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THE GLOBAL REGULATION OF INTERNATIONAL NURSE RECRUITMENT AND MIGRATION. A HISTORICAL-CRITICAL INSTITUTIONAL ETHICS OF CARE ENQUIRY

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Abstract

Since the Second World War, international nurse recruitment has become a high-level political matter in spheres of cross-border global governance. This paper traces the global politics-ethics nexus of this development through a focus on two multilateral agreements that regulate such recruitment: the International Labour Organization Nursing Personnel Recommendation (1977) and the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel (2010). Innovating a global historical-critical institutional ethics of care enquiry to frame and structure the analysis, the paper argues that these global-level agreements have been consistently intentionally permissive of the international recruitment of nurses. International organisations and the international community of state and non-state stakeholders have facilitated these global nurse labour dynamics, not despite two major regulatory initiatives but through them. We find that both multilateral agreements mostly meet the standards of a global ethic of care, but do not do so as far as a critical ethic of care is concerned. The weak global institutional framework, the lack of strong connecting mechanisms in the Global Code to national spheres of governance and law, the absence of lateral links to international legal codes in the areas of social and labour policy, and the failure to address historical (including colonial) legacies underpinning the systematic depletion of national nursing workforces in poorer countries present significant challenges in realising the level of nursing workforce sustainability necessary to achieving the health and health-related SDGs.

Keywords: care ethics; nursing workforces; international recruitment; global governance; multilateralism; world-systems.

1 INTRODUCTION

International nurse recruitment and migration have played out across richer and poorer countries in complex and diverse ways throughout modern history, but only relatively recently have they become problematised as a global ethical issue requiring concerted collective action at the level of global governance. The establishment of worldwide institutions, especially in the immediate post-WWII era[1], ushered in a global liberal economic and political order that included (amongst others) greater international integration of labour markets in health care. These macro-structural changes, combined with

[1] There was no UN system prior to 1945. Its predecessor, the League of Nations, was neither strong enough nor encompassing enough of all countries; empires had not yet collapsed and colonial powers were closed to "outside" influence as to how they and the territories they occupied were governed.

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advances in travel and communication technologies, built on pre-war and longer colonial trends to herald a growing reliance on overseas-born and/or -trained health professionals generally, and nurses particularly, to fill vacancies in the expanding health care services of many countries in the Global North and richer countries of the Global South.[2]

Although there is considerable variation in the proportion of overseas-born and/or -trained nurses in national nurse workforces, as there is in the strategies deployed to recruit them, there is no doubt about the significance of the internationalisation of nursing for health care services provision, workforce planning and wider development. Health and development advocacy actors, including source country governments, have long been concerned that rich destination countries at the apex of the "global nursing care chain"[3] have been able to recruit nurses from poorer countries without significant restraint.[4] This recruitment has meant that source countries have borne the investment costs of educating and training a professional nursing workforce without benefitting from corresponding health and development returns. With the general direction of nurses (and other health professionals) moving from poor to richer countries and from richer to richest countries, the distributive outcomes of these global labour dynamics on population health have been so regressive and catastrophic for the poorest source countries as to be characterised as "fatal flows".[5] At the same time, advocacy actors have highlighted the adverse labour conditions underpinning this international process: the appalling working conditions and lack of career development and other opportunities available to nurses in source countries, the dire recruitment practices used to draw nurses and other health professionals to work overseas and the grim working conditions they endure in destination countries.[6]

This paper responds to the overall question: "To what extent does the global regulation of international recruitment and migration of nurses evidence an institutionalised critical ethics of care?" It examines the historical-ethical antecedents to international nurse recruitment and migration with specific reference to the sphere of global governance. It focuses on the intersections between ethics and politics in shaping the global regulation of international nurse recruitment and migration during the eight decades since the post-World War 2 organisations and institutions of global governance were established. Above all, the paper is concerned with the extent to which the global regulation of international nurse recruitment and migration evidences a global institutionalised critical ethics of care. By this we mean global-level norms and standards that effectively practice valuing others and respond to, and meet the health and labour needs of, others, and in a way that also addresses the wider global dynamics of domination and inequality that give rise to those needs.[7] The relatively long sweep of post-war history beneficially affords a comparative perspective on ethical-political constellations at different periods across the decades.

Our focus on how nursing workforce supply issues have been construed as a matter requiring global regulation fills a notable omission in the now voluminous academic literatures on international health worker/professional nurse migration and its outcomes. With notable exceptions[8], these literatures have paid scant attention to the transnational domains of governance, regulation, policy, financing and provision. Notably, Wright et al.'s (2008) otherwise informative historical overview of ethical debates about physician migration omits to mention any involvement of international organisations in this

2 Yeates/Pillinger 2018, 2019; Choy 2003; Rafferty 2005; Yeates 2009.
3 Yeates 2009 a, p. 9, and chapter 4.
4 Pillinger/Yeates 2020; Gencianos et al. 2022.
5 Chen/Bouffard 2005.
6 Yeates 2009; Pillinger/Yeates 2020; Yeates/Pillinger 2019; Kingma 2006; Walani 2015.
7 Our distinction between institutional and organisational ethics of care follows that by Lanphier 2021.
8 Yeates/Pillinger 2019.

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field, despite their being active participants shaping the debates over time. At the same time, the global health labour migration literature tends to aggregate health professionals into a single analytical unit. Not only do nurses represent 45% of the global health workforce and are the single largest category of health workers,[9] but specificities particular to this sizeable workforce have not been adequately considered in the scholarship on global health and labour governance.[10] Our focus on the history of global governance in relation to the nursing profession renders visible a wider range of institutions, actors and ideas shaping the policy field than country-level studies have captured.

We innovate an expansive analytical framework for this task. Drawing on Joan Tronto's pioneering work on a feminist ethics of care[11], Fiona Robinson's critical ethics of care in international relations, and the concept of domination rooted in world-systems theory[12], we introduce a globalised and historicised critical care ethics framework developed by us for the purpose of this paper, rooted in social justice and rights. Our data was gathered through extensive archival research covering the seven decades since 1946[13]. Search terms 'international migration', 'international recruitment', 'health personnel', 'health professionals', 'health workforce', 'shortage', 'brain drain', 'brain circulation', 'health care', and 'health services' were used in combination to sift significant quantities of resolutions, policy initiatives, meeting notes, and studies spanning seven decades. This was a mammoth task. For example, constructing the UNGA's activity since its earliest days entailed searching about 18,000 documents on the UN database. Ascertaining WHO's history involved systematic searches of seven decades' worth of World Health Assembly (WHA) documentation at two major volumes per year each consisting of 100–300 pages. Similar searches were undertaken for ILO over the decades, and for other international organisations and bodies. In each case, documentation was sifted to check relevance and analysed to identify instances of intervention, connections and thematic threads using manual coding techniques. The results of this research exercise were used to construct a 'timeline' of principal UN activity (decisions, resolutions, recommendations) in relation to international health worker-migration, taken by organs and bodies of the UN and by its specialised agencies.

