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'Not in it for huge profits but because it's right': The contested moral economies of UK–India exports in health worker education and training

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Abstract

While the growth of global markets in health-related services may have significant consequences for healthcare provisioning and training, it has received relatively little attention from the social sciences. This article examines UK–India, and specifically England–India, exports in health worker education and training as one such global market, drawing on sociological scholarship on moral economies to understand how trading in this field is constructed and legitimated by the individuals and organisations involved, what tensions evolve, and what is at stake in them. We employ a qualitative mixed methods approach using publicly available materials on existing UK–India collaborations and primary data from interviews with key stakeholders in India and the UK, including government departments, arms-length bodies, NHS Trusts, trade associations and private providers. Our analysis illustrates the key discursive strategies used to legitimate engagement in these markets, and the complex and contested moral economies unfolding between and across these stakeholders

and contexts. Not least, we demonstrate the conflicting moral sentiments and the boundary work required to realise commodification. Situating cross-border trade in health worker education and training in a moral economy framework thus illuminates the social context and moral worlds in which this evolving trade is embedded.

KEYWORDS
cross-border trade, health worker education and training, India, moral economies, UK

INTRODUCTION

The provision of cross-border health-related services has been increasing over the last few years (Hanefeld & Smith, 2019). [Correction added on 25 August 2023 after first publication: In the previous sentence the reference citation was changed.] This has stimulated a rich vein of social science scholarship on the transnational entanglements of people, goods and services, engaging the multiple subjectivities, meanings, experiences, bodies and power relations of contemporary transnational healthcare. Existing research covers topics ranging from people living with non-communicable diseases seeking treatment elsewhere (e.g., Ormond & Lunt, 2020) to the movement of nurses and allied health professionals across continents (e.g., Bach, 2016; Walton-Roberts et al., 2017). However, beyond these foci, cross-border trade is also increasing for a wider range of health-related services which have so far escaped close study from sociological perspectives. Temporarily disrupted by the COVID-19 pandemic but now resumed, these include markets in the training of health workers, telemedicine, second opinion and referral services and healthcare management and advisory services (Hanefeld & Smith, 2019). In this article, we thus turn attention to existing engagements in one such market, namely the global market in health worker education and training, through the lens of contemporary UK–India relations. We examine the export and import of education and training as commoditised services being sold and purchased between individuals and/or institutions across borders, reflecting a wider reconfiguration of healthcare as an area of capitalist production and consumption, transforming health-related services into tradeable assets (Hunter & Murray, 2019). The small existing literature referring to trading in these activities to date has predominantly focused on mapping the breadth and scope of activity (Hanefeld & Smith, 2019; Smith et al., 2009). This article thus offers what we believe to be the first detailed examination of health worker education and training as an area of transnational trading and its socio-political context in two countries.

The second contribution of this article relates to the sociological understanding of social and economic organisation and specifically of the complex relations at play when individuals and institutions attempt to buy and sell across borders. Specifically, we suggest that the application of the concept of moral economy (Sayer, 2000, 2015) illuminates the understanding of how trading in health worker education and training is constructed and legitimated by individuals and organisations in a high-income country positioned primarily as 'exporter' (the UK) and those in a middle-income country positioned as 'importer' (India). Recognising how actors describe and justify their construction and realisation of global markets is key to understanding the complex social relations and practices as well as the implicit and explicit premises underpinning such

markets and ultimately to assessing their consequences for healthcare provision and health worker education. We thus ask: What types of engagement have developed in this market, and who are the key actors? What are their legitimating strategies for engaging in this market, and what are the tensions evolving around these? And, ultimately, what is at stake in these practices?

In the next section, we outline the moral economy scholarship that has informed our analytical approach, before turning to the empirical context of our cases in the UK and India, and the methods and findings of our research. We conclude with reflections on the changes taking place as a result of trading in health worker education and training and opportunities for further study.

MORAL ECONOMIES

The moral economy framework has recently gained traction in social science scholarship as a lens to study issues ranging from labour relations (Bolton & Laaser, 2013) to welfare systems (Morris, 2016) and housing (Alexander et al., 2018). Sayer, one of the key contributors to the approach, has advocated a moral economy perspective which studies the 'ways in which economic activities, in the broad sense, are influenced by moral-political norms and sentiments, and how, conversely, those norms are compromised by economic forces' (Sayer, 2000, p. 80). This understanding deviates from historian Thompson's (1971) initial rendering of the concept which focused on the discordance between social and commercial concerns to emphasise their intrinsic entanglements. This false dualism between moral and market economies fails to recognise the social basis for *all* relations in the realm of the economy and thus the constitutive role of morality in economic relations. As Booth has aptly noted, 'all economies, including the near-to-pervasive-market economies, are moral economies' (Booth, 1994, p. 662).

