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NURSING AND MIGRATION. HISTORICAL AND ETHICAL PERSPECTIVES ON EUROPE FROM THE 1950S TO THE PRESENT

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1 INTRODUCTION

Without migration, care and nursing in institutional and private settings would not be possible in Europe in their present form. In Germany, for example, migrants made up 17.8 per cent of the workforce in nursing and geriatric care in 2024 and have accounted for the entirety of the expansion of the nursing professions since 2022.[1] The presence of migrants in the nursing professions is the result of broader demographic developments in most European countries, which for many decades have been steadily transforming into immigration societies (without, of course, ever having been purely non-migrant societies), but their presence is also the result of specific measures to counter the persistent staff shortages in nursing that seem to be one of the constants in present-day European health systems. The historical link between migration and care thus points to a strong interconnection between different social, economic and cultural processes. While migration serves as a relief system for demographically ageing societies, it simultaneously exacerbates structural inequalities within the European care sector. This complex interdependence calls for an integrated perspective that combines historical, sociological and ethical analysis – not only to understand the current care crises, but also to trace the long-term evolution of social integration and solidarity across Europe.

Against the backdrop of an ageing society and the ongoing staffing crisis, governmental agencies and non-governmental actors in different European countries have been trying to recruit nurses from abroad. In 2025, various programmes were created to convince people from Mexico, the Philippines, Albania and Brazil to move to (Western) Europe and work in the nursing professions. However, recruitment programmes for foreign professionals are not a recent invention.

A look at earlier recruitment waves shows that the internationalisation of nursing has deep historical roots. To stay with the German example, qualified nurses and trainees have been recruited from abroad in both West and East Germany since the late 1950s. Migrants in the nursing professions have long represented a significant proportion of those employed in the German healthcare system and continue to shape it to this day. As early as the 1950s, other European states also found it necessary to look abroad to recruit qualified nurses and apprentices for the caring professions in order to mitigate a staffing crisis in their own health care systems. Since then, the nursing shortages have only been amplified by demographic changes and advances in health care. Today, partly through state-driven recruitment programmes, most countries in the Global North employ a substantial number of migrant nurses, transforming the profile of nursing in Europe, North America and Australia. Regular and

[1] Sachverständigenrat für Integration und Migration 2020; Mediendienst Integration 2025.

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irregular migration into formal and informal labour markets have played as much of a role as the increasing care dependency on migrants in ageing societies.

Despite this long-standing significance, the role of migration in the nursing professions has received surprisingly limited attention in historical research. For the most part, nursing historians and historians of medicine have left the professional and personal trajectories of migrant nurses unexplored. The same is also true for contemporary history and the history of migration. This gap in the research becomes even more conspicuous when it is contrasted with the history of other forms of migrant labour in more industrial (and hence, more masculine) settings, such as the *Gastarbeiter*, who arrived in Western Germany from the 1950s to the 1970s and are now an integral part of mainstream historical narratives.[2]

Only recently have historical studies begun highlighting the complex forms of marginalisation experienced by migrant nurses. Intersectional overlaps of class, migration and gender and the social construction of nursing as a profession long considered to be ancillary to medicine, made it easy for migrant nurses to be overlooked by their nursing contemporaries and by later historians. Nevertheless, the gaps and desiderata are conspicuous, both because migration history[3] and nursing history[4] have become established and productive fields of historical inquiry in recent decades, and because the topic is evidently relevant to current and future debates about the related topics of population health care needs, workforce planning and nursing policy for training and recruitment.

Gender plays a central role in these migration patterns, yet it has long been marginalised in historical research. As Mirjana Morokvašic was already arguing back in the 1980s, the autonomous migration of women was largely ignored.[5] Although the autonomous migration of women has been included in German-language social science research since the 1990s,[6] this area has remained a niche that has been ignored by the majority of migration researchers.

