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2012-06-26

http://hdl.handle.net/10138/322260

Wrede, S 2012, Nursing : Globalization of a female-gendered profession. in E Kuhlmann & E Annandale (eds), The Palgrave Handbook of Gender and Healthcare. 2nd edn, Palgrave Macmillan, Basingstoke, pp. 471-487. https://doi.org/10.1057/9781137295408

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Chapter 27

Nursing: Globalization of a female-gendered profession

Sirpa Wrede

Introduction

Governments, health managers and the general public in high-income countries invoke nurses as a central resource for achieving health political aims (Davies, 2007). This is hardly surprising, as nurses are the largest group of workers in healthcare holding formal qualifications. In OECD-countries nurses usually outnumber doctors three to one (OECD, 2008: 14-15). Recent research suggests, however, that even though policies in high income countries recognize nurses as important healthcare workers, the quality of nursing work from the point of view of the nurses as workers has been neglected. Recent health reforms have pushed for cuts in healthcare spending, resulting in deteriorating working conditions for nurses (Folbre, 2006). Neoliberal economic restructuring has emerged as a global force that has steered nation states to explicitly create and reinforce the redistribution and internationalization of care work, including nursing (Misra et al, 2006). For instance, recent research evidence from the United States, the country that employs the largest number of foreign nurses, demonstrates that dissatisfaction with the nursing workplace is the key reason cited by nurses working outside of nursing employment (Black et al, 2008).

The emerging interconnections of the global political economy is expressed in global care chains, as neoliberalism shapes policies in both sending and receiving countries (Yeates, 2005; 2008). Also, in 2000 when the total number of foreign-born nurses in the OECD-countries was estimated to be 710,000, nurses outnumbered doctors nearly two to one in the international migration of skilled health workers (OECD, 2008: 33). From a global development perspective the growing flows of nurses from low-income countries to high-income countries are problematic. Poverty boosts a brain drain when nurses and doctors trained by poorer countries benefit the health systems of affluent countries.

This chapter examines the cultural ideas underlying the globalization of nursing as female-gendered work on the one hand and as a profession on the other hand. Globalization of nursing refers here to the complex cultural and socio-economic dynamics that reorganize both professional ideologies and social orders among nurses.

Nursing in the UK, Finland and the Philippines serve as critical points of reference in the consideration of key themes in the social shaping of the nursing profession. The UK constitutes the site where the foundation of modern nursing ideology was laid in the mid-nineteenth century, an age when the British Empire provided an infrastructure for both exporting nursing ideology and importing migrant nurses. Finland offers an example of a welfare state context of a country that for many years served as a sending region in terms of nurse migration. Recently, and with a rapid pace, Finland has turned into a receiving region. Nursing in the Philippines, the third reference point country, has been tailored according to Western standards; for more than a half century Filipino nurses have emigrated to high-income countries serving as a global reserve for nursing labour. This selection of countries as reference points of globalization dynamics in nursing offers a means of demonstrating the complex interconnectedness of national settings as well as the continued transformative potential globalization holds for nursing as a profession. More generally, the analysis of nursing also sheds light on the gendering of globalization.

The chapter begins by considering the feminist literature analyzing the professional ideologies that shape nursing, arguing that transnational linkages and knowledge transfers are a permanent element in nursing professionalism. Second, the chapter further investigates how, in the mid-twentieth century, the welfare state provided the context for the rearticulation of nursing professionalism. The third theme is the global restructuring of welfare states, occurring internationally since the 1970s, that has increasingly opened the provision of healthcare to market mechanisms and efficiency campaigns and contributed to the further reframing of nursing work. The final part of the chapter explores the impact of these developments on nursing. The argument is that the complex social changes associated with the globalization of economy, politics and culture reorder the very foundation of professions and the arenas in which the professional organizations that represent professions act (see for example, Allsop et al, 2009).