Our systematic search for UN official documentation pertaining to its initiatives on cross-border health worker-migration was complemented by consulting the e-libraries of the Organisation for Economic Cooperation and Development (OECD), the World Bank, the International Organisation on Migration (IOM) and the Global Forum on Migration and Development. We concentrated on the official documentation emanating from the UN bodies and agencies in New York and Geneva. We did not include regional bodies of the UN or regional development banks. We limited ourselves to the discourses and commitments in official documentation, not whether they have been implemented in country-level contexts. In addition to our analysis of the primary (archival) research, we undertook secondary analysis of international health worker and migration datasets and academic research literatures.[14]

The analytical framework we have developed clearly demonstrates how the international community has collectively responded over time to the global nursing crisis, through cross-border spheres of governance and processes of global norm- and standard-setting, to govern international nurse recruitment and migration. This finding is based on routing evidence regarding how those institutionalised norms and standards fare in relation to our expanded care ethics analytical framework. We specify

[9] Boniol et al. 2022.
[10] Kingma called for a special global fund to support health systems strengthening and the human workforce to be set up, but this was incidental to her research, see Kingma 2006, p. 209.
[11] Tronto 1993.
[12] Wallerstein 1974, 2004; Chase-Dunn/Grimes 1995; Chase-Dunn/Hall 1997; Soederberg 2006.
[13] Yeates/Pillinger 2019.
[14] Ibid. pp. 45-46.

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key moral elements to assess the adequacy of two global agreements and apply them to a global context. Our overall aim is to bring nurses into critical care ethical enquiry in a field that remains predominantly focused on contemporary and short-term history, country-level spheres of governance, informal family care and health professionals in general, and to stimulate further theoretical and empirical research into global critical care ethics.

The paper develops through four further sections. Section 2 sets out the rationale and nature of the analytical framework used here. Sections 3 and 4 trace how nurses have featured within the ongoing ethical-political construction of global-level responses to the collective ethical dilemma associated with mass international health professional recruitment and migration. It shows how the politics of global policy have shaped the global regulatory response. The discussion focuses on the two multilateral agreements: the International Labour Organization (ILO) Nursing Personnel Recommendation (1977) (hereafter R157) (Section 3) and the World Health Organization's (WHO) Global Code of Practice on the International Recruitment of Health Personnel (hereafter Global Code) (2010) (Section 4). Section 5 concludes by returning to the paper's objectives of discussing the ethics-politics nexus in an historical and global framework. It considers the implications of this enquiry for future ethics-led research and reflects on their meaning and significance for current debates about the future of global governance of international nurse recruitment.

The overall argument presented is that global-level regulations in this policy space have been consistently permissive of the international recruitment and migration of nurses. International organisations and the international community of stakeholders have facilitated these global labour dynamics, not despite two major regulatory initiatives but through them. Furthermore, we argue that although R157 and the Global Code contain many positive elements that accord with a critical feminist care ethics, they fall short of this ethics' standards. This is principally due to the agreements' failure to sufficiently address structural dynamics rooted in histories of colonialism and uneven development, together with the weak global institutional framework in which they are embedded and upon which they partly rely for implementation.

2 GLOBALISING CARE: BUILDING AN ANALYTICAL ETHICAL FRAMEWORK

In 1993, Joan Tronto launched a stinging critique of care being framed as a personal moral disposition of and/or actions by women, an activity most appropriately analysed at the level of inter-personal relations between the care-giver and -receiver.[15] Her intervention called into question the gender bias (indeed, sexism) of care essentialism, the problems of abstract reasoning and decontextualised constructions of care, and the resultant invisibilisation and de-politicisation of care. The subsequent re-focusing of research towards what socio-institutional arrangements best promote gender-equitable care has proved productive for feminist scholarship across many disciplines.[16] This scholarship

[15] Tronto 1993.
[16] See, for example, Dalla Costa/Dalla Costa 1993; Duffy 2011; Ehrenreich/Hochschild 2002; Feder 1999; Folbre 1995; Gardner 1997; Himmelweit 1999, 2000, 2007; Hooyman/Gonyea 1995; Narayan 1995; Pearson 2000; Razavi 2012; Robinson 1999; Ungerson 2007; Williams 2012; Yeates 2004.

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redrew the boundaries as to what counts as a public affairs issue and showed care to be a significant, if severely undervalued, public good. Indeed, progress in public policy as a political practice of policy-makers, by contrast, has proved glacial in pace. Thus, Tronto (amongst others) continues to call out the de-prioritisation of genuinely gender-equitable care in public policy and political-philosophical treatises on the human condition.[17]

For the purposes of this paper, we focus on feminist scholarship in international relations (IR)[18] in the form of Fiona Robinson's work on a critical ethics of care. Taking up Tronto's ethics of care, she questioned whether and how what "we" value is visible and ingrained in the sphere of international relations among states. Like Tronto, she argued that an ethics of care demands "an awareness of social relations as a starting point for ethical enquiry"[19] and an orientation towards "problematising norms and structures that underwrite and sustain exclusionary structures"[20]. For Robinson, an IR-led ethical enquiry through the lens of a critical care ethics means engaging with how:

> [...] the structures of a globalising political economy sustain exclusionary social practices and structures in the contemporary global system: how boundaries are constructed, how 'difference' is assigned, and moral and social exclusion is legitimated.[21]

Although the sphere of cross-border governance was not the major focus of Robinson's work, she considered how the language and practices of multilateralism, interdependence and partnerships in relation to poverty and humanitarianism perpetuate exclusionary structures, gendered international norms and practices, and the cultural hegemony of Western values.[22]

A focus on geo-power and -politics in all its guises is clearly relevant for any sort of global analysis, but missing from Robinson's account is a robust theorisation of domination. World-systems theory proves helpful here for its focus on how historically embedded world-level structures and relations of inequality and exploitation between core, peripheral and semi-peripheral zones of the world actively condition development, resulting, for many countries, in "maldevelopment"[23]. This paper's focus on global-level norms and regulatory interventions is, like world-systems theory and Yeates' previous work, also rooted in a theoretical tradition inspired by historical materialism. This roots our concern with configurations of organisations, actors and ideas in the material contexts from which they originate and in which they operate, and their capabilities for promoting progressive social development. The resultant materialist analytics of global nurse labour governance retains a focus on the array of social forces shaping that governance over time, including capitalist social structures in general, globalising dynamics of health care services economies, and geo-politics. This materialist analytics connects the multilateralisation of international nurse recruitment and migration governance and policy with the ongoing multilateralisation of nurse recruitment and migration,[24] together with the legacies of colonial historical dynamics that continue to play out in national and cross-border spheres of governance.[25] These legacies are normatively very relevant for a critical global historical ethics of care. Notably, some have argued that former colonising countries have special responsibilities towards formerly colonised ones, particularly concerning reparations and the ongoing impacts of colonialism.[26] Versions of this

[17] Tronto 2013, 2017, 2018, pp. 21–27. See also fn 13.
[18] Robinson 1999.
[19] Robinson 1999, p. 165.
[20] Robinson 1999, p. 132.
[21] Robinson 2006, p. 131.
[22] Robinson 1999, pp. 97, 109–110, 158.
[23] See fn 9; Yeates/Holden 2022; Amin 2011. Yeates' 2004, 2009, 2014 "global nursing care chains" research draws on world-systems theory.
[24] Yeates 2014.
[25] Yeates/Pillinger 2019.
[26] Hickel 2018; Mehta 2019; Goldstone 2024.

