Also, financial difficulties in some of the NHS employers led to staff redundancy, and a freeze was put on the costly recruitment of nurses from overseas (Buchan et al., 2006). As recognised by a DH official, these agreements are less likely to be negotiated in the future:

There are those who want to promote bilateral agreements everywhere. To tell the truth, I don't know how feasible that could be because, for example, the UK can't have bilateral agreements of that nature (international recruitment type) with every country which would like one. That is impossible...For us I don't believe that at the moment we will be entering into the new agreements because the need is not there as it was in the short term back in 2000 and 2002. Agreements like Memorandum of Understanding with South Africa, possibly there is a chance that something like that might be replicated. But again how many times can we enter? There is a resource implication in terms of manpower and all the rest of it. That is not to say that we don't collaborate with colleagues in other countries who have requests for information and resources (Expert 2, International Officer, DH, interview date 29.04.2009).

Moreover, it was also noted in one of the DH reports devoted to the evaluation of bilateral co-operation agreements and MoUs, that ‘collaboration can take place with many countries without the benefit of MoU and much does occur outside the MoU even when one is in place’ (Ollier, 2007).

The continuation of bilateral labour agreements, in particular as recruitment schemes, is much in doubt. This is because such types of agreements are costly, and time-consuming, and as a DH official noted, place an administrative burden on the civil services of the countries involved:

...the general approach is that we try to avoid them partly also because of administrative burden on their [source country] civil service and ours [destination country] (Expert 11, Global Affairs, Department of Health, interview date 06.05.2009).

Furthermore, as a tool of labour recruitment, bilateral labour agreements face challenge and competition from the expanding global labour recruitment market, where the dominating role is taken by private agencies. The latter have proven to perform more flexible, adaptive and cost effective strategies, although their high level of competitiveness is often maintained by using ‘grey’ and even illegal practices in recruitment. This poses a more substantial regulatory problem for policy-makers at the national level, of how to monitor and control the activities of such private agencies to ensure their compliance with national and international laws, rather than ‘competing’ with them for foreign labour in the global market using government-to-government agreements.

Alternative measures to bilateral agreements in managing labour migration were seen by some British policy-makers in multilateral tools, such as the WHO Global Code of Practice. Such tools have more potential than bilateral agreements, as they set up an international framework covering more than two countries:

Multilateral action is probably more appropriate. And obviously we are completely involved with the WHO initiatives and it is likely to be a global code of practice or a global set of principles if you like (Expert 2, International Officer, DH, interview date 29.04.2009).

Finally, as stated above, bilateral labour agreements are losing their position in the recruitment business as many private agencies have successfully occupied this niche. However, this does not exclude the possibility of small-scale, temporary recruitment programmes between countries to target specific problems in the short term. If such recruitment programmes are to be introduced then prior to their conclusion, not only should government positions be agreed, but also the needs and expectations of employers in destination countries and recruited personnel in source countries, should be explored.

In respect of this matter, a number of recommendations were developed, based on the actors’ perceptions of the outcomes of bilateral labour agreements. Negotiation of recruitment agreements with a source country requires prior research into a number of dimensions that might facilitate, as well as challenge, their implementation, such as institutional factors, characteristics of recruited

personnel and employers' needs. First, institutional factors, which were described in detail in Chapter 5:

- post-colonial links between source and destination countries, which as practice shows, ensure similarity in educational programmes and the language proficiency of recruited personnel;
- the position of the government in the source country, as well as the perspectives of other relevant political actors such as professional organisations and trade unions;
- existing recruitment infrastructure, organised either centrally by the government of the source country (such as in the Philippines) or by private agencies.

Second, particular attention should be paid to the characteristics of personnel available in the source country for overseas employment. Such characteristics include their qualifications, language proficiency, motivations for taking up jobs overseas, expectations and future career plans. Finally, employers' expectations and needs should be considered to ensure a good match with the recruited personnel from abroad.

8.3 THEORETICAL AND METHODOLOGICAL CONTRIBUTIONS

This section summarises the theoretical and methodological contributions of this research. It first explains how analysis of bilateral agreements advances theoretical discussion developed in the policy tools approach about the selection of policy tools. It then outlines the contribution of this research at the methodological level, discussing the value of the manifest-latent terminology as a tool of data analysis in the interpretative approach.