This moral economy lens seems particularly apt for the study of health and healthcare markets because medical encounters are always also moral endeavours. Scholarship in this area has, for instance, interrogated the moral economy of survival amongst people living with HIV/Aids (Prince, 2012) or the professional cultures of healthcare (Hamlin, 2020). Of particular relevance for this article is Busfield's interrogation of pricing strategies by pharmaceutical companies. Through the analysis of public narratives and imagery fostered by these companies, Busfield observes the attempts to promote specific moral systems and to situate and legitimise certain activities within societal norms and values (Busfield, 2019). Her analysis outlines a plurality of norms and standards against which these companies' practices can be judged, and the attempts by these companies to instrumentalise particular discourses in public fora and justify practices such as price gouging. Such an approach has proved valuable for understanding different accounts on contested issues of economic organisation, especially those subject to commercial interests.

Two dimensions have hitherto remained somewhat under-explored in the existing literature. The first is the dynamic and tension-laden enactment of morality. While identifying key values guiding the enactment of a moral economy can provide valuable insight into how healthcare is understood, it has often been a rather static perspective. Stated alternatively, there are tensions and frictions that emerge at the interface of moral frameworks which often coexist, or even overlap, in the sector. Rasmussen (2004) has demonstrated this in his analysis of the moral economies at play in collaborations between academic researchers and drug companies in the USA during the interwar period. Unearthing the implicit norms, values and expectations in each group of actors as well as the larger societal forces shaping them, he has sketched the tensions unfolding in this new moral economy wherein industrial involvement became more acceptable within the scientific community. While the negative symbolic value of industry collaborations

did not vanish, the positive symbolic value of scientific innovation outweighed the opprobrium surrounding commercial involvement. Not only did the moral and political economies of the life sciences thus strongly influence each other, but the focus on tensions is key to producing a more complex understanding of moral economy—or rather moral *economies* that attend to pluralism, tensions and contestations at the nexus of multiple moral spheres within which people live (see also Alexander et al., 2018; Kofti, 2016).

Second, the global turn in moral economy studies, unfolding in the aftermath of the anti-globalisation protests of the 1990s (Calabrese, 2005; Edelman, 2005), has pointed to a transnationalisation of moral economic regimes that requires further elaboration. For instance, protest movements consisting of various, usually non-governmental actors based in multiple countries coalesce around concepts such as the 'just price' and 'food sovereignty' into transnational networks of solidarity (Trentmann, 2007). This is especially relevant given the enduring legacies of colonial relations of trade and expropriation. Trentmann has crucially emphasised the temporally shifting moral economies of international trade, or its 'historically changing moral landscapes' (2007, p. 1097) that often foreground discursive constructions of obligation and debt to, and proximities with, former colonies. According to Trentmann, moral economies thus 'operate with different degrees of reciprocity and sympathy in different contexts' (p. 1095).

Our focus is on UK–India, and in particular England–India, relations in health worker education and training, a case characterized by strong historical connections between the two countries. Such UK–India transactions are shot through with complex social, political, cultural, and economic connections on individual and institutional levels, making them a pertinent object of sociological enquiry. The transnational trading in health services we examine takes place in a sector characterised by multiple (sometimes competing) professions and knowledge systems, colonial histories and a spectrum of commodified and non-commodified relations, with England subject to deeper commercialisation than the other UK nations. To analyse this, we adopt a perspective that sees cross-border activities taking place across multiple moral economies and geopolitical configurations.

EMPIRICAL CONTEXT OF UK–INDIA HEALTHCARE EXPORTS

The public budget of the National Health Service (NHS) has been under pressure for some time. It has failed to keep pace with population healthcare needs that have been growing in the context of longstanding social inequalities, an ageing population and the COVID-19 pandemic. In England, individual NHS organisations such as hospital Trusts have increasingly been encouraged to generate additional income to prevent and address growing financial deficits through commercial activities such as parking charges, land sales and treating private patients. A cap on income generation from private patients by NHS hospital Trusts was repealed in 2012 as part of long-standing efforts to synthesise public and private practice in the NHS (Pollock, 2005). This reflected an underlying logic of shifting responsibility for healthcare budgets away from the central state (and funds generated by general taxation supplemented by National Insurance contributions) and onto other sources, encouraging a heightened sense of entrepreneurialism in the NHS (Chalkidou & Vega, 2013; Lunt, 2017). The capacity of Trusts to engage in such commercial activities was initially seen as limited and a significant barrier to expanding business operations (Lunt et al., 2015) but has more recently been bolstered by the expansion of commercial teams dedicated to the identification, management and expansion of commercial activities.

Budgetary manoeuvring was also accompanied by renewed emphasis on international revenue generation. Some, primarily London-based, NHS hospitals have attracted steady streams of international private patients for several decades (Lunt et al., 2015). However, in the last

decade, the UK government has sought to broaden the scope of international commercial activity, creating Healthcare UK in 2013 as a joint initiative of the Department of Health and Social Care, the Department for International Trade and NHS England with the aim of promoting the exporting of a wider range of infrastructures, technology and services. Healthcare UK claims to have supported £1.3bn in UK 'export wins', defined as the proportion of a contract's value that would accrue to UK companies, between 2016 and 2018 alone (Healthcare UK, 2018). Recent reports are more vague, presumably reflecting the limitations for exporting introduced by the COVID-19 pandemic (Healthcare UK, 2020). Currently, many public healthcare organisations pursue income through the provision of a growing range of transnational services (Chalkidou & Vega, 2013; Healthcare UK, 2013; Lunt, 2017), finding this increasingly necessary in the face of constrained public funds.

