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CARE, HEALTH AND MIGRATION

*Kim England, Isabel Dyck,
Iliana Ortega-Alcázar and Menah Raven-Ellison*

Introduction

'Care,' Marian Barnes writes, 'is fundamental to the human condition and necessary both to survival and flourishing' (2012, 1). There is a growing interdisciplinary literature on theorizing and expanding the concept of care, including using it as a broad framework for making moral, political and policy decisions (see, for example, Folbre 2012; Held 2006; Tronto 2013). Feminist care ethics, especially when in conversation with debates about political values, social policy and citizenship, offers an alternative conceptualization of society that recognizes that care is essential for human life.

Feminist geographers have been contributing to this rich vein of scholarship. This includes reflexive interventions about the ways forward for a more caring discipline and caring academic structures (e.g. Lawson 2007; Puāwai Collective 2019). Much attention focuses on the varied spaces and places associated with the politics, processes and practices of care, including connecting the spaces of everyday life with a range of institutions and state agencies (e.g. England and Dyck 2012; Milligan and Wiles 2010; Power and Hall 2018; Radicioni and Weicht 2018). Moreover, the wide appeal of care ethics and care more broadly, to feminist geographers, is apparent in a range of research, such as the politics of farming and animals (Gillespie 2016) and rethinking justice in urban theory (Williams 2017).

In this chapter, we focus on care through the lens of healthcare, specifically addressing immigration, citizenship and belonging in the context of the provision of healthcare in the UK. Feminist geographers have a long-standing commitment to intersectional analyses, and an additional dimension of healthcare is the complexity that comes from accounting for international migration and the ethnic diversity of the contemporary UK. We explore these themes thorough three different groups of immigrants: well-established immigrant communities from India and West Africa; international nurses recruited to address the National Health Service (NHS) nurse shortage; and asylum seekers who have been released from detention centres. Their different experiences of the same healthcare system demonstrate the significance of questioning taken-for-granted categories such as health, care and 'immigrant woman'.

Care, citizenship and the welfare state

At the core of feminist care ethics is a relational ontology of connection that positions people as embodied, interdependent beings. We are all vulnerable and dependent on others at numerous points throughout our lives, and we are each enmeshed in networks of care relations (Barnes 2012; Tronto 2013). This contrasts strongly with the autonomous, independent, individualistic neoliberal subject who, discursively, inhabits the policy documents of neoliberal capitalism.

Several scholars suggest extending care ethics beyond something restricted to the domestic sphere among intimates to thinking more broadly about bringing feminist care ethics into public debates in order to reframe political issues (Barnes 2012; Tronto 2013; Williams 2018). Tronto (2013) proposes revising political values around care as a set of concrete practices and a deep commitment to equality and justice, with the goal of producing a caring democracy with equal access to good care for everyone, while Folbre (2012, 183) argues that care ‘contributes to the development and maintenance of human capabilities that represent a “public good”’. Human capabilities have intrinsic value and also yield important positive spill-overs for living standards, quality of life and sustainable economic development’. In short, directly and indirectly, care provides individual and collective benefits. It has broad social value, and rethinking care as a public good is becoming a central aim of scholarship on feminist care ethics.

Actual healthcare policies reflect government decisions regarding the cost, quality of care, accessibility, delivery and programme evaluation. The UK has a publicly funded universal healthcare system – the NHS – premised on being comprehensive, universal and accessible to all citizens (and administered by the state, rather than the market). It was introduced in 1948, at a time when the public supported welfare measures to address social and economic inequalities with the goal of constructing a more equitable society. The UK welfare state was built around social liberalism, with state–market relations configured around greater state intervention to regulate and alter market forces to meet the goal of social equality. This is achieved by minimizing the risks inherent in unemployment, ill health and old age through the provision of some level of income security for individuals and households. Social ills, such as poverty, were seen as structural, and thus social programmes were built around a consensus of social rights and collective responsibility to provide for the basic social needs and economic security of the population. This is closely tied to the emergence of social citizenship – ‘the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in society’, as T.H. Marshall (1949/1992) famously defined them. Social citizenship rights allow citizens to make claims on the state for particular benefits and services, including the NHS for public healthcare. More broadly, citizenship is a multifaceted concept, and recent scholarship emphasizes that the same person or group might be privileged in some aspects of citizenship yet not others (Staeheli et al. 2012). For instance, legal/judicial citizenship entitles an immigrant to health services, but everyday exclusionary experiences, such as casual race-based discrimination, erode the sense of membership of, and belonging to, a community.