The making of moral boundaries of nursing: A gendered white and western project

Recent scholarship posits professionalism as a discourse consisting of a set of normative values and identities that both discipline and enable the social actors concerned by it (Fournier, 1999). The normative professional identities that contribute to the discursive government of professional fields are products of professional

ideologies influenced by both internal and external claims-making (Evetts, 2003). Arguing in this vein, this chapter holds that the Anglo-American understanding of professions as occupations occupying central roles in core societal activities forms an important cultural resource for the present globalization of healthcare work (Mortimer, 2005). Furthermore, these ideas can be identified as both historically important and as a potent influence internationally at the present time, even though the development of occupations in different national settings has followed divergent paths (Mortimer and McGann, 2005; Rafferty et al, 1997). It is important here to recall that ideas about nursing have in essence also been ideas about femininity and the value of women's work (Davies, 1995; Witz, 1992). The present reshaping of nursing as work and as an occupation further demonstrates how the gendered notions associated with nursing are rearticulated to fit the increasing globalization of healthcare and associated labour markets.

There is a vast literature to demonstrate how the British notion of nursing as a profession has influenced the shaping of the occupation in other countries (see for example, Choy, 2003; Henriksson, 1998). While the production of this disciplining professional identity may have followed different paths in different countries, it nevertheless has been everywhere influenced by the complex international exchanges and transfer of ideas instigated in the late nineteenth century by the founders of international nursing organizations. To the early internationalizers who were primarily internationally-minded social movement activists from the UK and the US, British nursing represented the yardstick for nursing as a profession. This particularly holds true for the development of nursing education. In the long-term, US nursing came to take more diverse shape, reflecting the diverse pressures of a healthcare system based on the dominance of private market actors rather than the state (Davies, 1980; Mortimer, 2005).

Given the dominant role of British nursing, the critical analysis of nursing history and of the position of nursing in healthcare examines the complex cultural merging of the influences of Victorian womanhood and family ideas, militarism, charity as well as religious calling into a professional ideology. In the exchanges between nursing professionalizers from different countries and the transfers of the British model of nursing education to other countries the professional nurse was embodied by the image of Florence Nightingale. The idea of nurses as ideal women was discriminatory in that it empowered a particular type of woman – representing the emerging middle-class – to become nursing leaders be it in the nursing organizations or in professional

settings (Wildman and Hewison, 2009). The rank and file nurse, by way of contrast, was conceptualized as a disciplined worker who embodied feminine virtues (Davies, 1980; Hallam, 2000; Rafferty et al, 1997). The feminist literature in the 1980s and early 1990s attributed the failure of the earlier professionalizers to their unsuccessful attempt to distinguish British nursing and midwifery from medicine by interpreting it as care work which, as 'women's work', is devalued in society in general and in the family in particular. Authors such as Davies (1992) and Witz (1992) pointed out that such patriarchal cultural ideas make it possible to treat rank and file nurses as a disposable labour force.

Addressing the sociocultural context of nursing in mid-nineteenth century England, Davies (1995) argued that the professionalization of medicine was an identity project for middle-class men who did not own land. Their ambition was to constitute medicine as a learned profession, which not only provided them with a respectable way of earning a living, but a way of acquiring social recognition. This project positioned nursing as an adjunct to the medical profession, leaving nurses in a deeply contradictory position when trying to pursue a professional project of their own. Patriarchal social relations supported medical dominance, at the same time that the organization of healthcare was becoming increasingly complex and formalized and created a foundation for complex nursing competences.

Late nineteenth century ideology of how the nursing profession should be organized was premised on the supremacy of Western culture in general and British culture in particular. Florence Nightingale's project of nursing served the very aims of the British Empire to civilize the colonies (Hallam, 2000). The Finnish case provides an example of how these British ideas travelled. The Finnish nursing pioneer Baroness Sophie Mannerheim was trained in London at the turn of the twentieth century and brought home the Nightingale tradition of nursing that served as a standard for the early nursing programmes in Finland (Henriksson, 1998). Similarly, the Nightingale tradition of recruiting gentlewomen to nursing was transferred to the Philippines by the US colonial rule that sought to Americanize the country's nurse training in the early 1900s (Choy, 2003).