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argument have featured in discussions of the sort of global-level interventions needed across the period examined here.[27]

The implications of these feminist analytical frameworks are twofold. First, although Tronto's focus was on family care, it is applicable to professional carers, including nurses, working in professionalised, institutionalised and highly-capitalised healthcare environments[28]. A care ethics in relation to nurses goes beyond the moral decisions individual nurses make during their professional practice (including decisions to emigrate/remain) and the micro-level nurse-patient relationship to also consider the macro-level determinants of relations between nurse workforces and population health as a whole. Second, and relatedly, the corollary of Tronto's and Robinson's insistence that the rightful focus of a care ethics-led enquiry should be on social, economic and political structures shaping who provides care and mutual support, under what material (and other) conditions, and with what effects and outcomes, is to bring the sphere of global governance squarely within the scope of enquiry. If, as Tronto has argued, an ethic of care involves the moral elements of attentiveness, compassion, nurturance, responsibility and responsiveness[29], then a critical care ethics enquiry directs our sights towards their "global" equivalents. In this vein, the classical concerns with caregivers' personal moral dispositions, decisions and responses become, in a globalised context, the quest for socio-institutional arrangements and practices that are: attentive to the health and care needs of populations and the nursing workforces caring for them; display compassion towards these populations; nurture long-term nurse workforce planning and funding in support of robust health care systems, universal health and care coverage and high-quality public services; evidence a clear responsibility to stop the depletion of collective human health resources from poorer countries and the exploitation of health labourers; and enshrine transnational obligations of all stakeholders to uphold their responsibilities in accordance with agreements, together with robust, responsive monitoring and accountability mechanisms. Because present-day workforce challenges are in part rooted in long histories of uneven development and colonialism, these transnational obligations include a clear responsibility of (former colonising) recruiting countries to compensate (former colonised) source countries for depletions.

But what would it mean for an institution or a formal agreement to demonstrate its capability to enact all these elements of a critical ethics of care? In order to answer this question, we need to move from identifying elements of a critical ethics of care to operationalising them. Figure 1 sets out a framework for this. It identifies what sorts of institutional mechanisms and actions are needed to fulfil the standards demanded by this moral approach. We deliberately eschew identifying specific criteria or exact thresholds because these are not appropriate for the paper's purpose of assessing the quality of a multilateral agreement. Indeed, such agreements are invariably restricted to setting out overall aims, principles, signatories' (and other stakeholders') responsibilities, mechanisms propelling action and monitoring overall standards. It is the presence or absence of particular elements, as operationalised in Figure 1, that enables us to draw an overall conclusion as to whether a global agreement meets the standards implied by a critical ethics of care approach. Finally, it is worth noting that the elements individually identified below are in practice closely interconnected.

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[27] As covered by Yeates/Pillinger 2019.
[28] Yeates 2004.
[29] Tronto 1993, 2013.

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Figure 1: Analytical framework to operationalise a critical institutional ethics of care in relation to global treaties on international nurse recruitment and migration

MORAL ELEMENTS	OPERATIONALISED THROUGH
Attentiveness to the health care needs of populations and the nursing workforces needed to meet them	Periodic comprehensive nurse workforce planning viz size, composition, practice and deployment, in relation to population health needs
Compassion towards populations' unmet health care needs and nursing workforce needs	Feed-in of evidence to timely and well-constructed action addressed to the problem(s) identified
Nurturing long-term comprehensive nurse workforce planning in tandem with robust health care systems and universal high quality public services coverage	Addressing the root causes of nurse international recruitment and migration Nurse workforce planning and investment International solidarity and cooperation among countries, especially for poorer ones
Responsibility to stop the depletion of nursing workforces from a country	Threshold of nurse workforce at which nurse recruitment from a country is not permitted Compensate sending countries for lost investment of health and development resources (nurses) due to recruitment/migration
to stop labour exploitation of nurses, including during recruitment to work overseas	Adherence to human rights and international labour standards, including decent working conditions, fair and ethical recruitment, and fundamental labour rights of migrant workers
Responsiveness of all stakeholders to address existing shortfalls in realising any of the above elements and preventing these from recurring	Robust monitoring, learning and accountability systems underpinned by timely data and results

Note: the moral elements of care are identified by Tronto (1993, 2013); they have been adapted by the authors of this paper to the focus and context of this paper'.

Looking at these issues through the lens of a critical ethics of care raises questions about how to balance the health care needs of the population in richer countries with those of poorer countries. How is the right of the individual to migrate to be balanced against the collective right to health and development? And what responsibilities do recruiting countries have towards source countries and the nurses they recruit from them? Such questions go to the heart of the problem: How far should international recruitment and migration be regulated in the interests of global public health, welfare and social development? And what should that regulation aim to do? Cognisant of Tronto's insistence that morality and politics are closely entwined, and in keeping with our historicisation of global governance interventions and their material bases, the emphasis of our discussion is on whether global regulatory

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agreements institutionalise a critical ethic of care and how they have changed over time. In keeping with our critical care ethics, we are also interested in whether global-level action in the shape of R157 and the Global Code have the capability to decisively "shift the dial" when it comes to the power and material inequalities underpinning international nurse migration and recruitment, leading to fairer distributive outcomes across the global nursing care chain.

3 THE NURSING PERSONNEL RECOMMENDATION, 1977

The first ever global agreement aimed at regulating the international recruitment and migration of nurses was negotiated and concluded through the International Labour Organization (ILO)[30] in 1977 and took the form of the Nursing Personnel Recommendation (hereafter, R157)[31]. In the ILO institutional framework, a recommendation is a distillation of labour-related norms and standards translated into positive guidance to governments, trade unions and employers (and other parties). It is not binding on governments in the sense that ILO conventions, once ratified, are. Two points of note about R157 are pertinent. First, the issues of direct concern to this paper are confined to just one article – Article XIII (there are 14 articles in all). Second, R157 needs to be read in the context of the UN's normative framework (holding that international migration is a human right and should be voluntary and freely chosen) and the ILO's body of labour norms and standards that promote dignity at work and high standards of decent work.[32]

Figure 2 maps key features of R157 onto our operationalised care ethical framework. Given that R157 is primarily an ILO labour standards instrument, most of its content concerns nurses' working conditions (education, training, career development, pay and overall working conditions). In addition, institutional governance, policy and implementation are framed in relation to overall ILO provisions, which cover our criteria of attentiveness, compassion and responsiveness. And, as far as the focus of this paper is concerned, although the inclusion of Article XIII is evidence in itself of these three criteria in a general sense, it is most direct and explicit in relation to the nurture and responsibility criteria. The Preamble refers to "shortages" of qualified nurses, many of whom "are not always utilised to best effect", as an obstacle to the development of effective health services. Article XIII's overall approach accepts, values and encourages international nurse migration, notably for its contributions to improving nurses' professional development and the standard of nursing care as part of an expansion of nursing (and other health) services. At the same time, it makes clear that international recruitment should be deployed as an exception in responding to staffing shortages. In this, it specifies very precisely the circumstances where these exceptions apply (Article XIII.67.1) (Figure 2) and stipulates the conditions under which such recruitment should take place (XIII.67.2). This international recruitment circumstances-and-conditions "red line" applies to nursing personnel involved in providing nursing care and nursing services anywhere.

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[30] The ILO is a specialised agency of the United Nations. It promotes internationally recognised labour rights, bringing together governments, employers, and workers' representatives from its 187 member states to set labour standards, develop policies and create programmes that advance "decent work" for everyone.

[31] ILO 1977. R157 was accompanied by a Nursing Convention (C149). ILO conventions are binding on ratifying parties but C149 was silent on international recruitment and migration.