The contemporary restructuring of the welfare state, including healthcare systems, involves reconfigured roles, responsibilities and governance arrangements between civil society, the market and the state in the name of neoliberal-flavoured fiscal austerity. As a state form, neoliberalism involves an agenda aimed at increasing economic efficiency and competitiveness through the rhetoric of free markets, privatization and marketization while reducing government spending, especially on social welfare programmes (MacLeavy 2012). Discourses of citizenship were formerly configured around collective responsibility, ameliorating social risk and social entitlements, and public healthcare became its cornerstone. As citizenship shifts towards

the neoliberal values of possessive individualism, consumerism and individual responsibility, social problems are recast as failures of the individual rather than the result of structural inequalities, and the ‘good citizen’ is an atomized market player, self-reliant, who does not look to the government for help (England and Ward 2016).

Health, place and policy

Geographers draw attention to the intertwining materialities and sets of socio-spatial relations that are dynamic and constitute the meanings and experiences of health. They make key interventions into understandings of the spatiality of the processes and practices of health and the difference that space, scale and sites make in the processes and practices of care (e.g. Brown et al. 2018; Crooks, Andrews and Pearce 2018). In addition, feminist geographers have brought other approaches into understanding health through the lenses of embodiment, ways of knowing, care theory and affect (e.g. Davidson and Bondi 2004; Greenhough et al. 2015). The meanings of health and the parameters of healthcare provision shift and have different consequences over time and cross-culturally, with political economy, social policy and migration regimes having profound effects on the border between health and ill health (Dyck 2006).

The specific form that a healthcare system takes at any moment reflects a nation’s underlying values regarding the balance between equity (providing access to necessary medical services to everyone) versus efficiency (minimizing costs and maximizing revenues), and it is generally the most complex system of a country (Rosenberg 2017). The NHS is touted as one of the world’s most comprehensive public healthcare systems. In the contemporary moment, the NHS seems in a constant state of crisis, yet it remains central to British national identity and it is still frequently ranked as the most popular institution in the UK (Burki 2018). Aneurin Bevan, the post-war Minister of Health in the Labour Government, oversaw the creation of the NHS. Funded by general taxation, it was premised on being comprehensive, universal and accessible to all citizens (and administered by the state). It was intended to provide healthcare on a uniform basis throughout the UK, based on regional health authorities (Burki 2018; Mossialos et al. 2018). However, current healthcare policy focuses increasingly on concerns about the escalating costs of healthcare and how to ‘contain’ and minimize public expenditures and make healthcare more ‘cost effective’ and ‘efficient’. In many instances, this has meant the erosion of healthcare as a public good.

In the rest of the chapter, we address the themes of care, citizenship and belonging in healthcare practices and policy through studies of the three migrant groups. These three instances also allow us to examine themes of inclusion and exclusion, access to care and self-care.