While, in the 1980s, the focus was still on making migrant women visible, the spotlight is now increasingly turning to other factors that contribute to discrimination and exclusion.[7] Migration history is thus linked to intersectional theories, as ethnologist Urmila Goel has emphasised.[8] These intersectional exclusions were further reinforced by racialised images of 'ideal' migrant workers. The recruitment and popularity of Asian women can be explained by the prevalence of racist stereotypes in German society: Asian women were considered hard-working, gentle, resilient and therefore particularly well suited to the nursing profession.[9]

In the field of nursing ethics, topics such as the possibilities and challenges of trancultural relations in nursing have been the subject of productive discussions since the 2010s, as have the ethics of the recruitment of nurses from abroad and the potential negative impacts on the health infrastructure of the migrants' countries of origin.[10]

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2 Notable exceptions include Mattes 2005 and more recently Cäsar 2024.
3 Möhring 2018.
4 Pfütsch 2025.
5 Morokvašic 1984.
6 Hebenstreit 1988; Mattes 1999; Westphal 1996.
7 Lutz/Amelina 2021.
8 Goel 2014.
9 Goeke/Tekin 2025.
10 Bonacker/Geiger 2021.

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2 HISTORICAL PATTERNS OF CARE MIGRATION IN EUROPE

The internationalisation of professional nursing has a long history – one that is surprisingly absent from the current public and political discourse surrounding the nursing crisis.[11] To better understand today's challenges, it is necessary to examine how nursing has historically depended on various forms of cross-border mobility – shaped by religion, colonial legacies, geopolitical shifts and labour shortages. This section offers selected national examples that illustrate how migrant nurses have long played a central role in European health care systems.

The history of nursing in Germany can, for example, be concisely retold as a genuinely international history that still shapes the sector today. Christian sisterhoods were pioneers of transnational female labour migration in the nineteenth century.[12] Since the creation of these communities, nurses have travelled to war and crisis zones or have been sent to distant regions – particularly, but not exclusively, to colonised territories, sometimes on missionary assignments.[13] Throughout the nineteenth century and even up to the beginning of the Second World War, the German Reich with its denominational sisterhoods was widely considered to be one of the 'cradles' of – and an important exporter of – professional nursing, even as British and American models of professionalisation were gaining traction internationally.[14]

In the 1950s, however, the number of nursing students plummeted in both West and East Germany: religiously and altruistically motivated nursing fell into crisis, not least due to social transformation processes such as modernisation and secularisation. This is when international recruitment programmes first emerged, both at the institutional level and later in national politics, as a response to the growing workforce shortage.[15]

In the Federal Republic of Germany (FRG), religious organisations were among the first actors to recruit qualified and trainee nursing staff from abroad in the postwar decades, aiming to counteract severe labour shortages in hospitals and other care facilities. Later, state actors became involved. Individual countries such as South Korea offered qualified nursing staff to the FRG because they hoped to gain economic advantages from exporting labour.[16]

As a result of intensive political, economic and religious networks – including those formed by missionaries and medical professionals – most foreign nurses in the FRG came from South Korea (by the early 1970s, there were about 5,000 of them). At the same time, approximately 3,000 Filipino and 1,500 Indian nurses were working there.

The German Democratic Republic (GDR) followed a different model, concluding agreements with African and South American countries to train and educate medical personnel, but to a much lesser extent than in West Germany. The state of research on these migrant groups is still limited and incomplete, with research tending to focus on the recruitment and experiences of migrant nurses in West Germany.[17] When it comes to migrant nurse recruitment in East (and West) Germany, only the work of Young-sun Hong can be listed: she provides an outstanding examination of this issue in the global historical context of humanitarian aid during the Cold War.[18]

[11] Kreutzer 2022.
[12] Czolkoß-Hettwer 2022; Hüwelmeier 2014; Kreutzer 2019.
[13] Büttner 2006; Kaminsky 2010.
[14] Kreutzer/Nolte 2016.
[15] Kaminsky 2012; Kreutzer 2014.
[16] Hong 2015, p. 260.
[17] Kreutzer 2022; Friedrich 2020; Goel 2014; Winkler 2014, pp. 361–365.
[18] Hong 2015, esp. pp. 250–286.