[32] Universal Declaration on Human Rights, 1948, Article 13. UN General Assembly Resolution 217 A; also, see Migration for Employment Convention and Recommendation (Revised), 1949, to which R157 makes direct reference (Article XIII.67.2). R157 is one instrument in a broader body of labour norms and standards and should be read in conjunction with them (R157 Preamble).

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Joan Tronto was insistent that care ethics must be understood in their political context. On this point, we remark that R157 was the apex global policy response to the anxieties about national technical personnel shortages that many source country governments had expressed in UN General Assembly (UNGA) resolutions[33] throughout the 1960s. Those resolutions highlighted the need for systematic assessments of human resources as part of a wider strategy of social and economic development planning, including urging developing countries to grow their education and training capacity to ensure they have sufficient health personnel to meet their own needs. Those calls were echoed by other UN agencies which had called for UN action to stop source countries' human health and development resources from being depleted.[34] Two reports (UN Secretary-General (UNSG), 1967, and ILO, 1967) stood out for highlighting that the most acute shortages were often to be found in the nursing and midwifery workforce's adverse working conditions,[35] in a debate otherwise largely referring to the emigration of male-dominated professionals (engineers, scientists, physicians).

These UN reports helped forge a growing consensus that such action was a global responsibility, and called for stronger global-level action to coordinate and steer national governments. UNESCO was clearest in this, insisting that "brain drain" was a global issue requiring a global response from UN and other international organisations.[36] It argued that "[i]t is obvious that the migration of specialists must be regulated",[37] but the question was how to respond. Amongst the possible responses it set out was a global labour compensatory facility, funded by recruiting countries to compensate source countries for "draining" their highly skilled labour and depleting their development resources.[38] Had such a response been instituted, it would have been the first ever global reparations fund, paid by rich (former colonising) recruiting countries for poorer (former colonised) source countries. In practice, however, UNESCO stood back from it, and came out in favour of an international declaration to raise public awareness of the catastrophic consequences of "the brain drain" and forge a political atmosphere conducive to solving the problems identified with mass international recruitment of highly skilled personnel.[39]

Although most of the impetus was driven by the ILO, UNESCO, UNSG and UNCTAD, the WHO's contributions were significant. On the one hand, it was an early participant in the debate, having referred to serious health workforce shortages in its first and third World Health Situation reports and in World Health Assembly (WHA) resolutions in the late 1950s and the 1960s.[40] These warned that worsening staffing deficiencies (including nurses) impeded the extension of health services, the elimination of disease and the improvement of public health.[41] Then, the WHO's focus was on supporting newly independent countries to address deficiencies in their health programmes, facilitating international exchanges of health personnel through its fellowships scheme, and advancing work to enhance the equivalence of medical curricula and qualifications internationally.[42] The latter two strands mostly seemed to facilitate international recruitment, but – arguably – addressed the "brain drain" problem insofar as non-recognition of overseas training required for professional development and advancement constituted a barrier to health professionals returning "home" to practise their profession. As

[33] UN resolutions play a key role in shaping global norms and making visible member states' "anxieties". They can be a prompt or precursor to further UN work on the issue at hand. With some exceptions (not relevant to this paper), they are not binding and have the status of a recommendation.
[34] ILO 1967; UNESCO 1966; UNSG 1964, 1967; UNCTAD 1971, 1975.
[35] See ILO 1967, pp. 17–18, regarding shortages of midwives, nursing staff and others in Central, North and Latin America.
[36] UNESCO 1968 a, p. 36.
[37] UNESCO 1968 a, p. 37.
[38] UNESCO 1966, p. 177.
[39] UNESCO 1966, p. 43.
[40] WHO 1959, 1967; WHA 1961. See Yeates/Pillinger 2019 for further information.
[41] WHO 1967, p. 34; 1969 b.
[42] The WHO initiative on equivalence of medical degrees (WHA 1968, 1969 a), promoted by the UN Regional Committee for Africa (AFR/RC17/R4), was primarily concerned with inadequately equipped and trained "manpower"(sic) in Africa (see WHO 1968, p. 5).

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permanent non-return meant a loss of potential dividends for source countries from their investments,[43] the curricula and qualifications strand of the WHO's work programme was a practical response to mitigating the impacts of overseas migration. The WHO did not publicly engage with the growing consensus on the need for global-level action at the time; its focus was country-level action and in this regard its sight was firmly fixed on countries in the Global South. In any case, the focus of WHO work was on physicians, not nurses (as judged by its work programme during the UN's First Development Decade (1965–1975)).

It was not until the end of the 1970s, that the place of nurses within the "new" globalising dynamics of health labour markets was explicitly recognised.[44] A major report was commissioned in 1974 in response to explicit demands by source country governments at the WHA year after year that global-level action was urgently needed. It provided new data about the extent and dynamics of nurse (and other health personnel) recruitment and migration, estimating that about "5% of all the world's nurses are outside their country of origin or training."[45] The authors reported that decolonisation had accelerated the pace of nurse emigration from newly independent countries, especially those in Asia[46]. The principal direction of this emigration was from (mostly former colonised) developing countries to developed countries of Europe, North America and the Western Pacific, and to the oil-producing states. Nurses were "even more inequitably distributed around the world" than physicians:

> Of the world's 3.6 million nurses, 3.1 million (85%) are in developed countries which contain only a third of the world's population. Thus, the two-thirds of the world's population living in developing countries have only 15% of the world's nurses. Asia, alone, which has over 40% of the world's population, has only 10% of the world's nurses. This situation is aggravated by nurse migration patterns. [...] the developed countries receive 92% of the migrant nurses but supply only 60%; the developing countries, on the other hand, supply 40% of the world's migrant nurses but receive only 8% [...] At the lowest level, Africa and Oceania receive very few nurses indeed. [...] [T]he developed countries are seen to gain 0.4% per annum and to lose 0.3% per annum, with Canada and the USA gaining more than four times as many as they lose. [...] All the developing areas lose more than they gain.[47]

In a context where the focus on the medical "brain drain" debate had referred to doctors, the WHO's specific focus on nurses helped feminise the global policy field. It proved to be an important starting point for a strand of WHO activity that grew into more substantial programming over time.

For the WHO, R157 was an opportunity to demonstrate the policy applications that the Mej'ia et al. study had raised – even before the report had formally concluded. The ILO's role as the organisational "host" for a new global regulatory instrument reflected the fact that the WHO was unable to make much headway on its own, given its institutional governance structures gave de facto controlling power to the rich, formerly colonial, countries.[48] For the ILO, R157 was an opportunity to demonstrate its engagement with the working conditions of skilled labour migrants in a highly feminised branch of the health workforce. Indeed, the mid-to-late 1970s was a period of intensifying ILO activism in standard-setting in international migration and recruitment. This followed up ILO's Migrant Workers Convention and Recommendation (1975) affirming that migration policy should take account of the

[43] Two WHO resolutions (WHA 1968, 1969) established the principle that qualified doctors from developing countries who emigrate for professional development should be encouraged to return to their countries voluntarily following placement.
[44] Mej'ia et al. 1979.
[45] Mej'ia et al. 1979, p. 43. Mejia et al. op cit. (broadly comparable with physicians (6%)).
[46] Mej'ia et al. 1979, pp. 46–47.
[47] Mej'ia et al. 1979, p. 47.
[48] WHO membership is comprised exclusively of national governments, unlike the ILO which has a tripartite governance structure. Even though governments can never be outvoted by Employers' and Workers' groups, the ILO's institutional structure gives rise to a different policy dynamic than the WHO's. WHA resolutions have no binding force, simply reflecting collective concerns raised by governments. Health regulations are used only for bio-health issues, while multilateral conventions take years to negotiate.