Health and well-being among migrants in London

Healthy lifestyle promotion is a core issue in the NHS debates over the use of finite resources, and an emerging question is how to engage populations effectively in taking control of their own health management. Such debate is situated within a political and social climate that increasingly places responsibility for health on individuals and families, a move noted in Nikolas Rose’s (2007) work on the emergence of a new ‘biological citizenship’ that discounts biological destiny. Despite a breadth of scholarship that demonstrates the complex embeddedness of health knowledge and practices in political, social and cultural processes, an uncritical, medicalized view of health usually prevails in health science and health promotion discourse (Dyck 2006). In such medicalized discourse an echo of cultural determinism lingers in essentializing stereotypes of particular immigrant or minority ethnic groups, which deserves to be challenged if policy

initiatives are to reach a diverse population. Certainly, there is growing recognition of the value of listening to those whom the policies aim to target and of integrating their perspective into the policy-making process (Cowden and Singh 2014). Briefing notes for NHS research and policy programme staff now explicitly encourage the involvement of members of the public as active partners in research. This recognizes that if NHS research reflects the needs and views of service users, it is more likely to produce results leading to improved health and social service (Hanley et al. 2004).

As part of a larger study examining changes and continuities in health practices in the context of international migration, Iliana Ortega-Alcázar and Isabel Dyck (2012) explored the complex understandings of the health practices, beliefs and needs of two contrasting and long-established migrant groups (from Nigeria and India) in London, and revealed how notions of health promotion are taken up in everyday lives. The study is based on 40 photo-elicitation interviews of migrants living in one of London's poorer, ethnically diverse boroughs. They were asked to take photos of anything that they considered important to their health and well-being: objects, places, people, activities and other events were given as examples. After the participants brought their photographs, prints were made and the photographs returned to the participant. An interview was then conducted in a location of their choice and, beforehand, the participants were asked to group the prints that they felt should go together. Each group of individual prints was displayed on a table and the participants were invited to talk about them.

The participants' photographs indicated how both physical and social spaces in the local area were important to their health and demonstrated transnational dimensions as part of their health practices. For instance, several individuals took photographs of the African and Indian shops in the local area, including the foodstuffs and products bought there, and explained that being able to buy these things contributes to their well-being. Sometimes, the products were directly related to their physical health, such as items for the preparation of natural remedies or what were considered healthy meals. Others were described as having cultural significance and related to well-being in a different way; one example was an African broom, which enabled the continuity of a particular everyday practice and played a significant role in countering the owner's feelings of displacement.

The significance of place to the participants' accounts of health and well-being was also shown in terms of the physical environment of their neighbourhoods. Their photographs included shots of gardens, parks and buildings such as libraries and community centres. These prompted discussions in interviews of the healthiness of a particular neighbourhood and how the location of a participant's housing might facilitate a healthy lifestyle, whether by its relation to local amenities or by the physical structure of the building. One older Indian woman photographed the view from her balcony, explaining that rather than using the lift (elevator), she uses the 'stairs because in that way it is exercise' and walks to the shops. Her other indoor photographs depicted particular institutional spaces within the neighbourhood that facilitated health, through both the activities and the provision of health information. These included the Age Concern Centre and the Indian Cultural Society, where she meets friends and attends exercise classes and health information classes run by NHS workers. In talking about the photographs, she wove an account of her everyday life that indicates how housing, urban structures and the presence of a local Asian community all contribute to her health.

The active configuration of place for health and well-being is further illustrated in other participants' comments concerning links between neighbourhood involvement and belonging in wider society. A retired Nigerian woman's narrative of her photograph choices of various activities and local groups showed that engaging with her community was pivotal to her well-being. She actively resisted views of immigrants as burdens on their host society and holding no

sense of attachment. About her voluntary work with the local Primary Care Trust, she said: ‘It makes me feel fulfilled. I’m contributing something to the neighbourhood and to society.’ She provides visible proof of the construction of herself as a healthy citizen, emphasizing her identity performance as a contributing citizen, which she interlinked with health or well-being practices.

Some participants moved beyond descriptions of particular health practices and provided interpretations that challenged the stereotyping discourses on health and migration framed in culturalist terms. For example, a young Nigerian woman actively resisted an essentialized and stereotyped view of Nigerian people being outside the dominant global health discourse and practice. She showed photographs of traditional ways of keeping healthy – for instance, she took a picture of a Nigerian dish, pepper soup, talking about its medicinal properties and use by women to recover after giving birth. Yet, throughout her narrative, she rejected a view of fixed ‘Nigerian’ health practices and beliefs that diverge from those of the UK as a result of ‘cultural difference’. There may be Nigerian perspectives on health practices, but not a single, unified Nigerian approach to practising health. She drew attention to the historical colonial links between the two countries, further questioning a common view in the dominant discourse on health and migration that places migrants’ health practices as inherently ‘other’.