In India, the contemporary context for healthcare is characterised by consistently low government spending on a comprehensive public system for healthcare provision. According to the World Health Organisation (2022), India spends only around 3% of its GDP on health, one of the lowest percentages devoted to public health worldwide. The New Public Management practices adopted by the Indian government during the early 1990s led to health sector reforms subsidising private capital development and formalising collaborations between state governments and private providers as partners in service provision (Baru & Nundy, 2008). Deregulation of foreign direct investment and the provision of state tax reductions, concessional loans and the selling of land at subsidised rates further fuelled the growth of an already well-established private healthcare sector (Nundy et al., 2020). While there is still a large but struggling sector of public service provision, it is predominantly corporate hospital chains which offer highly specialised and high-technology secondary and tertiary care and related diagnostics. Recent government-initiated reports flag the Indian healthcare market as a key opportunity for international investment with the potential to generate 2.7 million additional jobs in India between 2017 and 2022 (Sarwal et al., 2021).

At the same time, changes are underway in the social fabric of Indian society with the growth of an affluent and increasingly mobile urban middle-class. Training in medicine, and more recently nursing, is a highly prized mechanism for social mobility and out-migration. The growing demand for this education and training has not been matched by supply in public institutions, and private nursing and medical colleges provide a large share of health worker education: A decade ago, Reynolds et al. (2013) found that the private sector is responsible for producing 95% of nurses in India, and already in the mid-1990s, more than 75% of all medical colleges were private (Jeffery, 2019). The private sector has thus been key in shaping the marketisation of health worker education and training in the last two decades or so, illustrating the opportunities for profit in this sector (Chakravarti, 2011). Publicly-funded postgraduate seats for doctors with a Bachelors in Medicine/Bachelors in Surgery (MBBS) are reported to be in particular shortage (Times of India, 2020), posing a barrier for career development and driving demand for international opportunities for speciality training.

Ties between the UK and India in health services and education have existed since the opening of Kolkata's Medical College in January 1835 (Paul, 2021), establishing allopathic medicine and English as the language of instruction. In the ensuing years, Indian medical education became centrally geared towards satisfying the demands of the British General Medical Council, and entrants to the Indian Medical Service travelled to Britain to acquire diplomas from one of the colleges of surgeons (Jeffery, 1979). Colonial era policies have left a deep imprint on the Indian regulation of its health workforce (Sriram et al., 2021). Passing the examination for membership in a medical Royal College remains a key milestone for Indian medical graduates. Meanwhile,

NHS organisations are keen to use overseas doctors, nurses and allied health professionals from India to fill staffing shortages in the UK, supported by the training and accreditation offered by Royal Colleges; in 2022, over 9000 doctors from India practiced in the NHS, making Indian the second most common nationality after British (Baker, 2022). The lack of mutual recognition of health worker qualifications and training has become an important grievance in India in recent years and is currently being negotiated within a UK–India Free Trade Agreement, following recent success on mutual recognition in other sectors (Home Office, 2021).

METHODS AND MATERIALS

This article stems from a mixed methods study which analyses the transnational provisioning of services in healthcare, focusing on UK–China and UK–India relations. The larger study aims to understand recent attempts by public and private organisations to position the UK within a globalised commercial healthcare economy, asking how and why this ambition is being realised in England, China and India. Ethics approval for the project was granted by King's College London.

Data for this article include both publicly available sources and notes from qualitative expert interviews. First, we compiled key industry reports, policy documents, press briefings and documentation of conferences and public events through a structured online search. These were used to identify key examples of UK–India trading collaborations in this area, for which we constructed a set of 16 detailed profiles that brought together all publicly available information on their origins, features and trajectories. Second, we conducted 67 expert interviews in India and the UK between 2019 and 2022 with representatives from public and private hospitals, government departments, arms-length bodies, Royal Colleges, trade associations, education and training providers and independent healthcare consultants. Respondents were selected purposively to include a range of expert perspectives and were identified through an initial online search as well as existing professional networks. Respondents were informed about their rights to anonymity and confidentiality at the beginning of the interview and gave oral consent for participation. Interviews were conducted by SM and BH who took detailed notes during and immediately following the interview.

The documentary materials, detailed profiles and interview notes were analysed thematically (Braun & Clarke, 2021) using the qualitative software NVivo in an iterative process. BH read through the detailed profiles and interview notes and assigned an initial set of codes derived from the moral economies perspective outlined above, including the forms of relations that exist, how they are justified by the people involved and what is and is not considered legitimate practice. SM conducted a secondary round of analysis focused on a subset of the data relating to the theme of UK-India trading in health worker education and training, using the existing codes and repeated readings of the research materials to refine the coding framework. The process of analysis, codes and emergent ideas were discussed regularly by all authors.