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short-term labour needs and resources and the long-term social and economic consequences of migration for migrants and communities in source and recruiting countries, and that adverse human and wider social consequences of excessive or uncontrolled increases in international migration should be avoided.[49] The ILO regarded R157 as integral to the second phase of its action programme to promote women's working conditions and prospects at work through equal pay, and equality of opportunity and treatment in employment.[50] For both the ILO and WHO, then, R157 was an opportunity to pursue elements of their own institutional mandates and work programmes. Above all, R157 could help realise multiple goals: strengthen international standards on gender equality and labour migration; address health worker shortages and the development of health professions; promote wider UN principles on migration as a human right; and promote international development cooperation through the provision of technical assistance and international agreements.[51]

R157 was the first UN agreement to regulate international nurse and health worker recruitment. It complemented and extended the "no harm" principle of the Migrant Workers Convention (1949). And although it was confined to making "suggestions" for the practical application of the principles, R157 automatically benefitted from ILO's implementation-monitoring and reporting mechanisms. In practice, however, this has been hard to achieve, as Recommendations are not subject to ratification. In any case, the implementation of R157 has never arisen in the Conference Committee on the Application of Standards[52]. None of the General Reports by the Committee of Experts on the Application of ILO Conventions and Standards (including the only three dedicated to migrant workers) covered nursing personnel, whether migrant or not. Nor did they follow up issues to do with the implementation of R157 (or the Nursing Personnel Convention). In ILO governance of monitoring-implementation processes (under article 19), the Conference Committee may, request a report on a specific convention or general survey. However, it has never requested a report on the Nursing Personnel Instruments. Indeed, R157 does not seem to be even considered as a migration instrument: on neither occasion when the Conference Committee requested a report on ILO labour migration instruments (1999 and 2016) did it include R157. This collective failure by the ILO constituencies (governments, employers, workers) to make full use of the ILO's monitoring mechanisms has undermined the realisation of the international standards R157 set for international nurse recruitment.

4 THE WHO GLOBAL CODE OF PRACTICE ON THE INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL

Some three decades elapsed before the WHO was able to make good on demands made at successive World Health Assemblies (WHAs) by source country governments in the 1960s and 1970s to regulate international nurse recruitment. In May 2010, the 63rd WHA adopted the WHO's first, and the world's second, multilateral framework to regulate the international recruitment of health workers. Unlike the nurse recruitment and migration principles bolted on to R157, the Global Code was wholly dedicated to international recruitment; it related to all health workers, not just nurses. Figure 2 sets out the provisions of the Global Code in relation to our operationalised care ethics criteria. Like R157, the Global Code

[49] ILO 1976.
[50] ILO 1978.
[51] Both organisations made compromises to push the recommendation through. See Yeates/Pillinger 2019 for further information.
[52] This committee is a standing tripartite body of the International Labour Conference and an essential component of the ILO's labour standards supervisory system.

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aims to "establish and promote voluntary principles and practices for the ethical international recruitment of health personnel" while reaffirming the basic human right of everyone to migrate internationally.[53] It also addresses health worker shortages, though in a way that gives more attention to health systems and services than R157 did. In this, it refers to the need for health system strengthening, ensuring collective rights to health and development, especially in developing countries, as well as the need to "safeguard the rights of [health] personnel" (Table 2, attentiveness). The Global Code is far more explicit and elaborate than R157 about the institutional governance and effectiveness review mechanisms which are the basis of compassion and responsiveness. The actions and mechanisms needed to be spelt out because the WHO does not have a built-in implementation and monitoring structure like the ILO. The principle that all stakeholders could submit evidence to the ongoing monitoring process was not achieved at the time of the Global Code's conclusion, but six years later when an Independent Stakeholders Reporting Instrument (ISRI) was introduced. This specified that all "natural constituencies" can submit evidence to the WHO regarding the implementation of the Global Code.[54] In doing so, it fosters participatory policy making, which is a hallmark of democratic governance. Together with regular review points built into the Global Code's implementation, it facilitates upgrading the implementation mechanism over time[55] and enables it to become more responsive. This is a fundamental principle of accountability.[56] However, this presupposes that stakeholders have sufficient capacity and resources to engage with these participation and accountability mechanisms.

The approach of the Global Code to international recruitment of health personnel is similar to that of R157 insofar as it lauds the value and benefits of working overseas as part of professional and career development, and emphasises how that learning can reap dividends for source country health care systems on the return of the nurses (and other health personnel). In this, the Global Code is far more explicit about circular and temporary migration than R157 was, perhaps reflecting the growing importance of these forms of migration (and recruitment) in the international health labour market. A key difference between the two agreements is that the Global Code eschewed R157's assumption that international recruitment should happen only under exceptional circumstances and its criteria-led approach to those circumstances. Instead, it favoured a more general statement that "Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers" (Article 5.1), and that "All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible" (Article 5.4) (Figure 2, see appendix, p.19-21).

In short, the Global Code's ethical framework assigned explicit responsibility to recruiting countries to: adequately inform migrant health workers of their rights; provide the same working conditions as are enjoyed by nationals (the equality principle); avoid active recruitment from developing countries facing critical shortages of health workers and support the development of sustainable health systems, especially in low- and middle-income countries, through the provision of technical and financial assistance aimed at supporting workforce planning commensurate with future service needs, and developing working environments conducive to retaining health workers. Of note, financial reimbursement payable to source countries to compensate their loss of investment in human capital formation resulting from health workers being recruited to work overseas was dropped in the final stage of negotiations.

[53] WHO 2010.
[54] Only governments were originally identified as having access to the implementation mechanism. Although non-state stakeholders were incorporated into the process in 2016 through ISRI, this was only in relation to monitoring. The degree of engagement among stakeholders other than governments remains limited. See WHO 2016.
[55] This was the case for OECD Multi-National Enterprises Guidelines. The efforts of the ILO and UNCTAD secretariats also helped make the implementation mechanisms effective. See Sauvant 2015.
[56] Sauvant 2015.

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It is undeniable that the Global Code was a significant intervention in the global governance of international nurse recruitment and migration. The macro-political and -economic environment in which the Global Code was negotiated was significantly different from that when the ILO's R157 Recommendation was concluded. For one thing, it was overtly hostile to binding global agreements and measures for anything other than those concerning the promotion of "free" trade. Self-regulation was the default preferred mode. The formerly expansive labour activism of the ILO had rolled back its ambitions to focus on "core" labour standards. Also, in the early 2000s, the UN's authority was diminishing in a global policy field that increasingly took its inspiration from the USA and the rich-world-dominated World Bank and International Monetary Fund, which encouraged the liberalisation and integration of international (health) labour markets (amongst other things). Although the UN had always emphasised the benefits of time-limited international exchanges of nurses and other health workers, there was now a decisive shift in favour of temporary and circular migration – just at a time when permanent rights of settlement for labour migrants were coming under attack. These changes strongly conditioned the prospects for any meaningful global-level action to curtail international nurse (and health worker) recruitment by the richer countries of the world; they help explain the continued emphasis on the responsibility of all stakeholders to adhere to the spirit and letter of the Global Code.