Thus, a care ethics approach draws attention to social and cultural well-being as important dimensions of health, as well as the more usual conceptualization of physical and mental health. A sensitivity to social and cultural differences in health practices is critical for designing effective health policies, and those practices may vary across space.

Importing international nurses

Healthcare is a labour-intensive industry, and nurses make up the largest group of health professionals. In a context of publicly funded healthcare systems, nurses are an important part of healthcare as a public good and for supporting social citizenship rights. Thus, the availability of nursing personnel is fundamental to achieving effective health service delivery and maintaining an adequate level of overall public health. More and more countries are facing nurse shortages, and talk of a global crisis in the healthcare workforce has become common. The increased transnational migration of nurses and other healthcare professionals (particularly doctors) over the last decade has brought the idea of a ‘global health care economy’ (Kingma 2006) into common parlance.

The migration of internationally trained nurses into the UK began to increase substantially in the 1990s (Hardill and MacDonald 2000; Kingma 2006). It is difficult to track over time the nationalities of foreign-trained nurses coming to work in the UK. However, nurses are governed through the Nursing and Midwifery Council (NMC) and all nurses are required to register in order to practise in the UK. The NMC register captures the country of their initial registration and annually publishes summary data on registrants admitted (to 31 March each year). Kim England used these initial admissions data, which include information on the country where a nurse first registered (this is not necessarily their country of birth).¹ The NMC breaks down the public data into those who first registered in the UK, the European Union (EU) or ‘Overseas’ (classified as those who initially registered outside the EU).

Figure 31.1 indicates that the numbers admitted to the NMC register have varied over time, with rapid growth from 1999 through the early 2000s, then a drop off to 2010, followed by another period of growth and apparent slowdown from about 2015. The UK numbers are less variable than the non-UK admissions. This suggests periodic nurse shortages and cyclical ‘booms and busts’ in the UK nursing labour market. Breaking down the overall data by EU and

‘Overseas’ indicates a growing portion of overseas admissions to 2004, followed by a drop off, with indications of another upward swing beginning in 2015. EU nurses comprised a smaller proportion in the early 2000s, followed by an uptick from the mid-2000s, with a noticeable increase in the mid-2010s.

Nurse migration patterns tend to follow paths of historical economic and colonial relationships, and the UK has historically relied on Commonwealth countries to supply nurses to fill its periodic nursing shortages. Reflecting this, the NMC data (not shown) indicate that in 1999 the top sending regions were (in rank order) Australia, New Zealand, South Africa, New Zealand, the Caribbean and Canada. They accounted for 16 per cent of all new registrants and 80 per cent of those from overseas: by far the largest group were of nurses initially registered in Australia, followed distantly by South Africa. In the early 2000s, Australia and South Africa remained important, with a new trend of increased numbers from elsewhere in Sub-Saharan Africa accounting for about 25 per cent of each year’s overseas initial registrations. In addition, admissions to the register from the Philippines and India picked up markedly through the 2000s and soon became largest group of initial registrations; by 2012, those two countries accounted for 23 per cent of overseas registrants. The expansion of the EU over the past two decades caused an increase in numbers from the EU accession states, and there has also been active recruitment by some NHS Trusts from long-standing EU countries, such as Spain and Portugal. However, new registrants from the EU have dropped since the 2016 EU Referendum, and an uptick in ‘Overseas’ nurses is again evident.