The selection of bilateral agreements as a subject in the policy tools research, contributed to the policy tools approach in a number of ways. First, it brought up an unexamined area of cross-border policy tools. Second, it explored the selection of policy tools which were uncommon in previous government

practice. Third, this study proposed a number of clarifications to the model developed by Linder and Peters in explanation of the policy tools selection. Finally, this research suggested a methodological frame for the analysis of policy tools consequences, using Merton's manifest-latent terminology. This section will further develop each of these contributions of the study.

To begin with, some researchers on policy tools noted that, until recently, the policy tools approach was predominantly applied to research policy tools in the national setting. Previously, scholars focused mainly on government instruments and the relations between states and citizens (Linder and Peters, 1989; Salmon, 2002; Hood, 2007). Although there is rich literature on the new governance, many areas in relation to policy tools of the new governance are overlooked (Kassim and Le Gales, 2010). This research contributes to this gap by exploring labour agreements: instruments of cross-border operation negotiated between two governments.

Second, this study addressed another gap in the policy tools literature, namely a lack of research on policy tools uncommonly used in government practice. In particular, this research addressed the question of why the British Government selected bilateral labour agreements that were not customary in its previous policy for managing the inflow of the foreign labour. This thesis numerously pointed out that bilateral labour agreements were not typical tools in the British labour immigration policy but appeared in the policy arena during the early 2000s. Their life cycle was short, as by 2009, the government had become quite sceptical about the possibility of using these types of agreements in the future. This research investigated the reasons why these unusual policy tools were selected. This inquiry was based on the theoretical model of Linder and Peters, who proposed a composition of contextual and cognitive factors to explain policy tools selection. From such factors these scholars developed a concept of the problem situation, which became central in this study of bilateral labour agreements as uncommon policy tools introduced by the government. The problem situation in this research was described as conflicting interests between and within political actors, expressed as a human rights dilemma, which created a so-called 'policy trap' for the government. In order to simultaneously avoid this

trap and ensure implementation of its interests, the government introduced bilateral labour agreements. This allowed the British Government to somewhat avert accusations that it was contributing to the ‘brain drain’, and also to continue recruiting from source countries which were, in the expression of one of the DH officials, ‘happy’ to export nurses.

Third, this study contributes to the clarification of Linder and Peters’ model by adding a new dimension for analysis. In their explanation of policy tools selection, these scholars explored the role of perceptions expressed mainly by decision-makers; whereas this study examined the perceptions of a broader group of political actors who were involved in the policy discourse on international nurse migration. Such an approach has considered multiple angles to reach an understanding of how international nurse migration was problematised and perceived by relevant institutional actors. Moreover, examination of these actors’ reflections on bilateral agreements negotiated between the British Government and a number of source countries, contributed to understanding of the multifaceted role of these policy tools.

This latter point about the multifaceted role of bilateral labour agreements leads to a conclusive discussion in this section of the methodological value of the manifest-latent terminology in the study of policy tools on the grounds of an interpretative approach. The rationale for applying Merton’s distinction between manifest and latent functions rests on a number of factors. First, as noted in Chapter 3, a plethora of terms is used by scholars to describe the ‘hidden’ nature of outcomes produced by policy tools. Some of these include: informal and unofficial aims (Cotgrove, 1967); unexpected, unintended and unrecognized consequences (Campbell, 1982); symbolic and mythical politics (Edelman, 1985); hidden dimensions (Kassim and Le Gales, 2010); and underlying assumptions (Schneider and Ingram, 1990). Often scholars refer to these concepts without explaining their meaning or providing a methodology for ‘extracting’ these hidden, symbolic and underlying outcomes from empirical data. To respond to this conceptual proliferation and methodological gap, this study advocated the use of the original concepts of manifest and latent functions and dysfunctional consequences, suggested by Merton. The purpose of doing so was not only to

bring the scholarly language to common grounds but also, and more importantly, to describe the method of analysis, which aims to understand the underlying reality of policy tools consequences.