For the leaders of the British Empire, a British nurse constituted a civilizing agent that could transform the colonies (Hallam, 2000; Mortimer, 2005); but for nurse leaders internationally, the reform of the occupation opened doors to political action within their respective national settings. The International Council of Nurses was established in

1899 by largely Anglophone middle-class women eager to reform nursing into an occupation suitable for middle-class women (Mortimer, 2005). International collaboration offered useful strategies for the advancement of professional projects and arenas for knowledge transfers. The Nightingale project of nursing reform incorporated Victorian ideas about motherly 'true womanhood', at the same time as the role of the head nurse particularly was associated with efficiency and authority (Hallam, 2000: 20). These seemingly conflicting values justified an internal hierarchy within nursing; they supported the authority of nursing leaders and the subservience of the rank and file both towards matrons and doctors (Davies, 1995; Witz, 1992). With reference to the true womanhood of 'moral' women, Tronto (1993) argues that this discourse excluded women of colour, immigrant women, poor women, lesbians, and women who were not fit for the roles 'true women' play in society.

Summing up, recent research into nursing history demonstrates that the professional ideology shaping early British nursing associated with the larger projects of colonization has evident transnational consequences that are still relevant today (see for example, Hallam, 2000; Mortimer and McGann, 2005). The British Empire, with its civilizing activities in the colonies, created a demand for a new type of nurses who could act both as civilizing agents and as leaders for rank and file nurses by securing their input as disciplined workers. For the middle-class activists, the reform of the lowly occupation offered an avenue for defining nursing as a profession suitable for women of their own social standing (Hallam, 2000). The most central legacy concerns ideas about the internal organization of nursing. Accordingly, professionalizers of nursing outlined a class-based hierarchy for nursing that built on an internal division of labour. The professional nurse was portrayed as either a disciplined but caring 'angel' or a more militant agent of moral reform, who embodied a more privileged femininity. Both images are essentially white and Western (Hallam, 2000).

Nursing in the welfare state: Ambiguous legacies

In the UK, the gender-sensitive literature on nursing has not assigned the welfare state of the 1960s and 1970s any particular empowering potential vis-à-vis nursing. Rather, researchers have concluded that a managerial view of the occupation has largely dominated over a professional view (Davies, 1995; Dingwall et al, 1988). Furthermore, the literature has remained critical of professionalism as an occupational ideology, arguing that its yardstick for 'true' professionalism is the hegemonic masculinity of privileged middle-class men, entailing devaluation of feminine qualities (Davies, 1996).

Accordingly, the criticism holds that in the context of the welfare state too the professionalizers of nursing in the UK focused on the interests of particular segments within the occupation rather than the interests of all groups, aiming to protect or enlarge nursing's share of the market for well qualified, middle-class girl school leavers (Dingwall et al, 1988). This professional ideology persisted and remained largely untouched even in the 1980s as the managerial pressures boosted the demand for foreign healthcare workers who provided a cheap and flexible workforce in the British NHS (Hallam, 2000).

Experiences of the professional projects of female-gendered professions from the context of the Nordic welfare states have been interpreted in a somewhat different light. Indeed, Finnish scholars have argued that the social-democratic welfare state at the peak of its investment in social services in the 1980s provided an institutional matrix that was friendly to the professional projects of female-gendered professional occupations in social and healthcare, but also steered them in specific directions (Henriksson et al, 2006). By issuing specific mandates, the state bound female professions to the state and to specific styles of practice (Wrede, 2001). The Nordic welfare state is identified as favouring egalitarian social service professionalism over elitist professionalism. The latter refers to the idea that professional practice of certain key professions is based on universal knowledge and therefore the neutrality of these elite groups should be protected from state intervention. Furthermore, as guardians of neutral knowledge, elite professions are outlined as groups whose social authority goes beyond the context in which individual professionals practice – the idea of medical dominance over health care and healthcare professions is the classic example. From a critical perspective, elitism professionalism fuels 'tribalism', self-interest and social exclusion within and between professional groups. Social service professionalism, in contrast, emphasizes the role of professions as 'servants of the public' thus furthering a more egalitarian notion of professional knowledge when it forms the basis of a state-defined social service. When the state provides its citizens social services such as healthcare, the state not only has a democratic mandate to hold professions accountable for their styles of practice but commonly defines the boundaries within which they provide their services (Wrede, 2008b).