MORAL ECONOMIES OF UK–INDIA EXPORTS IN HEALTH WORKER EDUCATION AND TRAINING: TYPES OF ENGAGEMENT AND KEY ACTORS

Overall, we identified 16 cases of institutional UK–India collaborations in health worker education and training; these should be seen as indicative as such collaborations are difficult to

identify, particularly those that are built on relations between individual clinicians. Key actors in this field include governmental and arms-length bodies, private providers, NHS hospital and ambulance Trusts, Royal Colleges, universities, Community Interest Companies, charities, broker agencies as well as individual clinicians and public health consultants. The majority of collaborators in India are from the private sector, especially tertiary hospitals, and governmental actors appear largely absent in this field. Health is a state-level subject in the Indian constitution, and India-based respondents noted that the federal government was neither supportive of nor resistant to their engagement in international training and education, although it is promoting international investment in the healthcare sector (Sarwal et al., 2021).

Collaborations and services span short-term or one-off training programmes, usually in highly specialised areas; observerships; clinical fellowships and attachments; training of Indian nurses and allied health professionals recruited to the NHS; digital educational platforms; accreditation by NHS Trusts or Royal Colleges; on-site training; upskilling as well as combined consultancy and educational services. They are usually initiated through personal, especially diasporic, connections sometimes with the help of UK embassy trade teams and/or London-based Healthcare UK. Regular events such as the India–UK Healthcare Conferences are used for networking and to identify new partners for collaboration.

LEGITIMATION STRATEGIES

Within the discourses of our respondents, we discerned three distinct legitimation strategies for the activities they engaged in. Foregrounding of patient and health system benefits softened the emphasis on the commercial nature of exchange whereas a second line of argumentation accepted the marketised nature of the activities but laid emphasis on the beneficial advance of individual or institutional prospects within that context. A third, somewhat different, discourse spoke to concerns about colonial legacy, mobilising 'trade not aid' as the establishment of allegedly more equitable and reciprocal relationships.

Foregrounding of patient and health system benefits

Overall, public-facing materials relating to UK–India trading in education and training by organisations in both countries, and indeed many respondents in both settings, have emphasised patient and health system benefits offered by trading. Here, trading is presented as a way to produce the best healthcare systems and outcomes. CEO of digital training company Medvarsity, Gerald Jaideep, for instance, finds that 'partnerships with leading universities globally enable us to present the best courses and faculty to our students' (in Apurva, 2020, n.p.); this will ensure, writes an editor for BMJ India, that workers can 'practise the best possible medicine and ensure the best possible outcomes for their patients' (cited in Payne, 2013, n.p.). Many Indian respondents from the private sector advanced this narrative of benefit for service provision through international engagements. Given the dearth of specialised care especially in tier two and tier three cities, that is, cities with a population of between 50,000 and 100,000 and 20,000 and 50,000, respectively (Reserve Bank of India, 2011), international collaborations are considered to improve care, at least for paying patients, by allowing local clinicians to engage in speciality training and subsequently offer more advanced treatment. Cutting-edge training in emergency medicine, for instance, is an area in which India is seen as 'lagging behind', according to the CEO of a chain of private hospitals in Maharashtra, or where 'India can and needs to learn from the UK' (oncologist and former NHS consultant, Mumbai).

Organisations from the UK actively nurture a reputation of 'excellence' to encourage people in other countries to buy UK health-related services. Until a few years ago, Healthcare UK publicity materials emphasised the UK's then-top position in the Commonwealth Fund rankings for healthcare systems (Healthcare UK, 2020). In line with the UK government's international brand marketing campaign 'GREAT Britain and Northern Ireland' that ran from 2011, brochures setting out the UK's commercial education and training offers highlight the globally leading rankings for UK medical schools (Healthcare UK, 2013). In some instances, the role of India and Indian labour in producing that excellence was acknowledged and even used as justification for the sale of services to India. As part of a UK health trade mission to India in 2013, UK government Trade Envoy, Ken Clarke, pointed to the potential to use UK healthcare exports to increase collaboration between the countries: 'The historic partnership between Indian and British doctors has already saved millions of lives in Britain. On our visit [to India] we will be meeting with senior ministers and officials, and visiting hospitals and clinics, to work out how together we can save millions more' (Express Healthcare, 2013).

The global shortfall in health workers has also offered a rationale for the pursuit of new investment opportunities, where trading in education and training can be linked to an increased supply of workers. This is best illustrated by the Apollo Buckingham Health Science Campus in Crewe, England, a collaboration between India's largest private hospital chain Apollo and the UK's first private university, the University of Buckingham. Apollo's global ambitions are well documented in the Indian press (India Times, 2004; The Hindu Business Line, 2018) as well as scholarly discussions (e.g., Hodges, 2013; Jeffery, 2018). Its acquisition of the former Manchester Metropolitan University campus was justified by Dr Preetha Reddy, vice chairperson of Apollo Hospital Enterprises Ltd, as a response to the 'urgent need for increased numbers of well-trained healthcare professionals across the world' (in Ryan, 2018). Needless to say, claims of a moral basis for private sector expansion, particularly Apollo's, have long been questioned on the grounds of the commercial interests involved (e.g., Hodges, 2013; Jeffery, 2018).