The Global Code had come about in a context of political resurgence and the growing advocacy power of coalitions of state and non-state actors pressing for regulation in the interests of ethical recruitment of health workers. These coalitions had developed through campaigns for unilateral voluntary codes of practice on international recruitment of health workers during the 1990s. Initiated in advanced industrialised countries (also drawing in some developing countries) and "made" outside the UN system, they were bilateral or multinational in scope and often involved "the voices of employers, recruiters, unions, and migrants themselves".[57] The experience of these ethical codes and the advocacy coalitions that pressed for them was brought to bear in scaling up national-level coalitions into a global coalition advocating for a multilateral code uniformly applicable to all WHO member countries. The Global Code was a major step-change for the WHO.[58] Prior to then, the WHO had worked with individual governments one by one to strengthen the workforce components of national health systems. And whereas R157 was limited to nurses, the Global Code extended to all health workers recruited from overseas.

The Global Code's multilateral framework codifying universal principles and standards for ethical recruitment of international health workers has undoubtedly raised awareness, stimulated dialogue, and promoted the sharing of good practice, thereby succeeding in keeping the linked issues of ethical recruitment and health workforce shortages visible on global policy agendas. But there are several reasons to doubt its ability to engender transformative change in regulating international nurse recruitment and migration.

First, it is legally unenforceable:[59] the recommendation (Article 8.2) that the Global Code be incorporated into national policies and laws to make it legally binding has been systematically ignored by most governments.[60] Second, the Global Code permits substantial programmes of active overseas health worker recruitment so long as source countries do not have a critical shortage of health workers.[61] Third, the Global Code's provisions do not apply directly to "other stakeholders", such as private

[57] PSI 2012, p. 2.
[58] Lidén 2014.
[59] Bourgeault et al. 2016.
[60] The only major example to date of a government domesticising the Global Code is South Africa.
[61] The WHO's Health Workforce Support and Safeguards List (2020) (Red List) identifies countries whose low health workforce density renders them vulnerable to not achieving the UN Sustainable Development Goal target for universal health coverage (UHC) by 2030. These are countries from which no government should actively recruit health workers.

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recruitment agencies (PRAs), despite clear evidence that many PRAs' practices are unethical. Private enterprises and employers are not obliged to comply with the provisions of the Global Code, unless required by national law to do so.[62] To the extent that the Global Code has any leverage at all, it is over WHO member states, whose responsibility it is to ensure their systems attain the required standards. Fourth, the absence of a precise operational definition of "ethical recruitment" hampers coherence across other policy instruments (e.g. bilateral/regional labour agreements and trade agreements). Fifth, the Global Code asks Member States only to "[…] observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel" (Article 8.7; emphasis added). A bolder agreement could have called on governments to invest more, above and beyond the level of support they already provide, for health systems strengthening as part of the Global Code's provisions on compensation.

Sixth, the Global Code fails to make lateral linkages with other global initiatives. Provisions on the protection of recruited workers only refer to "fairness"; they give insufficient attention to equality of treatment of migrant health workers in accordance with ILO conventions on fundamental rights at work and migration. Also, there is no mechanism in the Global Code linking the international standards of ethical practice to other areas. For example, global health partnerships and global health development assistance are not required to sign up to the principles in the Global Code.[63] And the Global Code is weakened by not referring to international standards.[64] In this, the absence of "lateral" mechanisms isolates the Global Code from global conventions embedded in the UN normative framework, such as the UN Convention for the Protection of the Rights of All Migrant Workers and Members of their Families, and ILO conventions on labour migration and recruitment standards. Seventh, the absence of a clear link between the Global Code and national regulation is a further issue.[65] In this, it fails to sufficiently promote better collaboration and shared responsibility for implementation and monitoring between different government ministries (health, justice, finance, employment) in source and destination countries.[66]

Data suggests that compliance with the Global Code is very limited. Engagement with it by state and non-state actors is low, especially so in countries and regions worst affected by health workforce shortages.[67] The "mutuality of benefits" principle embedded in bilateral labour market agreements is mostly restricted to the minimum of providing education and training to recruited nurses (and other health workers).[68] In the same vein, Public Services International (PSI)[69] concluded that "progress with the Code's implementation has stalled".[70] Governments have called for more technical assistance to support them in implementing the Global Code,[71] but the ability of the WHO to provide this is severely hampered by resource constraints (even prior to the USA's withdrawal from the WHO in 2025) and its reliance on donor funding from countries which are major recruiters of nurses. This financing challenge is heightened by declining levels of official development assistance (ODA) and greater competition for what ODA funds do exist.

[62] Non-government stakeholders only participate in monitoring the implementation of the Global Code but no obligations are conferred upon them to implement it.
[63] Mackey/Liang 2013.
[64] Following the argument of Sauvant 2015.
[65] Campbell et al. 2016.
[66] Yeates/Pillinger 2013.
[67] The WHO reported that just 14 independent stakeholders contributed to monitoring the implementation of the Global Code, see WHO 2022. This had increased to 13 independent stakeholders and 38 private recruitment agencies in the subsequent (fifth) round of reporting, see WHO 2025.
[68] Yeates/Pillinger 2018.
[69] PSI is a public services global union federation spanning 154 countries, with a membership of more than 700 trade unions representing 30 million workers.
[70] Gencianos et al. 2024, pp. 14–15.
[71] Campbell et al. 2016; WHO 2015, 2025.

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In short, weak national capacity and health systems, especially in lower-income countries, have confounded the implementation of the Global Code.[72] A sign of fragility of commitment to the Global Code was seen during the Covid pandemic,[73] when OECD countries intensified international recruitment of nurses and other health workers.[74] The justification for breaching the Global Code in letter and in spirit revolved around the "essential nature" of international recruitment in responding to the Covid pandemic. Some governments targeted countries with severe health workforce shortages, including several countries in Africa on the WHO's Health Workforce Support and Safeguards List.[75] This recruitment depleted those countries' capacity to respond effectively to the pandemic,[76] and the depletion was so extensive that (for example) the government of South Africa added six categories of specialist nurses to its critical skills list.[77]

5 DISCUSSION AND CONCLUSION

For much of the 20th century, nurses have been invisible in research agendas on ethical international recruitment. Internationally mobile nurses were nevertheless the subject of the first multilateral agreement on international health worker recruitment – the ILO's R157 – as policy agendas of southern countries, the ILO and WHO coalesced. In the opening years of the twenty-first century, the focus on nurses was broadened to encompass other health professionals in the WHO's purpose-made Global Code of Practice on the International Recruitment of Health Personnel.

In what we understand to be the first systematic academic evaluation of its kind, we have innovated an expansive analytical framework to "benchmark" these multilateral agreements against operationalised elements of a critical ethics of care. A key empirical finding of our research is that both the agreements generally fare well against these elements but they do so in different ways and to different degrees. To a point, this is explained by their being negotiated and concluded in markedly different political-economic circumstances: the first during the global "post-war consensus" of embedded liberalism, at a time of expansive labour and gender equality activism through the ILO; the second during the global neo-liberal consensus that rejected social regulatory expansionism, when the human health and development costs borne by low- and middle-income countries became intolerably high. The substantive differences between the two agreements in terms of the operationalised care ethics have not been as great as their similarities, however: they both uphold the right to migrate and the rights of countries to actively recruit nurses and other health workers (almost) without restriction. However, a higher standard of responsibility in R157 applies to international recruitment compared with the Global Code. Ultimately, though, neither agreement stops individual nurses from being recruited to another country to practise their profession.