The manifest-latent terminology became a helpful instrument in the analysis of elite interviews, where policy-makers often presented a 'mixed' account of reflections about the intentions and consequences of their actions. In particular, analysis of actors' interpretations through the prism of manifest and latent functions, dysfunctions and aggregate functions helped to systematise actors' reflections on the bilateral agreements and present sociological accounts of the policy tools consequences.

In addition to this contribution to the analysis of policy tools consequences, it is worth mentioning a number of clarifications that were made to Merton's original distinction between manifest and latent functions when using these terms in a study conducted on interpretative grounds.

Examination of the policy tools functions in the frame of an interpretative approach distinguished between three understandings of the term 'function'. The first is a normative obligation or a functional imperative of what the policy tool or institution has to do. The second, defined by Merton, is objective consequence, and the third, identified by this study, is a construct produced in the researcher's reflection on actors' interpretations of what they intended to do and what they did.

Moreover, analysis of manifest and latent functions from an interpretivist perspective clarifies Merton's original distinction between manifest and latent functions. In particular, examination of multiple actors' interpretations revealed many levels of latency in addition to Merton's simple definition of latent function as neither intended nor recognised by actors. Three levels of latency were identified.

The first type of latent function includes consequences that are recognised by policy-makers as intended and fulfilled. However, contrary to manifest functions, which are recognised in the official policy discourse, this type of latent function is expressed by policy-makers in informal communication (for instance, interviews). The second type of latent function contains those consequences that are not

recognised by policy-makers at all (either in the official or informal discourse), but that are identified by other political actors in the public discourse and interviews. Finally, the third type of latent function is understood as consequences, recognised by neither policy-makers nor other political actors, but identified in the researcher's interpretations.

8.4 PROSPECTS FOR FUTURE RESEARCH

This thesis concludes by delineating potential themes for future research. These themes emerged at the stage of analysis of empirical data collected in this study but were set aside as they were not relevant to the key research questions. At this final stage of conclusion, it is appropriate to draw readers' attention to these themes and to explicate how they could be developed.

One of the topics that emerged from the analysis of the functions of policy tools concerned the legitimacy of the government's action and how this legitimacy is attained in the international policy arena. There are two directions that such research could take. First, it could investigate how the government uses a composition of 'hard' and 'soft' tools to legitimise its actions; and how the combination of manifest and latent consequences of these tools affects the implementation of government policies. The second path this topic could take pertains to inquiry of how the government adjusts and/or innovates certain policy tools to attain their policy goals. Research of these two themes could produce a strong counter-argument in the contemporary discourse about the diminishing role of the nation state in international affairs.

The second topic which emerged in analysis of the policy discourse around international nurse migration was the diffusion and implementation of international norms such as human rights, at level of the national policy (Checkel, 1997). As this thesis showed, bilateral agreements constituted a component of the British ethical recruitment policy. This policy originated in the context of conflicting claims expressed by many political actors in the language of human rights. A topic for future research could be developed to investigate first, policy actors' motivations for using the human rights framework to express their claims and interests, and second,

the rationale of policy-makers at the national level in adopting international norms and implementing them in the domestic context. An appropriate starting place would be to explore ideas about actors at the national level who invoke international norms to further their own interests in the domestic policy debate (Cortell and Davis, 1996), and that the argument that norms diffusion and their further implementation in the domestic context result from societal pressure on elites (Checkel, 1997).

Furthermore, previous studies on policy tools paid little attention to the concept of the policy tool career or policy tools life cycle. Although this concept was not a focus of this research, it did emerge in the course of this research and provided fragmental insights for further inquiry. For instance, this study demonstrated that bilateral labour agreements, which were originally negotiated in the 1960s primarily as recruitment schemes, gradually transformed in the contemporary policy discourse to become ethical voluntary arrangements between countries ensuring respect of the international etiquette. This turn in the career path of bilateral labour agreements was influenced by two at least two states of affairs. The first was a changing global environment where cross-border labour mobility has become more advanced and facilitated by a significant number of private recruitment agencies which assumed the functions previously implemented by bilateral labour agreements between governments. The second, illustrated by the British case, was a direct government action designed to avoid a policy trap. As this study has indicated, taking this concept into account helps to develop an understanding of the past and present status of policy tools, as well as their future prospects. The policy tools career is a helpful concept to trace the path taken by policy tools over time and to explain what factors contribute to their emergence, development, transformation and decline. Moreover, examination of the policy tools career contributes to the potential topic for research proposed above, about how policy-makers adjust policy tools to respond to their own needs, as well as to a changing economic context and policy discourse.