It is evident, nevertheless, that similar to the UK, professions in the Finnish context also had evolved in the early twentieth century as hierarchical social orders where 'true' professionalism and social privilege overlapped, reflecting the ideological potency of dominant masculinities as well as femininities (Wrede, 2008a; 2008b). Reminiscent of

the ideological connections between professional projects and British Imperialism, the professional projects of early nursing in the early twentieth century were part and parcel of the building of the Finnish nation state (Henriksson, 1998; Yrjälä, 2005). Nationalism remained a core element of the ideological projects underpinning the so-called Nordic welfare-state model and the associated professional projects that took shape from the 1960s onwards (Wrede 2008b). The social recognition of the value of nursing was ambiguous, however, as nursing remained women's work with comparatively low salaries. This persistent disadvantage is reflected in the fact that at least temporary employment in other countries, particularly within the Nordic region, has remained an employment strategy for many young Finnish nurses since the 1960s (Bourgeault and Wrede, 2008). Furthermore, even in the 1970s and the 1980s many professionalizers favoured elitist professionalizing strategies that contributed to a stratification and segmentation of the nursing workforce (Henriksson, et al. 2006).

From a Filipino perspective, nurse professionalism and the welfare state have an even more ambiguous history. Unlike in Finland where domestic activists played the central roles in importing the Anglo-american model of professional nursing to the country, Filipino nursing appeared in the early twentieth century as a result of the vigorous efforts of the American Rockefeller Foundation to establish nursing in the Philippines. The philanthropic efforts were a part of a global public health agenda, within which nursing education all over the world was developed according to US standards (Brush, 1997; Davies, 1980; Healey, 2008; Yrjälä, 2005). In the Philippines, US-style nursing was intended contribute to improving the public health in the islands (Brush, 1997). In the context of the US domination of the Philippines, however, the shaping of the nursing profession came to follow an imperialist logic; US nurse recruiters soon discovered Filipino nurses as a ready-made workforce for the US health system (Choy, 2003). The activities that eventually established Filipino nurses as the key group within the growing army of internationally migrant nurses from low-income countries was built on the foundation laid by the Rockefeller Foundation. Since the 1960s, Filipino nurses, primarily trained by the private sector and at the cost of the trainees themselves, emerged as an 'export product' for the country.

The Filipino government has both supported and designed the export of nurses, as the country has benefited from the remittance income sent home by the migrant nurses. With an estimated 85 per cent of Filipino nurses working abroad, and with rapidly growing international demand, nurse emigration currently threatens the efforts to sustain healthcare provision in the Philippines (Aiken et al, 2004). In the mid-twentieth century, the Rockefeller Foundation followed a similar strategy of also investing in

educating a nurse elite according to US standards in India, where this strategy had little success in lifting the social standing of nursing, an occupation traditionally stigmatized in wider Indian society due to the taboos associated with many nursing tasks (Healey, 2008). In the 2000s, as the number of educated Indian nurses has increased, a 'brain drain' has occurred (Hawkes et al, 2009).