There is a range of explanations for these trends. The UK is faced with an ageing nurse population, exacerbated by early retirement and turnover. Stress from inadequate staffing, increased workloads (sometimes without pay) and stagnating pay means that nurses leave the field or retire early, and retention has become a major issue (Marangozov et al. 2017). Some of the fluctuation is linked to institutional strategies to address concerns about patient care, nurse shortages and healthcare policy changes. In the late 1990s, the Labour government sought to ‘modernize’ the NHS, with plans and funding to expand the NHS workforce. Some funding went into increasing training opportunities for domestic student nurses. However, between 1998 and 2005

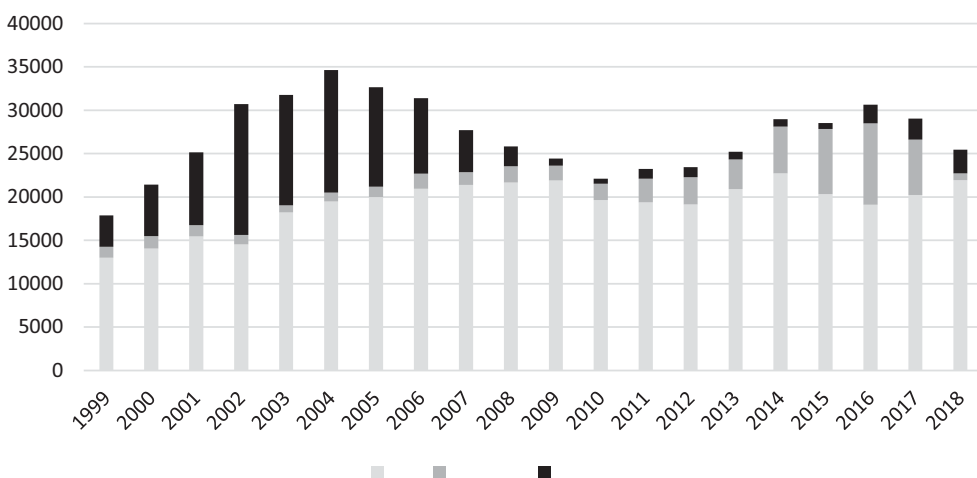


Figure 31.1 Admission to the NMC Register from the UK and non-UK countries, 1999–2018.
Source: NMC data, various countries.

there was also an explicit and coordinated policy to ramp up the international recruitment of nurses. Then, starting in 2005, the NMC introduced additional requirements aimed at overseas nurses (i.e. from outside the EU), including a period of supervision (to reskill nurses, relative to the UK healthcare system, and to safeguard patient safety); following this, in 2007 the NMC introduced more stringent English language requirements.

At the level of central government, in 2006 the Home Office removed many lower-grade nursing and general nursing occupations from the Shortage Occupation list for work permits. The 2008 shift to a points-based immigration system and the 2012 work permit immigration rules further impacted employers' ability to recruit overseas nurses. More recent austerity politics and the post-2008 recession impacted on NHS funding, with neoliberal-flavoured policies not only constraining public sector expenditures but causing a stagnation in pay, recruitment freezes, fewer training places and even redundancies. The 2013 Francis Report pinpointed the inadequate staffing levels as a reason behind the failings at the Mid Staffordshire NHS Trust (the subsequent review also recommended better nurse–patient ratios). In response, safer staffing levels were introduced, increasing the demand for nurses (Marangozov et al. 2017). By the mid-2010s, there were calls to return all nurses to the Shortage Occupation list, which the Home Office subsequently did.

While these policy decisions are reflected in the overall trends in the NMC's admissions data, a closer look reveals additional consequential geographies. Importing nurses has long been a popular 'quick fix' solution to address shortfalls. The UK has certainly been a significant player in the global migration of nurses. Starting in the early 2000s, concern was raised about the number of nurses coming from Commonwealth countries in Sub-Saharan Africa. Policy decisions resulting in the active recruitment of international nurses to 'solve' nurse shortages were interpreted as the UK depleting other countries of their nurses, in turn impacting on the ability of those governments to provide adequate healthcare for their own citizens and, potentially, to damage their country's future social and economic development (England and Henry 2013). Other, potentially more caring, strategies are also possible. For example, the Royal College of Nursing argues that the gap can also be addressed in numerous ways domestically, including by increasing wages, improving the retention of nurses and investing in nurse education. More broadly, coordinated strategic and long-term workforce planning could be a way to move the UK in the direction of a more caring democracy.