Although the two agreements fare well against the moral elements of a global ethics of care framework, the norms and institutional arrangements put in place through the two agreements struggle to meet the standards of a critical global ethics of care. Structurally, the global agreements have not launched

[72] WHO 2015, 2025.
[73] Yeates et al. 2022; Pillinger/Yeates 2020.
[74] OECD 2020, 2021; WHO 2022; Yeates et al. 2022.
[75] Yeates et al. 2022.
[76] ICN/CGFNS/Buchan 2022, p. 30; Africa News 2022.
[77] Magubane 2022.

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a significant challenge to the global relations of domination and inequality that historically gave rise to the global nursing workforce 'crisis' evident today. Across this entire period, developing source countries have continuously protested against their wealth being siphoned off through international recruitment to richer countries in order to fill nursing and other health vacancies in those countries. This dynamic has persisted, intensified even, over time, creating pronounced inequalities. Thus, ten principal high-income countries have 23% of the global stock of doctors, nurses and midwives while accounting for just 9% of the world's population[78]. Low- and middle-income countries remain focused on: targeted recruitment programmes resulting in the loss of specialists who are difficult to replace; needing to undertake international recruitment themselves as nationally trained graduates emigrate abroad; and the outflow of practising nurses to other countries as social care workers.[79] These are far from new phenomena or concerns. The Global Code's discourses of "international partnerships" and "mutuality of benefits" obscure the material reality underpinning these dynamics of intense inequality.

It must be concluded that, ultimately, these agreements have done more to secure wealthy countries' continuing access to the human resources for health of less wealthy countries than they have to limit it. Neither the WHO nor the ILO, nor any other multilateral or national organisation for that matter, has the authority and power to enforce restraining conditions on international recruitment beyond the exertion of moral leverage (save, perhaps, expulsion from the WHO, in extremis). The surge in international recruitment of nurses and many other health professional occupations during the Covid pandemic points to the fragile commitment by major recruiting countries to common international norms and standards. The incursion of active recruitment to "red list" countries and the stagnation of the implementation of the Global Code are, perhaps, the most apparent indicators of an unravelling global political consensus.

As we have suggested, critical questions about the Global Code are mounting in the face of growing evidence on the limited progress made in "shifting the dial" on international recruitment. Key issues for ongoing reviews of the effectiveness of the Code include: the scope of the agreement in relation to current international recruitment levels, trends and pathways and the recruitment practices of PRAs; the value of financial and technical assistance from recruiting countries relative to source countries' loss of investment; the challenges presented by temporary and circular migration and the contributions of the health and migrant diasporas to mitigate losses and maximise benefits of international recruitment.[80] A major issue of strategic importance is whether the Global Code should be opened for renegotiation or kept "closed", albeit with concerted efforts to strengthen its implementation. The risk that hard-won gains could be lost must be set against the prospective gains of broadening and strengthening its provisions. Either way, there is significant scope for strong global and national leadership among nursing professions and trade unions amongst others, to advocate the end of structural dependence of rich (core, formerly colonising) countries on overseas-born and -trained health and nursing workforces, and the dependence of poorer (semi-peripheral, peripheral, former colonised) countries on 'producing nurses for export[81]'. Only with structural changes in the political economy of nurse labour migration and recruitment, including a clear shift in favour of the presumption that "[a]ll Member States [will] meet their health personnel needs with their own human resources for health"

[79] Mahat/Cometti 2024.
[80] Mahat/Cometti 2024.
[81] Yeates 2009.

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(Article 5.4, Global Code) and strengthened compensatory mechanisms to address the ongoing legacies of historical (including colonial) development that deplete nursing workforces in poorer countries, does it seem that the standards of institutional practice consistent with a global critical ethics of care will be fully realised.

While we support a more engaged and historically-conscious debate about what strengthened global responsibility and accountability for the nursing and wider health workforce could mean, we reject the idea of establishing a dedicated international fund for health workforce and health systems strengthening.[82] Although such a fund could coordinate the disbursement of funds according to shared (global) priorities rather than according to the preferences of individual donors, it would reinforce the charitable model of international health assistance, while leaving untouched the crippling debt burdens that divert debtor countries' resources away from health systems strengthening to keeping to debt repayment schedules. It is easy to imagine that recruiting governments, which also tend to be principal donors of health-related financial and technical assistance, would reduce their overseas aid budgets by the amounts they contribute to such a global compensation fund. More promising may be to look outside of the health-migration nexus, in the form of a radical shift in the terms of international trade and investment to better support poorer source countries unlikely to meet the SDG health targets (or their future equivalents), coupled with international debt cancellation for those countries and a relaxation of the restrictions placed on their social spending by global institutional lenders, notably the World Bank and IMF. All of these would permit the increased level of investment in the health (and nursing) workforces that are required for strong health systems worldwide.

To conclude this paper, what are the implications of our expanded, 'thickened' analytical framework for how care ethics might be taken forward? A driving premise of this paper is that there is an unexplored possibility of using a care ethics framework to assess the overall moral quality of the two multilateral agreements that govern international nurse migration. This is a quite different approach than that which has dominated the field of care ethics to date, insofar as we have focused on regulatory instruments negotiated in spheres of cross-border (global) governance rather than in spheres of domestic (country-level) governance. Our study undertook a textual analysis of the two multilateral agreements, focusing on what the agreements say. Clearly, there is scope for further empirical research in relation to the quality of multilateral agreements viz how they have been implemented and in relation to other care professionals that do not share the labour conditions and occupational characteristics of nurses. Migrant social care professionals would be one prime focus for such a study, and would likely reveal a contrasting multilateral political-ethical institutional framework despite the significant overlaps between migrant nurse and social care workforces in practice. But a critical global ethics of care framework need not be confined to regulatory agreements pertaining only to migrant care workforces, as Robinson's application of care standards to poverty and humanitarian assistance has already demonstrated. A critical care ethics enquiry that looks beyond the health and social care sector prospectively opens up a wide range of other international agreements negotiated and concluded in global and sub-global multilateral forums pertaining to other sectors (e.g. trade and investment) whose ethical qualities can be assessed using the global institutional critical ethics of care approach and evaluative framework that we introduced and used in this paper. Our framework would, we believe, stand up to

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[82] Kingma 2006, p. 209; O'Brien/Gostin 2011; Mackey/Liang 2013; Ruger 2012. Van de Pas et al. proposed a global compensation fund with obligatory payments from high-income countries and private sector organisations, see Van de Pas et al. 2016.

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use in sectors other than nursing and care and provide a significant building block for further research into how the sphere of global governance interacts with and shapes public policy in domestic spheres. Such applications would be significant steps towards an expansive institutionalised care ethics of global governance and public policy.