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Germany was not alone in this development. Other European countries also began recruiting foreign nursing staff in the postwar decades, shaped by their own demographic, political and colonial histories. From the 1960s onwards, France for example, took in many migrants, mainly from former colonies such as Algeria, and from Southern Europe. This labour migration was essential to meet the demand for workers, including in the care sector. Many migrants worked in informal and precarious employment, often in domestic care. In the 1980s and 1990s, migration policy regulations were tightened, especially under Conservative governments, leading to more restrictive conditions for migrants and making integration more difficult. Nevertheless, migrants – especially from Africa – remained important players in the French care sector, both in the formal and informal economy.[19]

The dual development of restrictive policies and continued immigration had a strong impact on care migration in France. Since the 2000s, the importance of care migration has increased as the French government faces an ageing population and rising demand for care. Migrant women, often from African countries or former colonies, take on many care tasks, especially in home care. The recognition of care qualifications remains complex, and many migrant care workers labour under precarious conditions.

The historical dynamics of care migration in France reflect both long-standing colonial ties and the shifting role of migrant labour in modern welfare states. The Netherlands is also considered a typical migration society. As in France and Germany, recruitment of nursing staff began in the 1960s – often from former colonies. The Dutch authorities assumed that workers from Suriname, the Netherlands Antilles and Indonesia could be easily integrated into the domestic labour market.[20]

Recent scholarship has begun to widen the historical lens on care migration, drawing not only on national labour histories but also on transnational movements and global dynamics, for example the work on the United States' 'imports' of Filipino and Indian nurses since the late nineteenth century[21] and on the role of international organisations in the immigration of Greek nurses to Canada, Australia and New Zealand.[22]

In addition to these historical examples, a rich and growing body of sociological and anthropological literature offers analytical frameworks to explore the dynamics of migrant care. Sabine Hess's 2005 study of Slovakian au pairs in Germany[23] was fundamental in this regard.

Likewise, recent research on Eastern European care workers in divided Cold War Europe has highlighted the interplay between labour migration and ideological boundaries.[24] The concept of 'global care chains' is also highly relevant for the history and ethics of nursing by migrants, as it refers to the ethical dimension of uncompensated recruitment of medical personnel from poorer and needy countries. Arlie Russell Hochschild uses the term 'global care chains' to describe the worldwide shift of care work from poorer to richer countries, often by female migrant workers who leave their own families behind to fill the care gap in wealthier households. This creates and reinforces complex, cross-border networks and often exacerbates social inequalities.[25]

These broader conceptual discussions align with an emerging consensus in migration history: migration is not an exception but a historical constant. More specifically, migration as a phenomenon is far older than the modern nation states that have attempted to regulate it, and is not a 'symptom' of globalisation.[26]

[19] Pillars of Health 2023.
[20] Jennissen/Bovens/Engbersen/Bokhorst 2022, pp. 17–41.
[21] Choy 2003; Reddy 2015.
[22] Papadopoulos/Tourgeli 2023.
[23] Hess 2005.
[24] Lutz 2018.
[25] Hochschild 2014.

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3 QUESTIONS AND SUBJECTS

This diverse and interdisciplinary state of research lays the foundation for a historical and ethical exploration of migration in nursing. At the same time, it highlights the range of open questions and research potential that this field offers. The following thematic areas and questions provide a conceptual framework for the contributions in this issue.

Everyday experiences and professional identities

One key area of inquiry concerns the everyday professional lives and self-perceptions of migrant nurses. How did they imagine and conceptualise the roles of nurses and care recipients, and how did these differ between the countries of origin and the receiving countries?

How did cultural differences, relating to religious identities, assumptions about morality and gender roles, affect the practice of nursing and interpersonal relations in the workplace? How compatible was the training of nurses in the countries of origin with that of the receiving countries?

Experiences of care recipients

A second set of questions concerns the perspectives of care recipients. Migration can touch on the relationship between nurses and care recipients in different ways. For example, patients receiving nursing care from migrant nurses may have different values, expectations and prejudices that shape the nurse-patient encounter. Conversely, as care recipients themselves, migrant nurses may experience the caring encounter differently, according to whether they are nursed by non-migrant nurses or nurses of their own ethnicity.