Finally, the third topic which emerged when writing this thesis is of a more practical orientation than the previous two. It was noted that many scholars refer

to the lack of research about private agencies actively operating in the global labour market. With the exception of a number of studies on the individual migrant nurse experience (see Chapter 2), this topic remains insufficiently researched. A study of how these agencies operate, what their strategies are, how they respond to international and national regulatory norms, and what tools they use would certainly contribute to the field of research on the regulation of labour migration, as well as to the subject area of tools-centred studies, by exploring the impact of tools used in the private sector in international matters, such as the recruitment of foreign nurses.

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APPENDICES

APPENDIX 1 ETHICAL GUIDELINES ON THE INTERNATIONAL RECRUITMENT OF HEALTH WORKERS

National level
1. Guidance on International Nursing Recruitment (DH, England, 1999);
2. Code of Practice for NHS Employers involved in the Recruitment of Healthcare Professionals (DH, England, 2001; revised in 2004);
3. Guidance for Best Practice on the Recruitment of Overseas Nurses and Midwives (Department of Health, Ireland, 2001);
4. Internationally Recruited Nurses: Good Practice Guidance for Health Care Employers and RCN Negotiators (RCN, UK, 2002);
5. Supervised Practice Programme for Internationally Qualified Nurses (Independent Health Care Association, Registered Nursing Home Association and Voluntary Organisations Involved in Care for Elderly, UK, 2002);
6. Code of Practice (Scotland, 2006);
7. Guide for Nurses from Overseas Working in the UK (UNISON, 1999);
International level
8. Position Statement on the Ethical Nurse Recruitment (ICN, 2001);
9. A Code of Practice for the International Recruitment of Health Care Professionals (World Association of Family Doctors, 2002);
10. Pacific Code of Practice for Recruitment of Health Workers (Ministries of Health Pacific Island countries, 2007);
11. Commonwealth Code of Practice for the International Recruitment of Health Workers (Commonwealth Secretariat, 2002);
12. Statement on Ethical Guidelines for the International Recruitment of Physicians (World Medical Association, 2003)
13. Good Practice Guidance for International Nurse Recruitment (European Federation of Nursing Associations guidance)(2004 #0)
14. Global Code of Practice (WHO, 2010)

Source: Willetts and Martineau (2006); Connel (2007).

APPENDIX 2 GOVERNMENT-TO-GOVERNMENT AGREEMENTS ON
CROSS-BORDER MOBILITY OF HEALTH WORKERS

Countries	Date	Focus	Content
UK – Spain	2000	Nurses	Recruitment
UK – South Africa	2003	Nurses and doctors	Co-operation/exchange
UK – China	2005	Nurses	Restricted recruitment (only through approved agencies)
UK – Philippines	2002	Nurses	Restricted recruitment
UK – India	2002	Nurses	Restricted recruitment (except for regions: Andhra Pradesh, Madhya Pradesh, Orissa and West Bengal)
UK – Indonesia	2002	Nurses	Pilot project on recruitment
UK – Egypt	2001	Doctors	Education/training exchange
Poland – Netherlands	2002	Nurses	Recruitment
France – Germany	2005	Ambulances Emergency staff	Co-operation in the border regions
Romania – Italy	2002	Nurses	Recruitment
China – Singapore	1995	Nurses	Recruitment
South Africa – Cuba	1996	Doctors	Recruitment
Philippines-Bahrain	2007	Nurses	Recruitment
Kenya – Namibia	n/a	Nurses	Recruitment
UK (Scotland) – Malawi	2005	Nurses, midwives	Co-operation

Source: United Nations (2005); OECD (2004).