Other programmes, including between Health Education England (HEE) and Chandigarh-based INSCOL, a leading nursing education provider, equally emphasise the dearth of health workers and their mission to train and recruit especially nurses from India into NHS Trusts across England. Many contemporary training-cum-recruitment initiatives thereby contain a circular element, centring on health professionals' temporary stay in the UK and cast as subsequently contributing to advancing healthcare in India as the workers return. Such claims work to refute accusations of 'brain drain' and the depletion of health resources in India and emphasise both health-related and broader social benefits of UK exports, often described as win-win or even triple win situations. As Ged Byrne, Director of HEE explains, 'as opposed to ourselves as a Western economy, taking healthcare workers from other countries for our own benefit, we are now in a process, and have developed a series of mutually beneficial partnerships, which allow the flow of healthcare workers, technologies, research and innovation in both directions' (India Inc. TV, 2019). Nonetheless, existing evidence suggests that as little as 1%–2% of Indian health workers eventually return and re-integrate (Walton-Roberts et al., 2017).

Prospering in marketised environments

Project materials and respondents' comments draw attention to how institutions and individuals seek to capitalise on trading in education and training as a means to enhance their prospects in marketised systems for healthcare financing and labour. For example, engagement by UK public

and private organisations is driven to a significant extent by a desire to generate revenue. Healthcare UK's '5 Rs' to motivate exporting by UK healthcare eschew concerns with health improvement and advocate the potential gains for 'revenue, reputation, reach, recruitment and retention'. Respondents from NHS hospitals repeatedly emphasised the precarious financial circumstances of their institutions after years of real-terms budget cuts and the pressing need to find additional sources of revenue. Education and training are seen as a cost effective avenue to achieve this, and respondents often cast their hospitals' offers as using already-existing expertise, training materials and even infrastructure, as in the case of online training platforms and virtual teaching. This way, investment in domestic services can be 'scaled up to international work', rather than requiring separate investment (business developer, NHS Trust). In this respect, the COVID-19 pandemic was felt to have enhanced opportunities for trading, as it had incentivised UK hospitals to improve their online teaching systems; systems now to be reoriented towards external markets. Education and training is particularly attractive for institutions looking to export to India, as the relatively uncompetitive pricing of other services offered by UK hospitals, such as management consultancies, make it one of the few viable options for exporting.

International collaboration is also seen by NHS managers as a tool for improving staff experience in UK hospitals at a time of growing shortages and increasingly competitive labour markets for health workers. Hosting international visitors through observership programmes, for instance, exposes NHS staff to different clinical cultures and opens up opportunities for knowledge exchange. This is said to reduce attrition and aid recruitment since NHS staff, as one respondent put it, deliver care 'day in and day out, almost like robots' (director of international projects, NHS Trust). International commercial work is presented as a significant opportunity in this context, especially for younger members of staff who are 'socially conscious' and desire to support health systems development in other countries (consultant, NHS Trust). Here, respondents' managerial obligations towards their own healthcare personnel to provide opportunities for professional development and increase job satisfaction coincide with the quest for international commercial engagement.

In India, competition amongst hospitals to attract local and international healthcare users creates pressure to enhance the profile of the services on offer, in turn creating demand for collaborations with UK institutions. International affiliations and accreditations increase 'credibility' and lend 'authority' to such Indian hospitals (managing director of a private hospital, Tamil Nadu). To wit, both the actual skills inferred and the cultural capital gained from working with an international partner are highly valued in an increasingly saturated and competitive market for healthcare services. Such connections are especially important for institutions seeking to attract international patients due to the international currency and symbolic value of specific brands and accreditations.

At an individual level, competitive labour markets motivate Indian clinicians to seek international training, particularly in the case of postgraduate medical training. Past research has shown that a majority of physicians from India's premier medical institutions have opted to emigrate (Kaushik et al., 2008), but respondents in our study emphasised that rising salaries and improved facilities meant that highly qualified physicians not only return to India more frequently but also seek international training opportunities to gain an advantage within India itself. International fellowships and training thus offer opportunities for individual career development, at least for those who can afford the travel costs and observership fees in the UK. The director of one private hospital in India noted that the membership in or any other association with a Royal College was a 'very prestigious thing' for clinicians in India and 'polishes' providers in the eyes of a discerning domestic user base. This accumulation of cultural capital through international

brand association by elite Indian clinicians and managers may well help the already mobile elite further augment its own social status while increasing the distinction from the majority of often precariously employed junior doctors in an ever more competitive market.

A 'postcolonial' global health?