Health after detention

Our three case studies demonstrate how health, migration and care intersect variously for contrasting groups of migrants in the UK. This section focuses on the experiences of former detainees. Immigration detention is portrayed by UK government policy as a last resort in 'extreme cases', but recently the practice has become integral to the asylum process. In 2017, some 27,346 people were detained in the UK 'for the purposes of immigration control' and placed in Immigration Removal Centres (IRC), short-term holding facilities or pre-departure accommodation (Home Office 2018). Women accounted for about 16 per cent of detainees, and about a third of women detainees go on to be released.

Detainees are often ill prepared for release. Concerns about this have even been raised by HM Chief Inspectorate of Prisons, who observed of Yarl's Wood IRC: '[t]here was no systematic approach to assessing needs and helping detainees to prepare for removal or release' (2011: 16). Indeed, the only reference to preparing detainees for release within the Detention Centre Rules (2001), the primary guidance for UK immigration detention, is about their healthcare records and returning their material items to the detainees. Klein and Williams (2012, 743) suggest that:

Because release into the community does not correspond to policy rhetoric emphasizing an unproblematic progression through detention to removal or naturalization, it is more convenient for the UK government to airbrush the very large numbers of released migrants from view than to engage in a public discussion.

What little scholarship there is on the long-term implications of detention signals that former detainees experience marginalization, marked by fear of arrest, further detention and potential removal. Many also experience precarity, because they lack the legal entitlement to work or other means to achieve a decent quality of life. Additionally, the legacies of detention include negative effects on their mental health, social relationships, perceptions of the UK and sense of belonging (McGregor 2009; Klein and Williams 2012).

Menah Raven-Ellison (2015) focused on the ongoing legacy of detention and the consequences for the sense of belonging, social integration and the health and well-being of former detainees. She conducted in-depth narrative interviews with 16 previously detained women, all of whom had been detained in Yarl's Wood IRC, the main IRC for holding women. The women ranged in age from 19 to 60 years, the majority from nine different African countries and three from Asian countries. The complex interrelationship between health, well-being and the processes and legacies of detention emerged as a central point of concern. For two of her participants, Pru (a 42-year-old Burundian asylum seeker, detained for six weeks) and Jana (a 45-year-old Nigerian refugee, detained for three months), the erosive implications of uncertain status on migrants' everyday lives undermine the extent to which they see themselves as having choices and opportunities to plan for the future. However, Jana was awarded refugee status, and she identified this a turning point:

After winning your status then it becomes different, you know? You are able to have mail in your name, have proof of address, able to open a bank account, able to have an NHS number, you are able to have an ID – you are somebody, you are recognised as a person.

Refugee status bestowed on her a legitimacy and sense of purpose that she had lacked as an asylum seeker. The fact that she identified as having an NHS number and described herself as 'recognised as a person' suggests that she is recovering coherence and stability in her life, as well as some power and control and, with it, an emerging sense of belonging.

Both Pru and Jana, along with five other participants, described themselves as torture survivors. Rule 35 (3) of the Detention Centre Rules (2001) was created to identify people who have been tortured, to prevent their detention. There is consensus that detention is damaging to mental health, not least because it can arouse memories of incarceration, thus provoking re-traumatization. NGO workers find that this safeguard is often ignored, resulting in the incarceration of vulnerable individuals for whom detention is described as a 'second torture'. All seven respondents had been detained, but only Pru had been assessed and released from detention in accordance with Rule 35. The consequences for their well-being were significant, exacerbated by the poor overall standards of healthcare in detention. Their experiences of torture occurred not only in their country of origin but, in three participants' cases, including Pru's, during lengthy periods of enslavement in the UK by their traffickers.