**APPENDIX 3 BILATERAL LABOUR AGREEMENTS BETWEEN THE UK
AND SOURCE COUNTRIES**

Countries/ Full Title	Date	Parties (co- signers)	Main points	Category of health workers referred in agreement	Estimated number of recruits (if applicable)
UK- Spain Anglo-Spanish Recruitment Agreement	2000	Spanish Minister of Health, Celia Villalobos, and British Health Secretary, Alan Milburn	Co-operation in health related areas including recruitment of nurses; Recruitment is facilitated through the UK Embassy in Madrid.	Spanish nurses (initially); later expanded to recruit doctors, including GPs and dentists.	Approx. 1,300.
UK- Slovakia The Plan of Co-operation in the Fields of Medicine and Public Health	2004	British Health Minister John Hutton and Minister of Health of the Slovak Republic, Rudolf Zajac	Enable medical specialists in both countries to develop work across a range of issues, including exchange of specialists for the purpose of study and consultation.	N/A	N/A
UK – South Africa MOU on the Reciprocal Educational Exchange of Healthcare Concepts and Personnel	2003	South African Minister of Health Dr Manto Tshabalala and British Health Minister John Hutton	Co-operation on health related matters, including cross-border mobility of health workers.	Health workers from both countries (with no particular focus on the workforce type); Intends two-way movement of labour force.	Pilot cohort of 18 South African nurses (2005-2007) in London NHS Trust; 70 UK health professionals in South Africa (2003-2004), followed by 259 UK health professionals (2004-2005).
UK – China Letter of Intent on Cooperation in Recruiting Health Professionals	2005	Ministry of Commerce of the People's Republic of China and Department of Health of the United Kingdom	Regulation of the recruitment process. Enables Chinese agencies to comply with the principles of the Code of Practice (DoH 2004).	Nurses	Pilot cohort of 50 Chinese nurses.

Countries/ Full Title	Date	Parties (co- signers)	Main points	Category of health workers referred in agreement	Estimated number of recruits (if applicable)
UK – Philippines Recruitment Agreement; MoU on Bilateral Cooperation in Health Care	2002 2003	Philippine Ambassador to the UK Cesar Bautista and Deputy Director Director of Human Resources for the NHS, David Amos Cesar Bautista, Philippine Ambassador to the U.K., and Sarah Mullally, Chief Nursing Officer	Recruitment of nurses. Ensures ethical recruitment and employment.	Nurses	No precise data on the number of recruits.
UK – India Exchange of Letters (no written agreement)	2000	British Department of Health and Indian Ministry of Health	Recruitment of Indian nurses, except from regions: Andhra Pradesh, Madhya Pradesh, Orissa and West Bengal; Recruitment is facilitated through the UK High Commission in New Delhi.	Nurses	No precise data on the number of recruits.
UK- Indonesia MoU on the Recruitment and Employment of Health Professionals .	2002	n/a	Recruitment	Nurses	N/A (interview data indicates it was only a pilot project with a small number of recruits)
UK – Egypt The Anglo- Egyptian Medical Attachment	2001	N/A	Two-month fellowship in the UK to Egyptian doctors.	Doctors	N/A

Sources: Buchan (2008), Ollier (2007), Connell (2007), elite interviews; Media reports.

APPENDIX 4 LIST OF INTERVIEWS CONDUCTED

Position
1. Expert in the issues of health workforce, international recruitment and nursing, involved in consultancy and policy research on the health workforce, QMU, Edinburgh
2. Director of Overseas Nurses Network
3. Senior Officer, Bureau for Workers' Activities, ILO
4. Assistant General Secretary, Public Service International
5. Project Co-ordinator, Oversees Professionals into Practice
6. Head of International recruitment in England
7. Head of International Recruitment (India Project)
8. Officer in the DH previously co-ordinated international recruitment for all professional groups for the London Strategic Health Authorities
9. WHO officer Department for Health Policy, Development and Services (former senior officer in the Health Department of Ghana)
10. International Officer for Nursing and Midwifery (DH) involved in negotiation of the MOU with South Africa
11. Director of Workforce Capacity, Department of Health, involved in the negotiation of the agreements with the Philippines, Spain and India
12. Adviser (Health) Social Transformation Programmes Division, Health Section, Commonwealth Secretariat, involved in preparation of the Commonwealth Code of Practice in international recruitment of health professionals
13. Expert in the Evaluation of International Recruitment Initiatives for doctors, nurses and allied health professionals, School of Nursing and Midwifery, King's College, London
14. OECD Consultant involved in research on the UK bilateral labour agreements, Kingsley Napley Solicitors, London
15. Head of Global Affairs, Department of Health (England)
16. Public Health Adviser, Global Affairs, Department of Health, working on the issues of workforce and international relations
17. Head of Nursing, UNISON
18. Head of International Relations, UNISON
19. Senior Lecturer, expert in industrial relations and the nursing workforce, The Management Centre, King's College, London
20. Information and Research Officer for the Employment Relations Department, the RCN, involved in managing issues on the international recruitment of health professionals at the local/national level
21. RCN Officer, working on the issues of workforce and international relations
22. Recruitment Co-ordinator in Spain
23. Senior Nurse in the King's College Hospital, involved in the recruitment of nurses in 2003-2006 from India and the Philippines
24. Deputy Director of Human Resources at the Department of Health, involved in development of the ethical recruitment strategy of health professionals in England in 2000-2005 and negotiation of agreements with Spain, the Philippines and India