Exports in education and training are also cast by UK and indeed some Indian respondents as in line with calls for benefit sharing and the establishment of more equitable and reciprocal relationships in postcolonial global health encounters, testament to what Trentmann has called the changing moralities of space (Trentmann, 2007). Trentmann refers to the disruptions of space and time, including the transformation of cultural value systems, in the wake of globalisation. In this case, trading of health-related services sits within a 'global health' industry recently forced to face up to its colonial origins and their contemporary continuities (Horton, 2019). A respondent from a Royal College cited the ongoing 'spirit of colonialism that exists in the NHS' which is 'full of have-a-go Henrys' who understand global health as 'helping poor people pull themselves out of the mire'. The respondent stated that NHS health workers often have little exposure to other cultures, and even the electives frequently take place in 'old-fashioned mission hospitals' that retain 'the colonial point of view'. This awareness has changed how traditional aid-driven global health and its accompanying moral regimes are configured. Indeed, while this sentiment was somewhat more prevalent in our data gathered from Royal Colleges and social enterprises, UK respondents from both Royal Colleges and NHS Trusts were keen to emphasise that they took a different approach to aid-based initiatives, foregrounding a discourse of mutual learning. The provision of education and training, in particular, is depicted as fulfiling this responsibility; for instance, the Royal Colleges are described in a business development report as being at the forefront of 'assisting overseas healthcare systems and clinicians in reaching their health goals [through] information provision' (Gasking & Kalas, 2014), sharing the Colleges' knowledge and expertise 'without imposing UK specific structures' (ibid.). The respondent critical of the colonial mind-set in the NHS cited earlier similarly argued that, as academic institutions, the Royal Colleges can add great value to global health work by filling gaps in expertise. Respondents who used this line of argument foregrounded the need to create partnerships 'as equals' and avoid 'paternalistic' approaches (partnership manager, arms-length body, London). They emphasised the value of 'global knowledge exchange' (business development manager, NHS Trust) through such programmes in contrast to unilateral offers that can often be seen as 'imperialist' (international education manager, Royal College). A respondent working in a senior business role for a Royal College emphasised that when working internationally, the College aims to 'localise' its training to avoid this risk and stressed that their work is about 'partnership', filling gaps in expertise in other countries while also 'learning from partners' (international education manager, Royal College). This sentiment of reciprocity and partnership is especially strong in international commercial offers that blend the recruitment and training of nurses and allied health professionals, mirroring the WHO Global Code of Practice on the International Recruitment of Health Personnel that lays emphasis on mutual benefits and broader health system-related gains for sending countries. The Global Learners Programme, for instance, initially managed by HEE under its Global Health Partnerships initiative, has been described as a work-based educational experience in the UK that will 'enhance and add to their [recruits'] existing skills' (Health Education England, 2018). These programmes are not only represented as challenging the global 'brain drain' by involving a return element but also by placing great emphasis on education such that

they must be seen as investments in human resources for health outside the UK. Organisations involved in such programmes do not 'just want to be seen as those who are taking from countries but they [other countries] also get something' (manager, NHS Trust).

Indian respondents strategically mobilised the remnants of British colonial rule to advance their objectives, naturalising ties between the countries. Some argued that the UK and India were 'natural partners' (head, Indian trade association) and that an orientation towards the UK was 'part of our [Indian] culture' (co-chair healthcare chapter, Indian trade association). Some respondents, however, felt ambivalent about this, arguing that 'whether we like it or not, we have very strong connections to the UK' (director of India chapter, international project management company) and emphasising that there was still a 'Commonwealth mind-set' (CEO of a digital healthcare start-up) with little equality between the partners. Others emphasised that interactions are frequently short-term and unidirectional rather than formalised collaborations based on long-term commitments; as one respondent put it, 'we just paid some money and they [clinicians sent for specialised training] went' (COO of a Mumbai-based private hospital). Nonetheless, similarities in the educational, judicial and medical systems as well as the shared language facilitate collaborations with UK rather than US or other European stakeholders. Not least, these similarities and historical ties have created a large Indian diaspora that can be leveraged for building trade relations. This illustrates that India and the UK are being 'pulled closer and pushed apart by the shared colonial experience' (Wyatt, 2016), conditioning an often ambiguous relationship.

The focus on reciprocal relationships and mutual benefit advanced by UK-based respondents introduces the broader global (health) community especially that of the Commonwealth, as another actor in the making of the moral economies of healthcare exports and imports. At the same time, responsibility is raised for ameliorating the enduring effects of colonial expropriation and its effects on the governance of global health partnerships. This is in line with Trentman's observation of the discursive construction of obligations with former colonies in equitable and non-paternalistic ways. In other words, respondents balance the moral obligation to improve working conditions at home with the responsibility towards the enduring legacies of Empire. They do so by replacing more traditional aid-based relationships with trade relations, clad in moral arguments. Notably, the alternative to this trade-driven approach to global health equity, namely reparative strategies, was not discussed by respondents.