The migration flows of Filipino nurses, which have constantly grown during the last 50 years, are part of a larger movement of nurses across continents and country borders. The demand for a large number of nurses is related to the creation of large hospitals that boomed after World War II. The European countries that remained outside the War – Switzerland and Sweden – soon emerged as destination countries for migrant nurses. In the growing economy of the post war years, the demand for immigrant nurses also soon grew in many other western European countries, as well as in the wealthy new-world countries. The United States emerged as the largest importer of nurses; in the past 50 years the US has steadily imported nurses globally. The biggest group has been Filipino nurses, the other major source countries being Canada, the UK, India, Korea, and Nigeria (Brush et al, 2004). Since the 1940s, UK healthcare has also relied on 'overseas' recruits and other migrant nurses whose recruitment was facilitated by governments that have defined the training of nurses from former colonies as 'overseas aid', securing the availability of a growing number of primarily female black nursing trainees from former colonies (Hallam, 2000; Mortimer, 2005). The availability of overseas nurses may have contributed to the continued treatment of nurses as disposable labour (Davies, 1992). Such a management style serves to explain why many British nurses have moved to other countries, primarily to the US and other Anglophone countries, even though the domestic labour market has offered plenty of opportunities for employment.

The fact that the international migration of nurses has grown in the long-term demonstrates that the dynamic that creates the demand for migrant nurses is not a new one, even though it has been strengthened by the institutional changes in the welfare state during recent decades. From the late 1950s onwards, the welfare state projects of many high-income countries boosted the demand for the nursing labour force, but did not satisfactorily cater for the needs of nurses themselves as workers and professionals. The conditions for this workforce have been shaped by managerial ideologies that largely reinforce the image of much of nursing as lower-skill work, the bulk of which can be carried out by a disposable workforce as long as their work is organized by professionals (Davies, 1992; Hallam, 2000; Wrede, 2008a). The elitist

strategies of some segments within nursing contribute to this view. For instance, in the UK, the politics of nursing traditionally have been characterized by registered nurses' hostility towards auxiliaries and assistants (Dingwall et al, 1988). There is evidence from the Nordic countries to suggest that the egalitarianism of the social democratic welfare states counteracted such elitist professionalism, even though the basic dynamic of internal competition remained (Henriksson et al, 2006). Nordic women-friendly family policies also helped female professionals. But the situation is changing. Although feminist scholars of the 1980s considered the Finnish welfare state the woman's best friend – 'better than diamonds' – they now argue that this interpretation is no longer warranted in the early twenty-first century (Julkunen, 2004: 182). At the same time as the Nordic welfare states such as Finland are redefining the policies that organize nursing work they have also come to rely on an imported nurse workforce (Aiken et al, 2004; Bourgeault and Wrede, 2008).

The impact of the neoliberal reform paradigm on nurse migration and nursing care

As has already been suggested, the international recruitment of nurses started to increase as the governments of affluent countries intensified their efforts to find new pools of flexible, cheap health workers. Indeed, many governments now explicitly seek to redistribute and internationalize care work, including nursing work (Misra et al, 2006). Currently the international migration of nurses is booming and new destination countries are emerging, making the phenomenon even more global. In Europe, Ireland and Finland, both previously source countries, now recruit nurses from other countries (Aiken et al, 2004; Bourgeault and Wrede, 2008; Yeates, 2004). Saudi Arabia and Singapore are other new destination countries, while the former socialist countries, as well as developing countries, such as India and China, constitute new sending regions. Many governments aspire to enter the market of training nurses for export, an activity traditionally dominated by the Philippines, at the same time as their own health sectors are already suffering workforce shortages (Aiken et al, 2004). Indeed, Hawkes and colleagues (Hawkes at al, 2009) calculate that India is loosing one fifth of its nursing labour force to wealthier countries. A chain dynamic in the migration of skilled healthcare labour powerfully brings to light how social inequalities shape opportunities for nurses. Migrant nurses from first world countries, even though also influenced by push factors such as unemployment, differences in salary levels et cetera, are still privileged when compared with migrant nurses from the transition countries of eastern Europe or poor countries outside Europe (Larsen et al, 2005).