Contexts

Understanding care migration requires attention to its broader social, political and historical contexts. Did the migration of nurses take place as part of larger migration movements, or independently? How did the migration of nurses differ from other forms of labour migration and care migration? What are the similarities and differences between European countries in terms of their migration patterns and experiences? Who were the key actors involved in shaping, facilitating or hindering the migration of nurses; for example, were they international, state or local, such as religious organisations or specific individuals?

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[26] Bade/van Eijl 2010; Berlinghoff 2018.

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4 CONTRIBUTIONS

The articles in this special issue do not aim to cover the full breadth of this complex field. Instead, each individual article makes an important contribution to closing gaps in research and improving our understanding of the history of migration in nursing. All articles focus on the contemporary history of nursing and the ethical implications.

Nicola Yeates and Jane Pillinger open the issue with a global policy perspective. They trace the development of international recruitment since the Second World War, focusing on the major multilateral agreements: the International Labor Organization's (ILO's) Recommendation on Nursing Personnel (1977) and the World Health Organization's (WHO's) Global Code of Practice on the International Recruitment of Health Personnel (2010). They argue that these global agreements have consistently and deliberately tolerated the international recruitment of nursing staff. International organisations and the international community of state and non-state actors have promoted this global labour dynamic not despite two important regulatory initiatives, but because of them. Both multilateral agreements largely comply with the standards of a global ethics of care, but not with regard to a critical ethics of care, according to the authors' argument.

Claire Chatterton examines the migration of psychiatric nurses in the United Kingdom. When the National Health Service (NHS) was introduced in the UK in 1948, the shortage of nurses in all specialist areas was so severe that it threatened its ability to function. Although the situation in general nursing later improved, it remained a problem in psychiatric nursing at the time, where there continued to be significant difficulties in both recruitment and retention. For a long time, the Republic of Ireland was the main source of nursing staff in the UK. When the Irish government began to resist recruitment, English psychiatric clinics shifted their recruitment activities first to Europe and then to the British Commonwealth. This led to nurses from all over the world working together in the UK. Chatterton traces this process and asks questions about the experiences, problems and opportunities of this multi-ethnic collaboration.

As described above, there was a significant shortage of nursing staff in West Germany in the 1960s. To remedy this problem, nursing staff were recruited primarily from South Korea, the Philippines and Kerala in Southern India. Recruitment from India was organised in particular by individual clergymen, hospital directors and former migrants. Based on archival research, Urmila Goel reconstructs how the West German authorities reacted to this recruitment. She shows that there was no unified strategy among the authorities, but rather that their views differed considerably.

Care provided by migrants who live in the households of those in need of care is an essential component of many Western European care systems. In Germany, this form of care is viewed with ambivalence and is therefore the subject of emotional debate in the public arena. In their article, Matthias Hauer and Mark Schweda focus on the role of fear in this discourse, as it points to moral assumptions about care provided by migrants. They analyse how fear was communicated in the German discourse on live-in caregivers in various newspapers between 2017 and 2023 and examine the moral assumptions underlying these fears. Fear, they conclude, functions as a moral call to action. Its public communication expresses a perceived lack of political solutions to fundamental problems in care.

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Ann-Christin Wedeking focuses in her article on the current migration infrastructure. Since migration has been a constant companion of care in European societies since the 1960s, the recruitment system has also become more differentiated and professionalised in recent decades. Labour market institutions are playing an increasingly important role in the labour migration process, not only in Germany but worldwide. Although initial framework conditions and guidelines were already established in the 1970s, by organisations such as WHO and ILO, as Yeates' and Pillinger's article makes clear, the need to ensure ethically correct recruitment has only gained in importance in the international debate in recent years. Wedeking provides a systematic literature review of the discourse and the role of voluntary codes of ethics as regulatory instruments for ensuring the fair recruitment of nursing staff. It identifies three main strands of research: the development and evaluation of such codes, conceptual ambiguities concerning 'ethical recruitment', and structural and regulatory challenges relating to the role of employment agencies.

Taken together, these contributions offer new historical insights and ethical reflections that are urgently needed in light of Europe's ongoing care challenges and its reliance on transnational labour.

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