MORAL TENSIONS AND THE BOUNDARY WORK OF COMMODIFICATION

Respondents occupying various positions in UK–India trading for health worker education and training pointed to the contested nature of moral economies in this area. Underlying much of this was a conflicting moral sentiment over whether an activity should or should not be offered on a commercial basis. Respondents across a range of institutions noted long-standing relationships that traversed borders and which they considered 'philanthropic' in nature given the lack of commercial exchange involved. This included clinicians using study leave to travel from the UK to India to run training sessions or observerships in the UK for which participants paid no fee. But in the UK, this stance has been challenged by hospital leaders and government agencies concerned by the idea of 'giving away our services for free' (former global lead, UK government arms-length body), leading to disputed territory between individual clinicians, clinical departments and hospital managers. The result amongst these actors, and their counterparts in India, is a process of careful boundary work and negotiation along the continuum between philanthropic and commercial offers; here, we outline two strategies indicated by respondents.

Reconciliation through reinvestment

Despite several decades of commodification, NHS hospitals remain publicly owned and are largely free at the point of use for most people. Respondents noted that international commercial activities were seen by many staff, in particular frontline health workers but also senior managers, as of relatively little importance at a time of intensifying shortages in funding and staffing for their public service mandate. It was therefore often left to the commercial directors and business development teams to convince their colleagues of the merit of international commercial work. One starting point for this is a process of calculating costs to the hospital for placements by international visitors, in terms of staff time and other resources, as a demonstration of the financial losses incurred by existing activities. This is then used as a basis for introducing fees which are proposed to be 'reinvested' into strained public service provision. Trusts vary in their approaches regarding the nature of this reinvestment, variously allocating it to the host clinical departments to use for service provision, research or training; incorporating funds into hospital-level accounts; or holding them within a subsidiary company to finance the pursuit of further commercial opportunities. Some departments were more amenable to this commodification than others, for instance if there was more emphasis on some of the funds being held within the department as well as in departments with a stronger history of personal private work amongst clinicians. In other cases, as a business manager in a London-based Trust, noted, clinicians in their hospital were initially resistant to the commodification of observerships. They were eventually convinced on the basis that the structure, routines and processes for hosting fellows and observers already existed, rendering the fear of further pressure on already scarce resources unfounded. Today, the programme is being accepted across the Trust and is often perceived as leaving the ethical principles and morality of the core NHS values intact as it does not 'disturb' but only 'builds on' existing processes (business manager, NHS Trust).

The abstention from using precious NHS resources for trade in health worker education and training discursively reiterates primary responsibility for the provision of health services within the UK. Only the continuous reassurance that any surplus generated will be fed back into local services and will thus benefit the UK population averts a moral crisis. Here, frictions do not neatly unfold between clinical teams and business developers, but economic objectives are realised—or accepted—only to the extent that the moral primacy of local service provision is left intact. This is especially important as some disputed the use of minimal resources, suggesting that in-person training such as observerships can risk overburdening clinical departments, and different cultural sensibilities or value systems between hosts and observers can lead to conflict, conversely adding to the existing workload.

Detachment and dissociation

The relatively 'low-value' character of educational offers can also be mobilised to counter anticipated criticism of the commodification of health worker education, cast as leaving the moral integrity and inherent value of education intact. Respondents keenly emphasised that in contrast to more resource-intensive and high-risk opportunities, such as the provision of clinical care outside the UK, with educational offers 'the money doesn't make a big difference', as the lead for medical education at one Trust puts it. One respondent whose company offers educational content to Indian clients even noted that because their company did not generate much income, it was 'almost like charitable'. This suggests that educational offers may be valuable to some precisely because they do *not* generate significant revenue that can potentially perceived as unethical for public and even private sector actors. Engaging in education was often framed as noble or inherently good; one respondent,

providing education and training for newly recruited health professionals in the UK, emphasised that his organisation did not engage in this work to make 'huge profits [but] because it's right'.

The insistence on only small profit margins in educational offers works to appease those within and outside the organisation who may be critical of the pursuit of surplus value in both healthcare and education. Stated alternatively, the ethical value and inalienability of medical education is left unscathed precisely because monetary profits generated from their exports remain negligible, at least for larger Trusts with opportunities for much higher-income projects. The emphasis on minimum profit reflects an attempt to preserve a certain kind of moral integrity for the profession and public service against the accusations that might be levelled at commercial proponents. Here, then, tensions unfold between the moral framework and professional ethos purporting the ethical value of education and healthcare and the political-economic environment necessitating their commodification. Nonetheless, a few respondents questioned whether commercial work was ever appropriate in the NHS or equals 'selling your soul' (former director of global health, NHS arms-length body). As another respondent jokingly noted, while many in the NHS were more interested in more philanthropic approaches, they may now also have to consider some 'nasty commercial work' (senior civil servant, UK).