The increased managerial pressures on nursing – reflected in the demand for cheap and flexible nurses – are related to the neoliberal welfare state reforms that have become a global movement during the last three decades. Rather than being a unitary programme of specific measures, this movement can be conceptualized as a hegemonic global discourse of 'reform' and 'change' that has travelled 'along national highways' (Kuhlmann, 2006: 7). Commenting on developments in the UK in the 1980s, Davies (1992) argues that neoliberal reforms treated nursing in an archaic way that reinforced the subordination of women's work. Accordingly, when seen from the outside, nursing was understood as a fairly homogeneous activity requiring pairs of hands and qualities such as dedication, sympathy and altruism (Davies, 1992). The trivialisation of nursing enabled organizational neglect, and gender was implicated in the style of management applied to nursing in healthcare organizations in ways that expressed the devaluation of nurses as a workforce (for contemporary developments, see also the chapter by Barry et al).

International comparison suggests that neoliberal policies have favoured a commercially-minded 'market expert professionalism' over the social service professionalism that the earlier welfare state policies often were identified with (Sandall et al, 2009: 548). Such new forms of expert professionalism may even reinforce certain elements of an elitist professionalism. Expert positions – such as, for example, Nurse Practitioners or managerial positions – are only available for some (groups of) nurses. For the majority, the new policies promise to increase direct patient work. Aiming at greater efficiency, the new policies target the health division of labour with the aim of making nursing more efficient, for instance by the tailoring of nursing roles, skill mixes and teamwork to meet the specific needs of organizations (Bourgeault et al, 2008).

Finland provides an example of a country where the impact of the 'efficiency drive' of the 1990s, coinciding with a deep recession, has transformed the conditions for nursing. In a recent representative survey of registered nurses (RNs), nearly 40 per cent of nurses reported that they no longer would choose the occupation and one fifth said they were in doubt as to whether they would. Both groups reported similar reasons: poor salaries, poor working conditions, high responsibilities under considerable pressure and lack of recognition (Santamäki et al, 2009: 33). RNs who graduated during the years 1987-1995 are particularly discontent with the occupation (Santamäki et al, 2009: 36). When these nurses were entering the labour market, nursing was being reconfigured along the lines of new management ideals. Research

evidence further shows that the 'flexible' work roles that are tailored for auxiliary groups within nursing according to the needs of employing organizations threaten their occupational identity and commitment to the occupation. Auxiliary nurses are seen 'as the flexible workforce that is particularly needed for routine, work-intensive care domains'; thus they are forced to re-negotiate the occupational boundaries and give proof of their competencies in different organizational contexts (Wrede, 2008a: 133). It is likely that this reorganization of healthcare work has contributed to the demand for migrant nurses that emerged in Finland in the early 2000s (Bourgeault and Wrede, 2008).

Currently, it seems likely that migrant nurses will become a major segment in the nursing workforce in most high-income countries in years to come (OECD, 2008). The increased reliance on migrant nurses occurs in the context of skill mix reforms that, centring on the notion of skill, suggest a legitimate meritocratic hierarchy in the nursing workforce. As skill is socially constructed, however, it is evident that power differentials and cultural assumptions about gender, 'race', ethnicity and nationality emerge as highly significant cultural ideas in the social definition and evaluation of nursing skills (Hallam, 2000; Steinberg, 1990). Accordingly, neoliberal policies can be critiqued for supporting an elitist professional ideology that favours the professional interests of a few segments, such as for example Nurse Practitioners, over the shared social interests of all nurses (Henriksson et al, 2006). Indeed, critiques that adopt a global perspective identify social relations of inequality and labour exploitation *among* women as key features in the present re-organization of the global political economy of care (Yeates, 2004). When contemporary globalization processes forge a 'new' global economy of reproduction, governments perceive nurses 'produced' in low income countries as the future carers, primarily of care-intensive work such as care for the elderly and the long-term sick (Yeates, 2008).