APPENDIX 5 KEY THEMES DISCUSSED IN THE INTERVIEWS⁴⁷

I. Recruitment of foreign nurses in 2000-2005

- What was/were your position/responsibilities in the international recruitment of nurses in 2000-2005?
- How was the recruitment process organised?
- What tools did you use to recruit nurses? Did you refer to bilateral labour agreements? Which agreements did you use?

II. Bilateral agreements in the practice of international nurse recruitment

- When was this agreement(s) negotiated?
- Who took part in the negotiation(s)?
- What were the key points in the agreement(s)?
- What were the reasons to negotiate this agreement(s)? Why did you decide to negotiate agreements with certain source countries?
- How were agreements relevant to the ethical recruitment policy and the Code of Practice?
- How did implementation of this agreement(s) go? Is it still functioning agreement? Which agreement(s) would you characterise as successful/unsuccessful? Why?
- How would you characterise the overall role of this agreement(s) in the foreign nurse recruitment? What are the outcomes of the agreement(s)?
- Would you consider negotiation of these agreements in future?

⁴⁷ All interview schedules follow a similar structure, however, they were adjusted when necessary according to the interviewee's position and institutional affiliation.

**RECRUITING FOREIGN NURSES FOR THE UK:
THE ROLE OF BILATERAL LABOUR AGREEMENTS**

Project information

This study examines government-to-government agreements negotiated by the Department of Health (England) with a number of source countries (Spain, India, the Philippines and South Africa) on the cross-border mobility of nurses. This research poses three questions:

- What types of agreements were negotiated?
- What were the reasons for their negotiation?
- What was the role of the government-to-government agreements in the international recruitment of nurses to Britain?

To address these questions this research employs methods: (i) document analysis and (ii) interviews with policy-makers and key stakeholders involved in the policy discourse on the international recruitment of nurses. The project outcomes will be presented in the PhD thesis.

Interviews in this research

The purpose of interviews is to collect expert opinions of the key stakeholders involved in the international recruitment of nurses in 2000-2005. This will help to enrich and deepen factual information available in the policy documents.

Your participation in this research is voluntary. Interviews will be conducted individually. The interviewer will ask questions which you are free to answer in any way you wish. You may also feel unable or do not want to answer particular questions, and may refuse to do so. The interview shall take not more than 1-1,5 hours.

Contact details of the researcher:

Ms Evgeniya Plotnikova,
School of Social and Political Studies
Chrystal Macmillan Building, 15a George Square,
Edinburgh EH8 9LD
e-mail: E.Plotnikova@sms.ed.ac.uk

⁴⁸ distributed to interviewees

APPENDIX 7 INFORMED CONSENT FORM DISTRIBUTED TO INTERVIEWEES

INFORMED CONSENT FORM

**RECRUITING FOREIGN NURSES FOR THE UK:
THE ROLE OF BILATERAL LABOUR AGREEMENTS**

Confidentiality and the use of data:

Interviews will be recorded for the sake of factual accuracy. The tape recordings will be available only to the project investigator and will be used only for the research purposes. The researcher will refer to these materials in the reports and publications only in the anonymous form which means that respondents will be not named personally in any documents produced for public access, though there could be references to your post and/or the organisation you represent(ed) in 2000-2005.

I agree that information that I provide will be used in the PhD dissertation. I agree my comments and quotations to be referred to ...