CONCLUSION: FROM MORAL ECONOMY TO MORAL ECONOMIES IN UK–INDIA EXPORTS IN HEALTH WORKER TRAINING AND EDUCATION

In this article, we have reviewed the evolvement of cross-border trade in health worker education and training between the UK and India from a moral economy lens. Deploying a discursive approach inspired by the work of Sayer, Busfield and others, we have used different sources to understand the discourses, practices and interactions by various actors in this space and how they justify their market-based activities. We have found that cross-border trade in health-related services between the UK and India claims to fulfil several aims and obligations simultaneously: it produces significant patient and health system benefits, allows institutions and individuals to navigate marketised systems for financing and labour, and it contributes to building more reciprocal relationships in global health collaborations. But trade in health worker education and training also poses a challenge to established, non-commodified ways of working, forcing individuals to engage in the boundary work that will make the 'dirty work' of trading more palatable to its critics.

The examples we discuss in this article point to the ethical norms and practices that shape connections across national borders, illustrating the complex moral-economic regimes in health worker education and training between the UK and India. Aiming to forgo colonial relations of dependence and domination, reckoning with both the shifting global sentiment in health worker education and mobility as well as India's rise as an economic superpower, these new regimes centre on reciprocity rather than dependency as the ethical way to do *postcolonial* health business. Prevalent in the discursive strategies we have analysed is a liberal, individualist stance that centres on the principal equality of actors involved in economic transactions. The production and consumption of health-related services are cast as establishing or buttressing a partnership between equals. We have not only illustrated that economic and ethical arguments are inherently interrelated but also that increasing trade in health worker education and training cannot be prised apart from broader moral frameworks that govern which practices are considered acceptable and which are not. However, the assumption that power asymmetries are being addressed as relations are marketised is inherently problematic, as the historical trajectory of neoliberalism has shown. Increasing liberalisation and the marketisation of basic social services has, in contrast, led to a greater concentration of wealth

and power in the hands of a few as well as higher levels of inequality within and across societies. While the trading of health services may evoke sentiments of reciprocity and independence, it may well lead to the further accumulation of wealth for a few, already privileged actors.

We have shown how multiple and sometimes contradictory moral economies unfold between and across different audiences and allegiances. Our respondents juggle multiple regimes of value, and frictions unfold across and within individual institutions, the larger public and, not least, between Indian and UK actors. Even those moral economy approaches in line with Sayer's rendering of the concept have sometimes emphasised *the* moral economy of a particular (scientific) community (e.g., Rasmussen, 2004); in contrast, we have aimed to show that multiple such economies are at play across different communities, shaping the discourses and practices of the members of such communities. Our analysis thus steers the discussion of moral economy away from a simple contrast between contradictory arguments or practices from dominant and stable groups of social actors with coherent but incompatible moral frameworks. Tensions and frictions exist at multiple levels. For instance, while the value of free education seemingly clashes with a growing entrepreneurial spirit and the external pressure to innovate in the UK, respondents construct a fragile compromise through specific offers in health worker education and training, the profits of which are reinvested into local service provision.

Not all offers are equally acceptable though, and the negative connotations of healthcare exports need continuous discursive work. In India, a context in which for-profit healthcare and education have long been normalised, respondents across public and private sectors advocated for international collaborations independent of whether they are commercial or philanthropic in nature. While some Indian respondents expressed unease over exploitative practices and unreasonable profiteering, there was no general opposition to profit-oriented offers. As Sayer (2000) argues, normative questions tend to be forgotten once particular economic practices have become established such that legitimations may scarcely be needed. In some sense, then, there was a consensus amongst many India-based respondents that cross-border trading in education and training between the UK and India was an obvious activity in contexts where states had revoked responsibility for the adequate training and resourcing of the public healthcare system.

Situating cross-border trade in health worker education and training in a moral economy framework, this article has shed light on the social context and moral worlds in which this trade is embedded. While existing scholarship on trade in health-related services has predominantly focused on the description of their contours and evolvement, we have interrogated the meanings and rationales of the different actors engaging in it. This way, this article has expanded the understanding of trading in health-related services through the analysis of the morally charged discourses and practices surrounding it, testifying to the larger social and cultural frameworks that mould these practices and *vice versa*. As transnational trade in health worker education and training, along with other knowledge services, appears to be growing, prying open its complexity, social dynamics and global governance is key to the understanding of the globalisation of healthcare provision and to ultimately assess its consequences.

AUTHOR CONTRIBUTIONS

Sibille Merz: Conceptualization (lead); data curation (lead); formal analysis (equal); methodology (lead); writing – original draft (lead). **Benjamin Hunter**: Conceptualization (equal); funding acquisition (supporting); methodology (supporting); project administration (lead); supervision (lead); writing – original draft (supporting); writing – review & editing (equal). **Ramila Bisht**: Data curation (supporting); funding acquisition (equal); supervision (supporting); writing – review & editing (equal). **Susan Fairley Murray**: Funding acquisition (lead); investigation (equal); project administration (equal); supervision (supporting); writing – review & editing (equal).

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DATA AVAILABILITY STATEMENT

According to UK research councils' Common Principles on Data Policy, data supporting this study will be openly available via the UK Data Service at https://www.ukdataservice.ac.uk/.

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