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Appendix

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Figure 2: Comparison of ILO Nursing Personnel Recommendation and WHO Global Code in relation to critical institutional care ethics

MORAL ELEMENT	OPERATION-ALISATION	ILO NURSING RECOMMENDATION R157	WHO GLOBAL CODE OF PRACTICE
Attentiveness	Periodic comprehensive nurse workforce planning viz size, composition, practice and deployment, in relation to population health needs	Art II.4(1): "Member[s] should adopt and apply…a policy concerning nursing services and nursing personnel designed, within the framework of a general health programme and within the resources available for health care as a whole, to provide the quantity and quality of nursing care necessary for attaining the highest possible level of health for the population"; Art II.4.2: "The said policy should--(a) be co-ordinated with policies relating to other aspects of health care and to other workers in the field of health…; (b) include the adoption of laws or regulations concerning education and training for and the practice of the nursing profession and the adaptation of such laws or regulations to developments in the qualifications and responsibilities required of nursing personnel to meet all calls for nursing services; (c) include measures--(i) to facilitate the effective utilisation of nursing personnel in the country as a whole; (ii) to promote the fullest use of the qualifications of nursing personnel in the various establishments, areas and sectors employing them; and (d) be formulated in consultation with the employers' and workers' organisations concerned."	Article 3.6: "Member States should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel."
Compassion	Effective responses: feed-in evidence of timely and well-constructed action addressed to the problem(s) identified	Not specifically identified, but Art XIV.70 (Methods of Application) states R157 "may be applied by national laws or regulations, collective agreements, works rules, arbitration awards or judicial decisions, or in any other manner consistent with national practice which may be appropriate, account being taken of conditions in each country."	Article 3.7: "Effective gathering of national and international data, research and sharing of information on international recruitment of health personnel are needed to achieve the objectives of this Code." Article 5.4: "Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan."
Nurture	Addressing root causes of international recruitment & migration	Preamble: "[Notes] that the present situation of nursing personnel in many countries, in which there is a shortage of qualified persons and existing staff are not always utilised to best effect, is an obstacle to the development of effective health services."	Article 3.2: "Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed."
	Nurse workforce planning and investment	All Articles, esp: Art II.4(1) (see attentiveness, above) Art XIII.62 promotes "exchanges of personnel, ideas and knowledge, and thereby improve nursing care", using multilateral or bilateral arrangements, to (a) harmonise education and training for the nursing profession without lowering standards; (b) lay down the conditions of mutual recognition of qualifications acquired abroad; (c) harmonise the requirements for authorisation to practice; (d) organise nursing personnel exchange programmes."	Article 5.4: "Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible." Article 5.5: "Member States should consider strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs…" Article 5.6: "Member States should consider adopting and implementing effective measures aimed at strengthening health systems, continuous monitoring of the health labour market, and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population's health needs. Member States should adopt a multisectoral approach to addressing these issues in national health and development policies."

MORAL ELEMENT	OPERATION-ALISATION	ILO NURSING RECOMMENDATION R157	WHO GLOBAL CODE OF PRACTICE
Nurture	International solidarity and cooperation among countries, especially for poorer ones	Not specifically identified. Two articles relate to international nurses: Article XIII.68 (International Cooperation): "Nursing personnel employed or in training abroad should be given all necessary facilities when they wish to be repatriated"; Art. XIII.69: with regard to social security, members should (a) assume to foreign nursing personnel training or working in the country equality of treatment with national personnel; (b) participate in bilateral or multilateral arrangements designed to ensure the maintenance of the acquired rights or rights in course of acquisition of migrant nursing personnel, as well as the provision of benefits abroad.	Article 10.2 "International organizations, international donor agencies, financial and development institutions, and other relevant organizations are encouraged to provide their technical and financial support to assist the implementation of this Code and support health system strengthening in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and/or have limited capacity to implement the objectives of this Code. Such organizations and other entities should be encouraged to cooperate with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease-specific interventions are used to strengthen health systems capacity, including health personnel development."
Responsibility	Threshold of nurse workforce at which nurse recruitment from a country is not permitted	Article XIII.67.1: "Recruitment of foreign nursing personnel for employment should be authorised only-(a) if there is a lack of qualified personnel for the posts to be filled in the country of employment; (b) if there is no shortage of nursing personnel with the qualifications sought in the country of origin." Art XIII.67.2: "Recruitment of foreign nursing personnel should be undertaken in conformity with the relevant provisions of the Migration for Employment Convention and Recommendation (Revised), 1949."	Article 5.1: "Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers." Article 8.7: "Member States are encouraged to observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel, and assess the scope and impact of circular migration."
Responsibility	Compensate source countries for lost investment due to recruitment/ migration of nurses	Not specified	Not specified. Note, however: Article 5.2: international cooperation and coordination arrangements "should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate measures." (e.g. technical assistance; support for health personnel retention and for social and professional recognition of health personnel; appropriate training in source countries; health facilities twinning; access to specialized training, technology and skills transfers; support for return migration). Article 10.3: "Member States either on their own or via their engagement with national and regional organizations, donor organizations and other relevant bodies should be encouraged to provide technical assistance and financial support to developing countries or countries with economies in transition, aiming at strengthening health systems capacity, including health personnel development in those countries."

MORAL ELEMENT	OPERATION-ALISATION	ILO NURSING RECOMMENDATION R157	WHO GLOBAL CODE OF PRACTICE
Responsibility	Adherence to human rights and international labour standards, including decent working conditions, fair and ethical recruitment, and fundamental labour rights of migrant workers	All Articles, esp Arts V-X inclusive concerning workers' representation, career development, remuneration, working time and rest periods, occupational health provision, and social security	Article 3.4: "nothing in this Code should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them." Article 3.5: "Member States, in conformity with national legislation and applicable international legal instruments to which they are a party, should promote and respect fair labour practices for all health personnel. All aspects of the employment and treatment of migrant health personnel should be without unlawful distinction of any kind." Article 4.4: "Member States should, to the extent possible, under applicable laws, ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel and that migrant health personnel are not subject to illegal or fraudulent conduct. Migrant health personnel should be hired, promoted and remunerated based on objective criteria, such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce. Recruiters and employers should provide migrant health personnel with relevant and accurate information about all health personnel positions that they are offered." Article 4.5: "Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws."
Responsibility	Robust monitoring, learning and accountability systems underpinned by timely data and results	Not specifically identified (but see compassion, above.)	Article 5.6: Member States should consider adopting and implementing effective measures aimed at strengthening health systems, continuous monitoring of the health labour market, and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population's health needs." Article 6 – Data gathering and research 6.1 Member States should recognize that the formulation of effective policies and plans on the health workforce requires a sound evidence base. 6.2 Member States are encouraged to establish or strengthen and maintain, as appropriate, health personnel information systems, including health personnel migration, and its impact on health systems. Member States are encouraged to collect, analyse and translate data into effective health workforce policies and planning. 6.4 WHO, in collaboration with relevant international organizations and Member States, is encouraged to ensure, as much as possible, that comparable and reliable data are generated…for ongoing monitoring, analysis and policy formulation." Article 7.1: "Member States are encouraged to, as appropriate and subject to national law, promote the establishment or strengthening of information exchange on international health personnel migration and health systems…" Article 7.3 "Member State[s] should, as appropriate, designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code…and to submit reports and other information to the WHO Secretariat". Article 8 – Implementation of the Code 8.1 "Member States are encouraged to publicize and implement the Code in collaboration with all stakeholders." 8.4: "All stakeholders…should strive to work individually and collectively to achieve the objectives of this Code. All stakeholders should observe this Code, irrespective of the capacity of others to observe the Code." 8.6 "Member States should, to the extent possible, encourage and promote good practices among recruitment agencies by only using those agencies that comply with the guiding principles of the Code."

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