(Please, underline as appropriate):

- my former position title and organisation (where I worked in 2000-2005);
- only to organisation (where I worked in 2000-2005);
- used anonymously (with reference neither to position title nor to organisation).

I, hereby, agree to be involved in the above research project as an interviewee.

I have read the project information sheet and understand the nature of the research and my role in it.

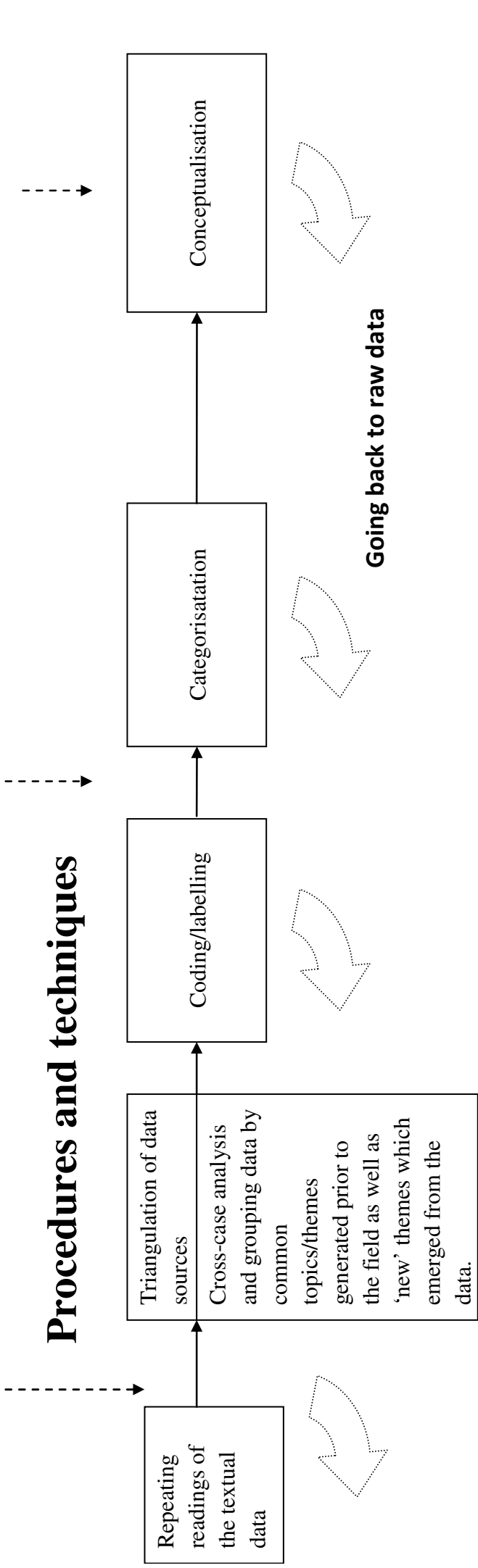
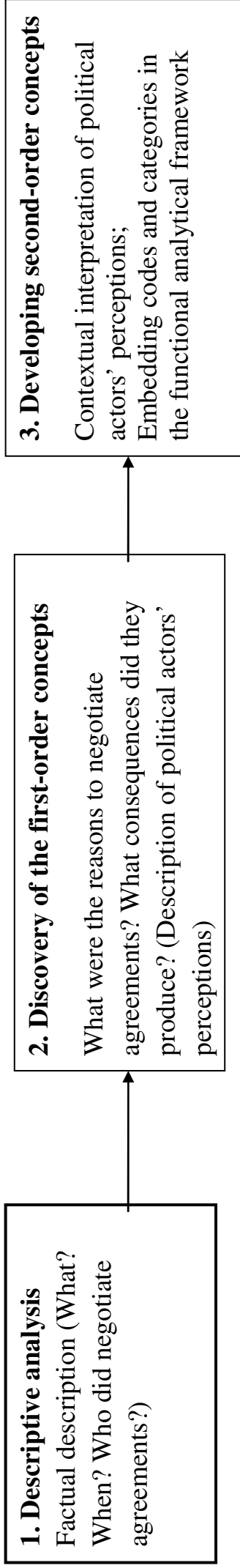
Name of interviewee:

Signature:

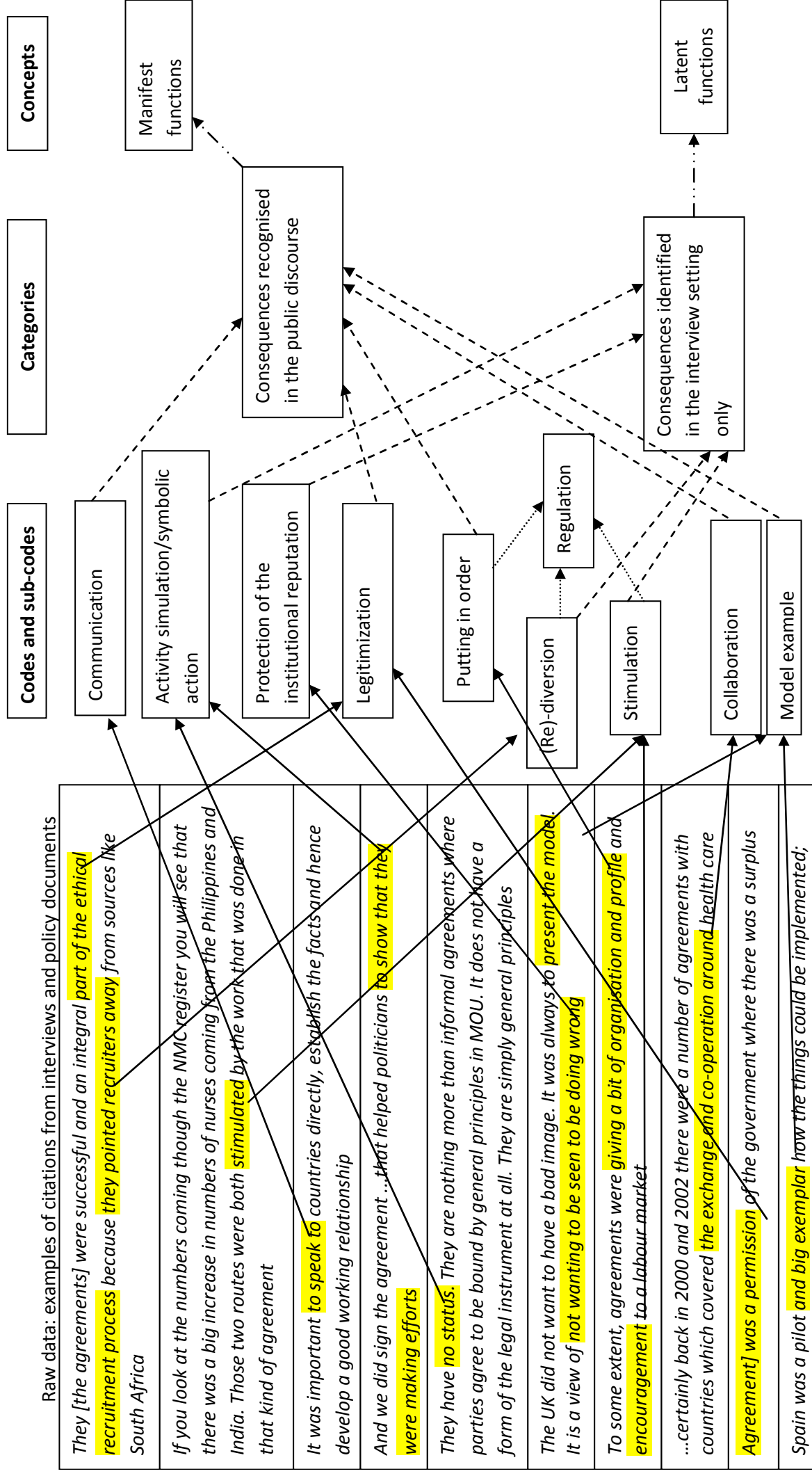
Date:

APPENDIX 8.1 QUALITATIVE CONTENT ANALYSIS: STAGES AND PROCEDURES

Stages



APPENDIX 8.2 QUALITATIVE CONTENT ANALYSIS: SCHEMATIC ILLUSTRATION



APPENDIX 9 PUBLICATION