Pru's experience illustrates some of the health concerns amongst migrants, for she was severely traumatized by an accumulation of factors, including witnessing atrocities in her home country, experiencing torture, being separated from family and then enduring three years of captivity and sexual exploitation in the UK. She would eventually be diagnosed with post-traumatic

stress disorder (PTSD). Pru experienced flashbacks that disturbingly transform her present-day experience of certain public places, seemingly converging unpredictably with past events. She described how horrific past events in Burundi merged with images of UK immigration officers chasing her, creating a distorted experience of space, rendering it unstable, unbounded and unpredictable. The distressing experiences discouraged her from engaging with her local community, increasing her social isolation and further undermining her emotional well-being. After release from detention, Pru received little support and was only eventually considered eligible for assistance from the local authority and mental health services when her behaviour became inappropriate and noticeably ‘out of place’.

There are glaring disparities between the priorities outlined in UK mental health policy and the relevance of these to individuals, such as Pru, who have a mental illness yet have a legally uncertain position in society. The NHS is infused with a recovery-orientated approach that claims to strive for the meaningful inclusion of individuals with mental health problems in society. Despite an admirable, seemingly caring philosophy, the narratives of people like Pru, who remain particularly marginalized in society and who already have limited rights and questionable legal status, expose the inconsistencies in the NHS’s inclusion rhetoric. Indeed, these experiences highlight the limitations of healthcare systems, as they can lack the ability to accommodate difficulties that fall outside of a medicalized, Western approach to pathology, not least how the care for these individuals is coordinated and delivered.

Conclusion

Geographers have made important contributions, theoretically and empirically, that demonstrate the links between places, people and health and how the interactions among them influence health, illness, survival and flourishing. In addition, viewing health through the lens of international migration spotlights intersectional analyses. We took up these ideas and interwove them with the growing interdisciplinary literature on theorizing and expanding the concept of care, including its use as a broad framework for making moral, political and policy decisions.

Iliana Ortega-Alcázar and Isabel Dyke’s work (Ortega-Alcázar and Dyck 2012) focused on the everyday practices of health citizenship of two well-established migrant groups in London to reveal how place influences their health and well-being, underscoring how appropriate engagement of social groups must play a pivotal role in the NHS’s creation and implementation of successful health promotion. Kim England’s analysis of NMC data showed how the UK has generally welcomed international nurse migrants to fulfil quickly its social citizenship obligation in terms of publicly funded healthcare, possibly at the expense of better long-term planning. Menah Raven-Ellison’s research with formerly detained migrants demonstrated the ways that the UK’s immigration policy and healthcare system serve to exclude some of the most vulnerable of migrants.

Our goal, through our case studies, is to show that feminist care ethics as practice, politics and discourse offers a possible route to reframe political debate and rethink citizenship and belonging in ways that centrally address healthcare and well-being. Care ethics is always about alerting us to relational power inequalities. An emerging trend in feminist geographers’ scholarship is to think more critically about care: to take seriously the empirical and conceptual implications of the spatial diversity of care practices across the globe (Raghuram 2016) and to expose the ‘uncomfortable politics of care’, because caring practices do not inherently produce good care (Bartos 2018). Our three case studies speak to the ways that the UK’s healthcare policies are interwoven with differential power relations and reveal unequal caring through the

different boundaries of inclusion and levels of exclusion experienced by each of the groups. This, in turn, shows that the NHS is not as comprehensive as it implies. In short, viewing health provision through the lens of care ethics makes it apparent that the discourses, practices and provision of healthcare are embedded in broader cultural contexts and are situated in policies formulated in particular political-economy moments. More broadly, the trend towards a deeper engagement and a further sophistication of understandings of care brings new challenges, as well as opportunities for robust feminist geography scholarship, going forward.

Note

- 1 The NMC does not publish a list of specific countries. A Freedom of Information request was filed to receive these data.

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