Globalization of nursing

It is too early to claim that nursing is a globalized profession. At present nursing still remains largely organized within distinct national contexts and governed at the national level. Also, in most countries, the proportion of foreign-trained nurses remains below ten per cent (Aiken et al, 2004). But the situation is rapidly changing as a consequence of the complex configurations of economic, political and cultural globalization. For instance, in the European context, a process of Europeanization of health policy can be identified, occurring primarily as a consequence of the activities of EU institutions

outside of the health field (Greer, 2006). An unprecedented restructuring of nursing is taking place globally in national as well as transnational contexts as a result, for instance, of the growing relevance of transnational trade in health services. Trade in health services includes cross-border healthcare delivery, consumption of health services abroad, the commercial presence of transnational companies in national health systems, as well as the managed large scale movements of healthcare personnel (Chanda, 2001). The scholarship on nurse migration provides evidence of how so-called global cities, such as London, that are hotspots of global markets, also have a high proportion of foreign trained nurses (see for example, Aiken et al, 2004). In the US – the main receiving country for foreign trained nurses in the world – the growing demand has turned the international recruitment of nurses into a lucrative business for recruitment agencies (Brush et al, 2004). As a consequence future scholarship on nursing will have to tackle a complex challenge that goes beyond the traditional scholarship on gender and the professions. The politics of nursing as limited to national settings perhaps was always too narrow a perspective. But now more than ever, the literature on nursing needs to engage with the literature on global care chains that attempts to capture the ways the transnational and globalizing dynamics currently transforming nursing are gendered (Yeates, 2004; 2005; 2008).

A transnational perspective on care not only emphasizes the historical legacy of global inequality, but also of institutionalized relationships of subordination (Choy, 2003; Yeates, 2004). From this perspective gendered migration patterns between countries, such as the so-called global care chains (Hochschild, 2000), are understood as transnational processes through which historical relationships between countries give rise to the specific preconditions and conditions for contemporary developments (Yeates, 2004). For instance, it has been argued that, in the case of Filipino nurses migrating to the US, nursing is not simply a gendered and racialized institution, but an international arena for the conflict and cooperation of predominately women workers worldwide and that from this perspective, migration, colonialism and imperialism are intertwined (Choy, 2003).

This transnational perspective links nurse migration to exploitation and (neo)colonialism rather than simply to the structural forces within the national boundary of the receiving region, such as the ‘pull factors’ of labour force shortages or high salaries (Choy, 2003). In her analysis of the migration of nurses from the Philippines to the US, Choy argues that:

> the desire of Filipino nurses to migrate abroad cannot be reduced to an economic logic, but rather reflects [an] individual and collective desire for a unique form of social, cultural and economic success. (2003: 7)

She further states that such success has been seen as 'obtainable only outside the national borders of the Philippines' (2003: 7). In a similar vein, Ishi (1987) stresses the importance of demands of the service economy in high income countries. The economic exploitation of low income countries therefore reinforces the cultural, political and military hegemony of high income countries.

Those who stand to loose in the new global healthcare labour markets are nurses migrating from poor countries like the Philippines. To be sure, international migration of health workers can be defended with reference to the opportunities that international recruits from poorer countries gain in terms of access to economic mobility by migrating. However, their status also needs to be considered in the context of destination countries. High-income countries continue to have strong capacities to regulate nursing work at national as well as transnational levels and strong nursing trades unions enact protectionist strategies vis-à-vis international recruits. These developments may contribute to producing nationality and non-domestic education as sources for new hierarchies of super and subordination within nursing. Even though nurses are privileged if compared with domestic workers or sex workers, female migrants from low-income countries tend to be particularly vulnerable to the gendered inequalities associated with international migration. Indeed, migrant nurses from low-income countries stand to loose opportunities and encounter exploitation, if, for instance, their credentials are not recognized and they end up in assistant roles (see also Ribeiro, 2008). For low-income countries this constitutes brain drain, even brain waste, if the nurses they train end up as unrecognized care workers elsewhere. This loss of human capital is most acutely a loss for the populations of the poor countries where the development of healthcare services is hampered by the shortage of labour force that is difficult to mend.

Conclusion

Kuhlmann (2006) has drawn attention to the similarities of professionalism and citizenship as normative concepts that provide legal solutions for the management of individuals and populations. She further holds that both build on a hegemonic masculinity that denies women and all people labelled as 'others' full access to

citizenship and to the professions (Kuhlmann, 2006). Wrede (2008b) suggests that it is helpful to identify the privileged femininities upheld by professional ideologies of female professions as dominant, even hegemonic femininities. The literature cited in this chapter that has critically assessed the ideologies underpinning professional nursing has demonstrated that the hegemonic femininity in nursing is that of white, middle-class women whose activities uphold western interpretations of healthcare work. This professional ideology also dictates the internal social orders that stratify nursing and divide it into segments. Historically, this professional ideology has nevertheless succeeded in producing the disciplining identity for rank-and-file nurses in a persuasive way; that is, by producing an image of nurses as 'angels' that embody specific feminine virtues (Hallam, 2000). This persistent imagery has served to make male nurses and other than white, middle-class nurses invisible. This imagery is currently in flux, but in the context of globalization inequality it is likely to persist.

In a context where welfare services become commodities sold and bought in transnational markets, the new professionalizers of nursing steer some segments of nurses towards providing a marketable expertise, while the majority are shaped into flexible workers. Against this background, the concepts of brain drain and brain gain, often used in literature on so-called skilled migrants such as nurses, as well as the notions of push and pull factors are simplistic, if not linked to the wider framework of the gendered and racialized injustice embedded in international migration.

The complex impact of globalization on nursing is not, however, merely the emergence of new transnational connections and an internationally diverse workforce. Transformative cultural change occurs also within the national context, when new healthcare cultures emerge. Both non-local reform ideas and migrant nurses are agents in the transformation of nursing, challenging the idea of nursing as a nationally-bounded, unitary profession. Traditionally, registered nurses had a strong basis in their professional ideology of unity, while the lower skill groups of auxiliaries and assistants were excluded from making claims on being professional. The current emphasis on multi-professional teams, specialization of nurses into specific tasks and the emphasis on separating leadership into a separate function are examples of new, internationally spread ideas that reorder nursing work, challenging traditional professional ideologies and orders. The complex new division of labour boosts new group identities and divided loyalties. Focusing on a high-income country context in particular it is evident that some groups and individuals within nursing gain new professional opportunities, while some tasks may disappear from the nursing jurisdiction. Nurses from low-income

countries, on the other hand, gain new economic and professional opportunities, but also face a high risk of encountering exploitation and discrimination.

For nursing as a group with a shared professional ideology and imagery, the future is ambiguous. To be sure, the wider politics of expertise and flexibility are increasingly transnational and the problematic legacies of professionalism that helped to construct nursing as an elaborate hierarchy seem to be revitalized rather than counteracted by present developments. As a result, when nursing is globalized along national pathways, the references to professionalism and skill produce new, complex orderings of nurses reflecting the specific dynamics of particular settings. Research into these phenomena requires gender-sensitive analysis that considers the intersections of gendered injustice with other local and global forms of inequality. Furthermore, a critical transnational perspective is needed, paying close attention to how wider, transnational patterns of economy, politics and culture transform the politics of nursing at different levels.

Summary

- Historically, gendered ideology configured professional nursing as a female profession with an internal, class-based hierarchy and an associated internal division of labour. In the context of the nation state professional nursing has been articulated in relation to state projects such as imperialism, nationalism and the welfare state.
- Neoliberal economic restructuring has emerged as a global force that has steered nation states to explicitly create and reinforce the redistribution and internationalization of care work, including nursing; neoliberalism shapes policies in both sending and receiving countries.
- The transnational perspective links nurse migration to exploitation and (neo)colonialism rather than simply to the structural forces within the national boundary of the receiving region, such as ‘pull factors’, like labour force shortages or high salaries.
- When nursing is globalized along national pathways, references to professionalism and skill produce new, complex orderings of nurses within the wider profession. Research into these issues requires gender-sensitive analysis that considers the intersections of gendered injustice with other local and global forms of inequality.

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